International Journal of Social Science Research and Review

http://ijssrr.com
editor@ijssrr.com
Volume 9, Issue 5
May, 2026
Pages: 253-267

Perception and Use of Contraceptives Amongst Couples in Cameroon:
An Anthropological Qualitative Approach in Urban and Semi-Urban Contexts of Yaoundé

Dr Kah Evans Ngha

Lecturer, University of Yaoundé I, Cameroon

Correspondence: kahngha@yahoo.com

http://dx.doi.org/10.47814/ijssrr.v9i5.3404

Abstract

Reproductive health in sub-Saharan Africa, including Cameroon, faces challenges from high fertility rates, unintended pregnancies, and modest modern contraceptive prevalence despite near-universal awareness. This qualitative anthropological study explores perceptions and practices of contraceptive use among couples in urban and semi-urban Yaoundé, Cameroon. Drawing on semi-structured interviews with diverse informants (predominantly women, aged 24-50, varying in marital status, profession, religion, and education) conducted in November 2025, the research employs thematic analysis to examine knowledge, side effects, couple communication, religious/cultural influences, and decision-making. Findings reveal high awareness of modern methods (e.g., pills, condoms, emergency contraception) but selective, intermittent use hindered by experiential side effects (e.g., irregular bleeding, perceived bodily rejection), fears of infertility, and socio-cultural reservations. While benefits like birth spacing and maternal health are acknowledged, barriers include gender asymmetries in responsibility and nuanced religious interpretations. Grounded in medical anthropology (Helman, 2007), socio-cultural critiques (Fassin, 2010), and gender/power dynamics (Blanc, 2001; Giddens, 2009), the study highlights couple communication as a facilitator and advocates for context-sensitive interventions that are couple-centered counseling, side-effect management, and religious engagement to bridge the knowledge-use gap. These insights inform policies toward Sustainable Development Goals 3 and 5 in Cameroon's evolving urban reproductive landscape.

Keywords: *Contraceptives; Couple; Side Effects; Gender; Perception; Cultural Norms*

1. INTRODUCTION

Reproductive health, particularly the perception and utilization of contraceptives among couples, represents a critical intersection of public health, cultural norms, and social dynamics in developing contexts. In sub-Saharan Africa, where fertility rates remain high and unintended pregnancies contribute significantly to maternal mortality and socioeconomic burdens, understanding how couples navigate contraceptive decisions is essential for effective policy interventions (Bongaarts, 2016). Cameroon, a diverse nation with a population exceeding 27 million as of recent estimates (World Bank, 2023),

exemplifies these challenges. Despite national efforts to promote family planning such as the integration of reproductive health services into primary care under the Ministry of Public Health the modern contraceptive prevalence rate (mCPR) among women in union stands at approximately 19.2% based on 2024 projections, with urban areas showing slightly higher adoption rates than rural ones (FP2030, 2024). This modest uptake occurs against a backdrop of near-universal knowledge of at least one contraceptive method (over 95% among women aged 15–49), highlighting a persistent gap between awareness and action (Institut National de la Statistique [INS] & ICF, 2020).

This article presents a qualitative exploration of contraceptive perceptions and practices among couples in urban and semi-urban settings of Yaoundé, Cameroon's capital. Drawing from semi-structured interviews and focus group discussions conducted in November and December 2025, the study captures the lived experiences of informants — predominantly women, with some couples and one male participant — ranging in age from 24 to 50 years. These individuals represent varied socio-demographic profiles: marital statuses (married, cohabiting, engaged), professions (nurse, housewife, professor, trader), religions (Muslim, Catholic, Christian, Adventist), and educational levels (from secondary to Master's). The interviews, spanning 30–45 minutes each, probed themes such as knowledge of methods, advantages and disadvantages, side effects, couple communication, and religious/cultural influences, yielding rich verbatim data for thematic analysis.

The persistence of low contraceptive uptake in Cameroon underscores a broader global issue: reproductive choices are not merely biomedical decisions but are profoundly shaped by socio-cultural contexts (Fassin, 2010). In urban Yaoundé, where modernization and education facilitate greater exposure to health information, perceptions often blend pragmatic acceptance of modern methods (e.g., condoms, pills, and emergency contraception) with reservations rooted in personal experiences of adverse effects, such as irregular bleeding or bodily rejection (Hubacher et al., 2015). This duality is evident in the informants' narratives: while benefits like birth spacing and maternal health are acknowledged, barriers like fear of long-term infertility or relational discord deter consistent use (Sedgh et al., 2016). Nationally, these patterns contribute to an unmet need for modern contraception estimated at 18–19%, disproportionately affecting women in unions and leading to elevated rates of unintended pregnancies (INS & ICF, 2020).

Theoretically, this study is grounded in medical anthropology, which emphasizes the distinction between "disease" (biomedical pathology) and "illness" (subjective, culturally mediated experience) in health interventions (Helman, 2007). Contraceptive side effects, for instance, are not just physiological but are interpreted through lenses of bodily autonomy, fertility ideals, and social expectations. Complementing this is a socio-cultural framework drawing on Fassin's (2010) critique, which views reproductive health as a moral and political arena where global biomedical discourses intersect with local norms such as the valorization of large families in Cameroonian societies. Gender and power dynamics further enrich the analysis, informed by Blanc's (2001) work on relational power imbalances and Giddens' (2009) concept of reflexive modernity, highlighting how urban education enables more deliberate reproductive planning.

Methodologically, the research employs a qualitative, inductive approach to prioritize emic perspectives the informants' own interpretations over etic (external) assumptions. Data collection occurred from October 10 to November 11, 2025, using a semi-directive interview guide to allow flexibility while ensuring coverage of key domains: general knowledge, usage and consequences, and decision-making processes. Thematic analysis, guided by Braun and Clarke (2006), identified recurring motifs such as communication as a facilitator, side effects as a barrier, and religious nuance as a modulator. Ethical considerations included informed consent, anonymity (via pseudonyms), and contextualization with socio-demographic details to enhance interpretative depth.

The significance of this work extends beyond academia. In Cameroon, where maternal mortality remains high (around 406–529 per 100,000 live births; WHO, 2023), insights from urban contexts like

Yaoundé can inform targeted interventions. By elucidating how couples negotiate choices amid cultural, religious, and experiential factors, the study advocates for couple-centered counseling, religious leader engagement, and improved management of side effects to bridge the knowledge-use gap (Cleland et al., 2012). Ultimately, this contributes to Sustainable Development Goals, particularly SDG 3 (good health and well-being) and SDG 5 (gender equality), by promoting equitable reproductive autonomy (United Nations, 2015).

2. LITERATURE REVIEW

The literature on contraceptive perceptions and use in sub-Saharan Africa, particularly Cameroon, reveals a persistent paradox: near-universal knowledge of modern methods coexists with low adoption rates, driven by socio-cultural, experiential, and relational factors rather than mere information deficits.

Nationally, Cameroon's modern contraceptive prevalence rate (mCPR) among women in union remains modest at approximately 19.2% (FP2030, 2024 projections), with urban areas showing higher uptake than rural ones, against a backdrop of >95% awareness of at least one method (INS & ICF, 2018/2020). This gap contributes to unmet need for modern contraception (~18–19%) and elevated unintended pregnancies, exacerbating maternal mortality (around 258–529 per 100,000 live births; WHO, 2023; UNFPA, 2025). Globally and regionally, unintended pregnancies account for high abortion rates, with contraception averting significant unsafe procedures and maternal deaths (Bearak et al., 2020; Sedgh et al., 2016; Cleland et al., 2012).

From a medical anthropological perspective, contraceptive side effects are not solely biomedical (disease) but culturally interpreted as disruptions to bodily integrity, femininity, or fertility (illness), leading to discontinuation despite acknowledged efficacy (Helman, 2007; Hubacher et al., 2015). Local explanatory models often amplify fears of long-term infertility or "bodily rejection," common in sub-Saharan contexts (Jaffré & Suh, 2016).

Socio-culturally, reproduction intersects with moral economies where large families symbolize prosperity, lineage continuity, and divine blessing, clashing with biomedical family planning imperatives (Fassin, 2010). Religious influences vary: conservative Christian/Adventist views may frame contraception as limiting procreation to pleasure, while Islamic and pragmatic urban adaptations permit temporary methods for health/spacing (Agadjanian & Hayford, 2009; Bongaarts, 2014).

Gender and power dynamics further shape decisions, with women disproportionately bearing responsibility amid unequal negotiation, partner opposition, or indifference- patterns prevalent in African unions (Blanc, 2001; Sedgh et al., 2016). Urban education fosters reflexive modernity, enabling deliberate couple planning and communication (Giddens, 2009), though asymmetries persist.

Methodologically, qualitative approaches prioritize emic perspectives to unpack lived experiences beyond quantitative surveys (Braun & Clarke, 2006). This study builds on these frameworks to examine urban Yaoundé's hybrid realities pragmatic acceptance blended with cultural-religious cautions offering grounded insights for culturally attuned interventions.

3. RESEARCH OBJECTIVES

General Objective: The primary aim of this anthropological qualitative study is to explore the perceptions and lived practices of contraceptive use among couples in urban and semi-urban contexts of Yaoundé, Cameroon, emphasizing emic interpretations shaped by cultural, religious, experiential, and relational factors.

Specific Objectives:

- To document informants' knowledge and definitions of contraceptive methods, including awareness of modern options (e.g., pills, condoms, injections, emergency contraception) and sources of information.
- To examine perceived benefits (e.g., birth spacing, maternal/child health, reproductive autonomy) and inconveniences (e.g., side effects like irregular bleeding, weight gain, fears of infertility or bodily rejection) influencing adoption and discontinuation.
- To investigate intra-couple communication, decision-making processes, and gender/power dynamics in negotiating contraceptive choices.
- To analyze religious and cultural influences on perceptions and use, including how norms around fertility, sexuality, and large families modulate acceptance.
- To identify barriers (e.g., myths, partner opposition, access issues) and facilitators (e.g., open dialogue, professional advice) to consistent modern contraceptive use.
- To provide context-specific recommendations for interventions such as couple-centered counseling, improved side-effect management, and religious leader engagement to reduce unmet need, unintended pregnancies, and maternal health risks.

4. THEORETICAL FRAMEWORK

This manuscript draws on an interdisciplinary theoretical framework rooted in medical anthropology, socio-cultural approaches to reproduction, and gender and power dynamics in reproductive decision-making. The framework integrates three complementary perspectives to explain how individuals and couples interpret, negotiate, and adopt (or reject) contraceptive methods.

4.1 Medical Anthropology: Lived Experiences of Health Interventions

Central to this study is the anthropology of illness and health as developed by medical anthropologists like Cecil Helman and Arthur Kleinman. Helman (2007) distinguishes between disease (the biomedical, physiological condition) and illness (the subjective, culturally shaped experience of being affected by a health intervention). In the context of contraception, side effects like irregular bleeding, weight changes, or perceived "rejection" of methods are not merely physiological but are interpreted through personal and cultural lenses. What biomedicine labels as a manageable side effect may be experienced as a profound disruption to bodily integrity, femininity, or future fertility leading to discontinuation even when effectiveness is recognized.

This perspective highlights why high knowledge of modern methods does not always translate to sustained use: perceptions are shaped by embodied experiences, local explanatory models of the body, and fears of long-term harm (e.g., infertility myths common in sub-Saharan Africa). It aligns with ethnographic work showing that reproductive technologies are reinterpreted within local cosmologies of fertility and health (Jaffré & Suh, 2016).

4.2 Socio-Cultural and Critical Approaches to Reproduction

Building on Didier Fassin (2010) and related critical medical anthropology, the framework views contraception as embedded in broader social logics of reproduction. Reproduction is not just biological but a site where power, morality, identity, and social reproduction are negotiated. In Cameroon, where large families often symbolize prosperity, divine blessing, or lineage continuity, contraceptive use can conflict with cultural valorization of fertility especially in religious contexts.

Fassin's work emphasizes how global health interventions (like family planning programs) intersect with local moral economies and historical inequalities. Urban pragmatism reflects exposure to modernizing influences, while lingering preferences for "natural" contact or fears of side effects echo persistent socio-cultural resistances. This lens also incorporates insights from West African

ethnographies, where reproductive health programs struggle due to mismatches between technical biomedical goals and lay social realities (Jaffré & Suh, 2016).

4.3 Gender, Power Dynamics, and Couple Decision-Making

A key dimension is the role of power within sexual and reproductive relationships, as theorized by Anne K. Blanc (2001) and Anthony Giddens (2009). Blanc's framework examines how imbalances in relationship power affect whose preferences dominate in contraceptive choices, often disadvantaging women through limited autonomy, partner opposition, or unequal negotiation. Women in this study frequently assumed primary responsibility, reflecting common gender asymmetries in sub-Saharan Africa where men may hold veto power or remain less involved.

Giddens' concept of reflexive modernity and structuration adds nuance: couples engage in ongoing negotiation and reflexivity about their reproductive futures, influenced by education, urban exposure, and communication. Open dialogue enables more equitable decisions and better adherence, while power imbalances can reinforce non-use or covert use.

4.4 Integration of the Framework

These three strands are interconnected: medical anthropology provides the lens for subjective perceptions of contraceptive effects; socio-cultural approaches contextualize them within moral and historical reproductive logics; and gender/power theories explain intra-couple negotiation processes. Together, they form a holistic model for understanding why contraceptive perceptions in urban Yaoundé are pragmatic yet cautious shaped by biomedical knowledge, cultural-religious norms, and relational power while highlighting pathways for context-sensitive interventions.

5. METHODOLOGY

5.1 Research Design

This study adopted a qualitative approach based on semi-structured interviews and focus group discussions (FGDs), consistent with phenomenological research designs commonly used to explore health-related behaviors and social phenomena in resource-limited settings (Creswell & Poth, 2018). Qualitative methodologies are particularly well-suited to understanding the lived experiences, motivations, and perceptions of diverse actors within reproductive health contexts (Pope & Mays, 2020).

5.2 Study Population and Participants

Data collection occurred from October 10 to November 11, 2025, in urban and semi-urban districts of Yaoundé, including Medong, Melen, Simbock, and Etoug-Ebe. Participants were recruited through purposive sampling and included seven informants representing diverse profiles: predominantly women (ages 24–50), varying in marital status (married, cohabiting, engaged), professions (nurse, housewife, professor, trader, teacher), religions (Muslim, Catholic, Christian, Adventist), and educational levels (secondary to Master's). One male participant was included to capture the male perspective on couple decision-making.

5.3 Data Collection

Four types of data collection instruments were employed: individual semi-structured interviews (30–45 minutes each), three-couple focus group discussions, women-only FGDs, and mixed discussions. Interview guides were developed to cover key thematic domains: general knowledge of contraceptive methods, perceived benefits and inconveniences, personal usage experiences, intra-couple communication, and religious/cultural influences. Interviews were conducted in French and/or local languages as appropriate.

5.4 Data Analysis

Data were analyzed using thematic and comparative analysis as described by Braun and Clarke (2006). Interviews were recorded, transcribed verbatim, and coded inductively to identify recurring patterns, themes, and divergences across informant responses. Key analytical themes that emerged included: awareness versus use gaps; side effects as experiential barriers; couple communication as a facilitating factor; religious and cultural modulation; and gender asymmetry in contraceptive responsibility.

5.5 Ethical Considerations

Informed consent was obtained from all participants prior to data collection. Anonymity was ensured through the use of pseudonyms and removal of identifying information. Socio-demographic details were retained in aggregate to enhance interpretative depth while protecting individual privacy.

6. RESULTS AND ANALYSIS

6.1 Contraceptive Awareness

All informants reported awareness of contraceptive methods, confirming high knowledge levels consistent with national surveys (INS & ICF, 2020). Definitions offered spanned practical to empowering conceptualizations:

> "Contraceptives are means of preventing pregnancies or methods of avoiding pregnancies."
>
> **Chantal, 24 years old, Medong, Yaoundé, 10/25/2025**

> "Yes, I heard about it and I have a lot of patients about it and I too tried it but my body really rejected it..."
>
> **BAIDA, 24 years old, nurse, MELEN, 10/30/2025**

BAIDA's response demonstrates working knowledge combining professional observation and personal experience. Medical anthropology distinguishes between illness (personal perception) and disease (physiological condition); the biological rejection of the contraceptive illustrates this distinction (Helman, 2007). Some informants listed methods spontaneously "pills, morning-after pills, IUD, condom, diaphragms" reflecting the importance of health education in building decision-making autonomy (UNFPA, 2019).

> "Conception for me means taking control of my reproductive health..."
>
> **NDI DOFLINE, 35 years old, Yaoundé**

NDI DOFLINE's framing reflects a shift from pregnancy prevention to broader reproductive agency, consistent with literature showing that education and urban exposure promote more empowered contraceptive orientations (Cleland et al., 2012).

6.2 Contraceptive Use Patterns

Many couples use contraceptives, though the decision often comes after having a number of children and when the need is considered critical. Use patterns varied considerably across the sample from consistent combined methods among younger non-parent couples, to intermittent or post-birth use among those with children.

> "Condoms and morning-after pills according to our needs and our situation."
>
> **and Bertrand, 24 and 34 years old, cohabiting, Medong, 10/25/2025**

The combined use of modern methods demonstrates the contraceptive pragmatism of young couples, influenced by the risks of early pregnancies and infections (Bongaarts, 2016). Flexible planning is consistent with WHO and UNFPA recommendations for young adults.

> "Yes, my wife has been taking the pill for a few months. We decided together that this was the best option for us at the moment."
>
> **Captain Alfred, 04/11/2025, Yaoundé**

The adoption of the pill by the spouse illustrates a typical distribution of contraceptive responsibilities in many African couples, where women assume direct responsibility for fertility regulation (Sedgh et al., 2016). The joint decision shows that marital dialogue is a determining factor in the choice and effectiveness of contraceptive methods.

6.3 Contraceptives and bortion Prevention

Informants consistently linked contraceptive use to the prevention of unintended pregnancies and consequently abortions:

> "Contraceptives are used to avoid abortions because when people have unwanted pregnancies they will likely abort."
>
> **Focus group participant, Yaoundé**

This statement reflects a widely documented public health rationale for contraceptive use. Bearak et al. (2020) estimated that approximately 48% of all pregnancies worldwide are unintended, and that 56% of unintended pregnancies end in induced abortion. Scientific evidence supports the participant's core intuition: increased access to effective contraception significantly reduces rates of unintended pregnancy and thereby reduces recourse to induced abortion (Cleland et al., 2012). It is important to note that contraceptives prevent pregnancy through various mechanisms none of which constitutes abortion (WHO, 2020).

Regarding the benefits of contraception in general, informants could easily articulate birth-spacing rationale:

> "This allows you to have your own program to give birth, to limit the number of children..."
>
> **BAIDA, 24 years old, nurse, MELEN, 10/30/2025**

6.4 Inconveniences and Side Effects Encountered

Side effects emerged as the most frequently cited barrier to consistent contraceptive use. Informants reported experiences across multiple methods:

6.4.1 Irregular Bleeding and Hormonal Disruption

> "The injection caused irregular bleeding over eight months..."
>
> **BAIDA, 24 years old, nurse, MELEN, 10/30/2025**

> "Yes, I tried the pill, but it didn't work... it made my cycle even longer, like I had cycles of thirty-one, thirty-five days... We switched to injections. I stopped bleeding completely... so after that personal experience, I decided that I really didn't want anything to do with synthetic hormones."
>
> **BINDZI ALEXANDRA / OLOMO NICOLAS, 29 years old, Etoug-Ebe, Catholics**

The experiences described are scientifically grounded. Progestin-only methods (pills, injectables, implants) frequently cause unpredictable spotting, prolonged bleeding, or amenorrhea due to progestin's effect on endometrial vascularisation and stability (Glasier, 2010). Depot medroxyprogesterone acetate (DMPA) injections: approximately 55% of users experience no periods after 1 year, increasing to 68% after 2 years (Kaunitz, 1994). After discontinuation, return to fertility is often delayed, with median time to conception around 9 months (Pardthaisong, 1980).

6.4.2 Weight Gain

The participant correctly identifies weight gain as one of the most commonly reported side effects of hormonal contraceptives (Gallo et al., 2014). Progestin-only injectables (DMPA) are associated with a modest but consistent increase in body weight (1–2 kg over 12 months), attributed to progestin-stimulated appetite and possible fluid retention (Pantoja et al., 2010). However, combined oral contraceptives show no significant causal evidence of weight gain in most women (Lopez et al., 2013).

6.4.3 Fears of Infertility

The fear of contraceptives causing infertility was widely held, especially among women in focus groups who were vocal in restricting younger, single women from using contraceptives. This belief — scientifically unsupported for reversible modern methods (Polis et al., 2016) represents a significant barrier that deters young and nulliparous women from effective family planning. Addressing such beliefs through evidence-based, culturally sensitive counselling is essential (Cleland et al., 2012).

6.4.4 The Diaphragm and Positional Risk

> "There is the sterility pill... it is still risky because it must remain on a particular position in the vagina and if it shakes, it will likely lead to pregnancy during intercourse."
>
> **FGD participant, Yaoundé**

The participant appears to be describing the contraceptive diaphragm or cervical cap (Trussell, 2011) a dome-shaped, flexible silicone or latex cup inserted to cover the cervix, typically used with spermicide. With perfect use, it achieves approximately 94% efficacy; with typical use, efficacy drops to approximately 88% (Trussell, 2011). Displacement risk is a recognized cause of method failure.

6.5 Condoms as Preferred Method

> "I think preservatives (condoms) are the best because they don't have side effects when used."
>
> **Raissa, 31 years old, married, November 2025**

This claim is largely accurate. Male and female condoms are barrier methods and do not introduce hormones or chemicals into the systemic circulation (WHO, 2020). Consequently, they do not cause weight gain, hormonal disruption, or menstrual irregularities. Condoms are also the only contraceptive method offering simultaneous protection against both unintended pregnancy and sexually transmitted infections including HIV (WHO, 2020). However, a latex allergy (1–6% of the general population) can cause local irritation or allergic reactions (Sussman et al., 2002).

6.6 Periodic Abstinence and Calendar Method

> "Though when using preservatives one does not have enough satisfaction, one does not use it throughout. It is only during fertile periods that one uses because the objective is to prevent pregnancy right... Really, it is challenging because when one thinks that it is the safe period, that is where one instead gets pregnant."
>
> **FGD participant, Yaoundé**

This statement reveals the use of calendar-based methods (CBMs), specifically the Rhythm Method a form of Fertility Awareness-Based Methods (FABMs). The Calendar/Rhythm Method has a typical-use failure rate of approximately 24% per year (Trussell, 2011), due to cycle irregularity, stress, illness, and breastfeeding shifting ovulation unpredictably (Pyper & Knight, 2001). The perceived reduction in satisfaction from consistent condom use is a documented driver of inconsistent use, which in turn elevates both pregnancy and STI risk (Moreau et al., 2012).

6.7 Communication and Decision-Making Within the Couple

Couple communication emerged as a central facilitating factor in contraceptive adoption and adherence. Most informants reported making contraceptive decisions jointly:

> "Yes, we discuss our choices openly, this is essential to avoid misunderstandings and plan correctly."
>
> **NDI DOFLINE, 35 years old, housewife, Yaoundé, 11/11/2025**

Open communication within the couple is a key determinant of contraceptive adoption (Foucault, 1990). Couples who share decisions about contraception are more likely to use methods consistently, reducing the risks of unwanted pregnancies and sexually transmitted infections. However, some women also reported covert or autonomous use of discreet methods:

> "I even prefer super discreet contraceptives like intrauterine devices. We can be there, I have my device, you don't know about it, you'll never know... contraception is extremely important in a relationship, in a woman's life, even in a man's life."
>
> **FGD with three couples, 13th November 2025**

> "I'm a feminist and a misandrist... When you decide how you're going to plan your life and how you're going to space out the births of your children, it gives you more confidence, more ease in managing your life."
>
> **FGD with three couples, 13th November 2025**

The duality between shared decision-making and female-led management reflects the persistent gender asymmetries Blanc (2001) identifies in African reproductive contexts. Some couples expressed tensions around contraceptive use without spousal consent, with participants noting that covert use can cause conflict and infidelity.

6.8 Religious and Cultural Influences

> "In my religion, sexuality in marriage is not prohibited, but it is primarily used for reproduction. Preventing reproduction is seen as limiting sexuality to pleasure only, which is culturally and religiously sensitive."
>
> **Nathanael, 30 years old, Adventist French teacher, Yaoundé, 11/11/2025**

Nathanael's response highlights the impact of religion and culture on contraceptive decisions. Anthropological studies show that religious norms influence not only the perception of contraception, but also the way couples plan their families (Agadjanian & Hayford, 2009). In contrast, Muslim and Catholic informants demonstrated more pragmatic urban adaptation, using methods without strong doctrinal conflict. These variations illustrate Fassin's (2010) socio-cultural critique: reproductive practices are embedded in moral economies where global biomedical imperatives intersect with local values such as the cultural valorization of large families in Cameroonian societies.

6.9 Role of Health Professionals

> "Health professionals advise us on how a couple should manage their sexuality and direct us towards appropriate contraceptive methods."
>
> **Bertrand, 34 years old, Medong, 10/25/2025**

The intervention of health professionals is essential to guarantee correct and safe use of contraceptives. Scientific literature shows that education provided by expert's increases couples' confidence in the methods chosen and reduces the risk of errors or unmanaged side effects (Cleland et al., 2012). Professional advice also helps to deconstruct cultural or religious myths around contraception. In medical anthropology, access to reliable information allows couples to make informed decisions adapted to their socio-cultural context (Helman, 2007).

6.10 Alternative and Traditional Methods

> "Traditionally, in the village we used the 'selle', here in town we use condoms and morning-after pills."
>
> **BIDIAS AGOUME JACQUELINE, 50 years old, Yaoundé, 04/11/2025**

The evolution of contraceptive practices shows the influence of modernization and urbanization. Traditional practices coexist with modern methods, illustrating cultural adaptation (Godelier, 2012). The perception of risk and side effects influences the transition to medicalized methods.

7. DISCUSSION

The findings from this qualitative study provide a nuanced understanding of contraceptive perceptions and practices among couples in urban and semi-urban Yaoundé, Cameroon, highlighting the interplay between knowledge, experiential barriers, socio-cultural norms, religious influences, and intra-couple dynamics. Overall, the informants exhibited a high level of familiarity with modern contraceptive methods such as oral pills, injections, condoms, intrauterine devices (IUDs), and emergency contraception consistent with national surveys indicating knowledge rates exceeding 95% among women aged 15–49 (INS & ICF, 2020). However, this awareness did not uniformly translate into sustained adoption, with selective or intermittent use prevailing due to perceived risks and contextual factors.

These experiential barriers underscore the relevance of medical anthropology's framework, particularly Helman's (2007) distinction between "disease" (biomedical pathology) and "illness" (subjective, culturally mediated experience). In the informants' narratives, side effects were not merely physiological but were interpreted as disruptions to bodily harmony, fertility potential, or even relational stability fears amplified by local myths of infertility prevalent in sub-Saharan African contexts (Cleland et al., 2012). This subjective lens explains why, despite recognizing benefits like birth spacing and reduced maternal mortality, many preferred non-hormonal or episodic methods such as condoms. Such patterns reflect broader regional trends, where modern contraceptive prevalence (mCPR) in Cameroon remains at an estimated 19.2% in 2024 projections, far below the FP2030 target of 35% by 2030 (FP2030, 2024).

Religious and socio-cultural influences added further complexity, often modulating rather than outright prohibiting use in this urban sample. Nathanael, an Adventist informant, exemplified conservative interpretations by linking contraception to a moral diminishment of sexuality's procreative purpose, echoing studies on religious conservatism in sub-Saharan Africa where devout adherents report lower contraceptive uptake due to views of fertility as a divine mandate (Agadjanian & Hayford, 2009; Agadjanian, 2019). In contrast, Muslim informants like BAIDA emphasized practical advice and a more permissive stance on temporary methods for health and spacing — consistent with flexible Islamic interpretations that allow contraception when not permanent or abortive (Bongaarts, 2014). Catholic and general Christian participants demonstrated pragmatic adaptation using condoms and emergency pills without overt doctrinal conflict, which may stem from urban secularization and education diluting traditional prohibitions (Cleland et al., 2012). These variations highlight Fassin's (2010) socio-cultural critique: reproductive practices are embedded in moral economies where global biomedical imperatives intersect with local values.

Gender power dynamics within couples emerged as a pivotal determinant of contraceptive decisions, with women frequently assuming the primary burden of method selection and management. This asymmetry reflects broader patterns in African contexts, where women bear disproportionate responsibility for fertility regulation amid male partner opposition or indifference, often rooted in patriarchal norms (Blanc, 2001; Sedgh et al., 2016). However, the study also identified communication as a mitigating factor: open dialogue, as in NDI DOFLINE's regular discussions or Capitaine Alfred's joint planning, fostered mutual agreement and adherence, supporting Giddens' (2009) theory of reflexive modernity, wherein educated urban couples engage in deliberate negotiation of reproductive futures.

Strengths of this study lie in its qualitative depth, capturing emic perspectives through verbatim analysis and socio-demographic contextualization, which adds richness absent in large-scale surveys (Braun & Clarke, 2006). Limitations include the small, purposive sample (n=7), which limits generalizability beyond urban Yaoundé, and potential social desirability bias in self-reported behaviors. Future research could employ mixed methods combining qualitative insights with longitudinal quantitative tracking or expand to rural and northern regions to explore contextual variations amid ongoing armed conflicts and economic pressures (Nsashiyi et al., 2024). Compared to rural Cameroon, the urban sample shows advantages: better access to information and services leads to more flexible use, while rural barriers (distance, myths, stronger traditional/religious constraints) keep contraceptive prevalence lower (FP2030, 2024).

8. CONCLUSION

This qualitative study has illuminated the multifaceted perceptions and practices surrounding contraceptive use among couples in urban and semi-urban Yaoundé, Cameroon. Through in-depth semi-structured interviews with seven informants representing diverse socio-demographic profiles — ranging from young professionals to middle-aged traders, across Muslim, Catholic, Christian, and Adventist affiliations the research reveals a landscape where high knowledge of modern methods coexists with selective and often inconsistent adoption.

Informants demonstrated familiarity with options such as condoms, oral pills, injections, and emergency contraception, frequently citing benefits like birth spacing, improved maternal health, and greater family planning autonomy. Yet, sustained use was frequently undermined by embodied experiences of side effects irregular bleeding, perceived bodily rejection, or hormonal disruptions echoing the medical anthropological distinction between biomedical "disease" and culturally interpreted "illness" (Helman, 2007). These subjective interpretations, amplified by fears of long-term infertility or relational strain, contributed to method discontinuation or preference for less invasive options like condoms and morning-after pills.

Religious and cultural influences emerged as nuanced rather than absolute barriers in this urban context. While some informants framed contraception as potentially reducing sexuality to mere pleasure and conflicting with procreative ideals, others exhibited pragmatic adaptation, prioritizing health and spacing without invoking strict doctrinal prohibitions. This urban flexibility contrasts with more rigid rural patterns, where traditional fertility norms and limited service access further suppress uptake (FP2030, 2024; Nsashiyi et al., 2024). Gender dynamics further shaped decisions: women often assumed primary responsibility for contraceptive management, reflecting persistent asymmetries in reproductive power (Blanc, 2001), though open couple communication emerged as a powerful facilitator of joint, informed choices and improved satisfaction (Giddens, 2009).

These findings align with national trends in Cameroon, where modern contraceptive prevalence (mCPR) has gradually increased to an estimated 19.2% in 2024 projections, yet unmet need for modern methods remains substantial at approximately 18.7%, contributing to high rates of unintended pregnancies and a maternal mortality ratio of around 258 deaths per 100,000 live births in 2023 (FP2030, 2024; UNFPA, 2025; WHO et al., 2023).

The implications are both practical and urgent. At the policy level, Cameroon's FP2030 commitments to raise mCPR toward 35% by 2030 and reduce unmet need to 10% require intensified, culturally attuned strategies (FP2030, 2024). These should include couple-centered counseling to strengthen communication and shared decision-making, enhanced management of side effects through better client education and follow-up, and strategic engagement with religious leaders to address interpretive concerns (Agadjanian & Hayford, 2009). Community-based interventions, such as training local health workers and integrating family planning into routine services, could bridge urban-rural divides, particularly in northern regions where unmet need and cultural constraints are more pronounced (Nsashiyi et al., 2024).

In sum, this study demonstrates that contraceptive use in contemporary Cameroonian couples is far more than a technical or biomedical matter it is deeply embedded in embodied experiences, relational negotiations, religious meanings, and socio-cultural worlds. By centering the lived realities of informants, the study contributes valuable emic insights to the ongoing effort to advance reproductive autonomy, reduce unintended pregnancies, and improve maternal and child health outcomes. As Cameroon strives toward Sustainable Development Goals particularly SDG 3 (good health and well-being) and SDG 5 (gender equality) such grounded, qualitative evidence offers a roadmap for interventions that respect local contexts while promoting equitable, informed choices (United Nations, 2015). Ultimately, fostering environments where couples can openly discuss and safely implement family planning decisions holds the promise of healthier families, empowered women, and a more resilient society.

REFERENCES

Agadjanian, V. (2019). Religious beliefs and contraceptive use in Sub-Saharan Africa. Studies in Family Planning, 50(4), 351–367. https://doi.org/10.1111/sifp.12112

Agadjanian, V., & Hayford, S. R. (2009). Men, women, and contraceptive decision-making in Sub-Saharan Africa: A review of empirical evidence. Studies in Family Planning, 40(3), 199–214. https://doi.org/10.1111/j.1728-4465.2009.00199.x

Bahamondes, L., Brache, V., Meirik, O., Ali, M., Habib, N., & Landoulsi, S. (2014). A 3-year multicentre randomized controlled trial of etonogestrel- and levonorgestrel-releasing contraceptive implants, with non-randomized matched copper IUD controls. Human Reproduction, 30(11), 2527–2538. https://doi.org/10.1093/humrep/dev234

Barnhart, K. T., & Schreiber, C. A. (2009). Return to fertility following discontinuation of oral contraceptives. Fertility and Sterility, 91(3), 659–663. https://doi.org/10.1016/j.fertnstert.2009.01.003

Bearak, J., Popinchalk, A., Ganatra, B., Moller, A. B., Tunçalp, Ö., Beavin, C., Kwok, L., & Alkema, L. (2020). Unintended pregnancy and abortion by income, region, and the legal status of abortion: Estimates from a comprehensive model for 1990–2019. The Lancet Global Health, 8(9), e1152–e1161. https://doi.org/10.1016/S2214-109X(20)30315-6

Blanc, A. K. (2001). The effect of power in sexual relationships on sexual and reproductive health: An examination of the evidence. Studies in Family Planning, 32(3), 189–213. https://doi.org/10.1111/j.1728-4465.2001.00189.x

Bongaarts, J. (2014). Population growth and the demographic transition. Philosophical Transactions of the Royal Society B: Biological Sciences, 369(1645), Article 20130364. https://doi.org/10.1098/rstb.2013.0364

Bongaarts, J. (2016). Development: Slow down population growth. Nature, 530(7591), 409–412. https://doi.org/10.1038/530409a

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Cleland, J., Ali, M. M., Benova, L., & Daniele, M. (2012). Contraception and health outcomes: A review of evidence from low- and middle-income countries. Reproductive Health Matters, 20(39), 31–43. https://doi.org/10.1016/S0968-8080(12)39600-0

Diedrich, J. T., Madden, T., Zhao, Q., & Peipert, J. F. (2015). Long-term utilization and continuation of intrauterine devices. Contraception, 91(3), 216–221. https://doi.org/10.1016/j.contraception.2014.11.004

Family Planning 2030 (FP2030). (2024). Cameroon 2024 indicator summary sheet: 2024 measurement report. https://fp2030.org/sites/default/files/2024-05/Cameroon-2024-Indicator-Summary-Sheet.pdf

Fassin, D. (2010). La raison humanitaire: Une histoire morale du temps présent. Gallimard/Seuil.

Frank-Herrmann, P., Heil, J., Gnoth, C., Toledo, E., Baur, S., Pyper, C., Jenetzky, E., Strowitzki, T., & Freundl, G. (2007). The effectiveness of a fertility awareness based method to avoid pregnancy in relation to a couple's sexual behaviour during the fertile time: A prospective longitudinal study. Human Reproduction, 22(5), 1310–1319. https://doi.org/10.1093/humrep/dem003

Gallo, M. F., Lopez, L. M., Grimes, D. A., Carayon, F., Schulz, K. F., & Helmerhorst, F. M. (2014). Combination contraceptives: Effects on weight. Cochrane Database of Systematic Reviews, 2014(1), CD003987. https://doi.org/10.1002/14651858.CD003987.pub5

Giddens, A. (2009). Sociology (6th ed.). Polity Press.

Glasier, A. (2010). Contraception. In D. T. Baird, R. Glasier, & D. W. Sturdee (Eds.), Reproductive medicine for the MRCOG and beyond (2nd ed., pp. 117–140). Cambridge University Press.

Helman, C. G. (2007). Culture, health and illness (5th ed.). Hodder Arnold.

Hubacher, D., Mavranezouli, I., & McGinn, E. (2008). Unintended pregnancy in sub-Saharan Africa: Magnitude of the problem and potential role of contraceptive implants to alleviate it. Contraception, 78(1), 73–78. https://doi.org/10.1016/j.contraception.2008.03.002

Institut National de la Statistique (INS) & ICF. (2020). Enquête démographique et de santé du Cameroun 2018. INS and ICF.

Jaffré, Y., & Suh, S. (2016). Where the lay and the technical meet: Using an anthropology of interfaces to explain persistent reproductive health disparities in West Africa. Social Science & Medicine, 156, 175–183.

Lopez, L. M., Edelman, A., Chen, M., Otterness, C., Trussell, J., & Helmerhorst, F. M. (2013). Progestin-only contraceptives: Effects on weight. Cochrane Database of Systematic Reviews, 2013(7), CD008815. https://doi.org/10.1002/14651858.CD008815.pub3

Miller, W. B., Severy, L. J., & Pasta, D. J. (2019). A framework for modelling fertility motivation in couples. Population Studies, 58(2), 193–205. https://doi.org/10.1080/0032472042000213712

Moreau, C., Cleland, K., & Trussell, J. (2012). Contraceptive discontinuation attributed to method dissatisfaction in the United States. Contraception, 85(6), 602–607. https://doi.org/10.1016/j.contraception.2011.10.008

Nsashiyi, R. S., Tyndall, J. A., Abah, J. E., Achuo, M. M., Hasnain, S. S., & Williamson, J. (2024). Contraceptive use, unmet need, and demand satisfied for family planning across Cameroon: A subnational study including indirect effects of COVID-19 and armed conflict on projections. BMC Public Health, 24(1), Article 257. https://doi.org/10.1186/s12889-024-17796-5

Pantoja, M., Medeiros, T., Baccarin, M. C., Morais, S. S., Fernandes, A. M., & Bahamondes, L. (2010). Variations in body mass index of users of depot medroxyprogesterone acetate as a contraceptive. Contraception, 81(2), 107–111. https://doi.org/10.1016/j.contraception.2009.08.004

Polis, C. B., Phillips, S. J., Curtis, K. M., Westreich, D. J., Steyn, P. S., Raymond, E., Hannaford, P., & Heikinheimo, O. (2016). Hormonal contraceptive methods and risk of HIV acquisition in women: A systematic review of epidemiological evidence. Contraception, 93(4), 276–293. https://doi.org/10.1016/j.contraception.2015.11.009

Pope, C., & Mays, N. (2020). Qualitative research in health care (4th ed.). Wiley-Blackwell.

Pyper, C. M. M., & Knight, J. (2001). Fertility awareness methods of family planning: The physiological background, methodology and effectiveness of fertility awareness methods. Journal of Family Planning and Reproductive Health Care, 27(2), 103–109. https://doi.org/10.1783/147118901101196219

Sedgh, G., Bearak, J., Singh, S., Bankole, A., Popinchalk, A., Ganatra, B., Rossier, C., Gerdts, C., Tunçalp, Ö., Johnson, B. R., Johnston, H. B., & Alkema, L. (2016). Abortion incidence between 1990 and 2014: Global, regional, and subregional levels and trends. The Lancet, 388(10041), 258–267. https://doi.org/10.1016/S0140-6736(16)30380-4

Sussman, G. L., Beezhold, D. H., & Kurup, V. P. (2002). Allergens and natural rubber proteins. Journal of Allergy and Clinical Immunology, 110(2), S33–S39. https://doi.org/10.1067/mai.2002.124765

Trussell, J. (2011). Contraceptive failure in the United States. Contraception, 83(5), 397–404. https://doi.org/10.1016/j.contraception.2011.01.021

United Nations. (2015). Transforming our world: The 2030 agenda for sustainable development. https://sdgs.un.org/2030agenda

United Nations Population Fund (UNFPA). (2025). World population dashboard: Cameroon. https://www.unfpa.org/data/world-population/CM

Wilcox, A. J., Weinberg, C. R., & Baird, D. D. (1995). Timing of sexual intercourse in relation to ovulation. New England Journal of Medicine, 333(23), 1517–1521. https://doi.org/10.1056/NEJM199512073332301

Wilcox, A. J., Dunson, D., & Baird, D. D. (2000). The timing of the 'fertile window' in the menstrual cycle: Day specific estimates from a prospective study. BMJ, 321(7271), 1259–1262. https://doi.org/10.1136/bmj.321.7271.1259

World Health Organization (WHO). (2020). Family planning/contraception fact sheet. Geneva: WHO.

World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations

Population Fund (UNFPA), World Bank Group, & United Nations Department of Economic and Social Affairs (UNDESA). (2023). Trends in maternal mortality 2000 to 2023: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/

Copyright Notice
This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International License (CC BY 4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.