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Knowledge, Attitude and Factors Limiting Family Planning Practices among Women of Child Bearing Age in the Molyko Health Area-Buea, Cameroon

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Abstract

Background: The slow increase in the proportion of contraceptive use despite the availability of a wide range of contraceptive methods accounts for the continuous unacceptably high Maternal Mortality Rates (MMR) in Cameroon. The birth of babies at intervals less than two years also contributes to high MMR. Some factors have been found to influence the practice of family planning.

Aim: The aim of this study was to assess the knowledge and attitude of women of child-bearing age (WOCBA) towards family planning and to identify factors that limit family planning practices in the Molyko Health Area (MHA).

Methods: A community-based cross-sectional study design was used to investigate knowledge and attitude towards family planning and identify factors that limit family planning practices. Purposive and simple random sampling techniques were used to select the study area and sites (quarters) respectively. The purposive sampling method was employed to select the study area, which was the MHA while the simple random sampling technique was used to select seven out of the 12 quarters in the MHA. The participants were enrolled from the seven quarters in the MHA. Participants were made up of 176 WOCBA (15-49years) who were enrolled by purposive and consecutive convenient sampling methods; two participants per household in the selected quarters. Only participants who gave their consent to participate in the study were included. Data was collected from May to June 2022 using a semi-structured pretested questionnaire. Based on the number of questions for each section, participants who scored 50% and more for the section on knowledge were said to be knowledgeable (good knowledge) while those who scored below 50% had poor knowledge (not knowledgeable). Similarly, those who scored 50% and above for the section on attitude were said to have positive (good) attitude while those who scored below 50% had negative (poor) attitude. Data collected was entered into Microsoft excel and analysed using SPSS version 26.0l. Descriptive statistic was used to describe study participants. Chi-square test was used to determine association between variables.

Results: Out of the 176 participants, 10(5.7%) were disabled. Majority 106(62%) of the study participants had poor knowledge on family planning. Also, 150(87.7%) had poor attitude towards family planning. Most 94(55.5%) participants mentioned having used family planning services; among them, 20 (33.3%) reported that the non-supportive partner influenced their

practices, 13(21.7%) said they stopped taking contraceptives due to non-effectiveness and 5(8.3%) said they had a fear of being judged. There was no association between marital status and knowledge level of the participants; however, there was an association between the level of knowledge and family planning practices (P=0.001).

Conclusion: Most of the participants had poor knowledge and poor attitude towards family planning, which needs attention. The major factors that limit family planning practices were the lack of a supportive partner and fear of side effects. Adequate information about family planning services needs to be disseminated.

Keywords: Family Planning Practices; Contraceptives; Maternal Mortality; Barriers; Child Bearing Age

Abbreviations: MMR: Maternal Mortality Rate; WOCBA: Women of Child Bearing Age; FP: Family Planning; MHA: Molyko Health Area.

Introduction

According to the World Health Organisation approximately 22million unsafe abortions occur every year globally accounting for about 47,000 maternal deaths annually from complications due to unsafe practices for termination of pregnancy [1]. High levels of maternal and neonatal mortality in developing countries are either due to the incorrect and inconsistent use of contraceptives or the absence of its use. Family Planning (FP) is the informed decision made by individuals and couples on their desired number of children, including the choice to have no children, and the age at which they wish to have them. This is a form of preventive health care which is achieved through the use of contraceptives [2]. Family Planning (FP) services are offered by trained nurses integrated into the prenatal and postnatal packages of some activities while others in some hospitals create special FP units for delivery of their services [3].

Sub-Saharan Africa is one of the regions with the highest number of maternal deaths with the most common causes being severe bleeding, infections and complications during delivery [4]. In 2020, sub-Saharan Africa registered 545 maternal deaths per 100,000 live births; indeed, in 2020 sub-Saharan Africa alone accounted for 70% of maternal deaths worldwide [5]. Globally, in 2021 among the 1.9 billion women of reproductive age group (15–49 years), 1.1 billion have a need for family planning; of these, 874 million are using modern contraceptive methods [6]. Maternal mortality is too high; in 2020 approximately 287 000 women died during or following pregnancy and childbirth; almost 95% of all maternal deaths occurred in low and lower middle-income countries in 2020 [7]. Meanwhile most of these death could have been prevented partly through the use of FP.

In Cameroon, maternal mortality remains unacceptably high and despite the availability of a wide range of contraceptive methods, contraceptive use is very low [7,8]. In a study carried out in 2018 in Ghana, the use of contraceptives was recorded as follows; condoms (3.6%), injectable (2.5%), oral pills (1.3%), implants (0.5%), IUDs (0.2%) [9]. A study conducted by Layu, et al. [10] in Buea Health District, Cameroon revealed that 91% of the respondents practiced at least a method of contraception.

Maternal Mortality Rate (MMR) has increased over the past years, from 690 deaths /100 000 live births in 2010 to 789 deaths/100 000 live births in 2014 [11]. Recently, in 2017 MMR was estimated at 529) maternal deaths per 100 000 live births [4]. It is estimated that up to 1/3 of maternal deaths can be prevented by using contraception in women who are seeking to postpone or delay postpartum [12]. Maternal mortality is estimated to be about 1.8 times higher in women not using modern contraceptives than among modern contraceptive users [13]. Good knowledge and correct use of contraceptives in some developing countries has reduced the annual number of maternal deaths by 40% in the last 20 years and has reduced the MMR by 26% in recent years. If the factors limiting the practice of family planning are addressed, it is estimated that maternal mortality still occurring in these countries can be avoided by more than 30% [14].

In most cases, women get sensitised about contraception yet they do not practice family planning hence, a significant gap between women's reproductive preferences and the use of contraceptives. Although national surveys have extensively looked into contraceptives uptake or awareness of the varied family planning methods, little is known about family planning in most communities such as Molyko Buea. The aim of family planning is preventing pregnancy related health risk in women [15]. Family planning services offer counseling to every family whenever they want and help them attain their reproductive goal. In addition to the fact that babies born at frequent intervals are not fully developed and there is increase in disability rate, there is also a significant increase in maternal deaths when babies are made at intervals less than two years.

Thus, to enhance the ultilisation of family planning services, it is necessary to invest in providing access to these services and to eradicate the factors that limit the access to family planning services [16,17]. Considering the fact that some women of childbearing age have negative attitude towards family planning, due to false and misleading information Obasi, et al. [18], this study sought to assess the knowledge, determine the attitude and identify factors limiting Family Planning (FP) practices in the Molyko Health Area, South West Region. Findings from this study may inform strategies to enhance the ultilisation of FP services, which might curb the high rate of abortions and maternal deaths in this area [19].

Materials and Methods

A community-based cross-sectional study was conducted from March to June 2022 to investigate knowledge and attitude towards family planning and identify factors that limit family planning practices. Both qualitative and quantitative approaches were employed to collect and process data. A questionnaire made-up of both open and close ended questions was used to collect data. The target population comprised all women of childbearing age (15-49years) residing in seven quarters which were selected by a simple random sampling technique from Molyko Health Area in Buea Health District. All Women of Childbearing Age (WOCBA) who gave their consent to participate in the study were included. Eligible participants were recruited from Checkpoint, Malingo, University 1, 2, 3 and Ndongo 1 and 2 quarters in Molyko Health Area in Fako Division of the South West Region of Cameroon. Molyko is a neighborhood in the Buea Municipality, it is a cosmopolitan residential area. Even though it is a Bakweri polity, most of the inhabitants are immigrants from different tribes and regions of Cameroon. Majority of the inhabitants here are students, business men and women while a few others are labourers, teachers and drivers. This area has major tertiary institutions hence, a majority of its occupants are students among which we can get a large proportion of WOCBA. The Molyko Health Area is made up of 12 quarters.

The sample size was calculated as follows:

$$n = \frac{z^2 pq}{d^2}$$ (Cochran sample size formula) [20]

n = the desired sample size
z = standard normal deviation usually set at 1.96 (which corresponds to 95% confidence level)
p = the proportion in the target population to have specific characteristics = 13% (prevalence was gotten from study conducted by Edietah and collaborators titled 'contraceptive use and determinants of unmet need for family planning; a cross sectional survey in the North West Region, Cameroon [21].
q = 1-p
d = absolute precision or accuracy, normally set at 0.05.
n = $(1.96)^2$ x (0.13) (1-0.13) / $(0.05)^2$ = 173.8(174) participants.

A sample of 176 participants who were WOCBA selected by purposive and simple random or consecutive convenient sampling methods; two participants per household who met the inclusion criteria and gave their consent, participated in the study. Data was collected on participants' knowledge, attitude and factors limiting Family Planning (PF) practices. Participants' knowledge on FP was evaluated using 10 questions each given a point, making a total of 10 points. A score of 0-4 on 10 (00-40%) was referred to as not knowledgeable (poor knowledge) while a score of 5-10(50-100%) was referred to as knowledgeable (good knowledge). Similarly, attitude was scored on a scale of 4, participants with scores of 2 and above on 4 (50-100%) were considered to have positive (good) attitude while those with scores of below 2 (00-49%) had negative (poor) attitude towards FP.

Before administering the questionnaire, it was pre-tested by administering 15 copies to 15 WOCBA who were not part of the study sample. Their responses confirmed the clarity and validity of the questions. Copies of the questionnaire were then administered to the study participants who completed the various sections of the questionnaire. The researcher read the questions to participants who could not read and their responses were written down.

Data collected was entered into Microsoft Excel and analysed using SPSS version 26.0l. Descriptive statistic was used to describe study participants. Using frequency tables the percentages of responses were determined. Chi-square test was used to determine association between variables.

Results

All 176 respondents enrolled, participated in the study giving a response rate of 100%. Majority 137(77.8%) of the women were of the age group 15-25 years and the least 9(5.2%) being 34-49 with a mean age and standard deviation of 23.68+\- 4.27. Majority 149(84.7%) of the participants were single and 8(4.5%) participants were cohabiting. More than half 147(83.5%) of the participants had attained tertiary level of education while 3(1.7%) had primary level and 10(5.7%) had disabilities. One hundred and seventy five (99.4%) of the study participants indicated that they were Christians Table 1.

Characteristic	Category	n (%)
Age (Years)	Mean(SD)	23.68 +/-4.27
	15-25	137 (77.8)
	26-33	30 (17.0)
	34-49	9 (5.2)
	Total	176 (100.0)
Current Level of Education	Primary Level	3 (1.7)
	Secondary Level	26 (14.8)
	Tertiary Level	147 (83.5)
	Total	176 (100.0)
Employment status	Unemployed	- (-)
	Student	112 (63.6)
	Employed	49 (27.8)
	Applicant	15 (8.5)
	Total	176 (100.0)
Marital Status	Single	149 (84.6)
	Married	19 (10.8)
	Cohabiting	8 (4.5)
	Total	176 (100.0)
Religion	Christianity	175 (99.4)
	Islamism	0 (0.0)
	Others	1(0.6)
	Total	176 (100.0)
Have disability	Vision impairment	7 (4.0)
	Others	3 (1.7)
	Don't have	166 (94.3)
	Total	176 (100.0)

Table 1: Socio-Demographic Characteristics of Study Participants.

Regarding participants' knowledge on FP, 171(97.1%) of the participants had heard of family planning. More than half 89(52.0%) heard from school while 6(3.5%) from TV/ internet. Out of the 171 who had heard of family planning, 143(83.6%) of them actually had the right answer with respect to the correct definition of family planning. Most 149(87.1%) of the participants reported the preventing pregnancy as the predominant importance of family planning. With respect to the types of family planning methods used, 119 (69.6%) knew modern contraceptives as a family planning method, 45(26.3%) confirmed natural methods such as the Rhythm and LAM methods. A Majority 94(55.0%) made use of a Family planning methods meanwhile 77(45.0%) did not.

A total of 139(81.3%) made use of modern contraceptives, 25(14.6%) used natural methods and 7(4.1%) used traditional methods. Ninety six (56.1%) reported pharmacy/ hospitals /clinics as sources of family planning services. More than half 100(58.5%) of the participants never had or knew the side effects of family planning while 29(17.0%) stated weight gain and bleeding or spotting (Table 2). A scoring system was made on 10 to assess knowledge; participants who scored seven and above were considered to have good knowledge while those who scored below seven were considered to have poor knowledge. From the cut off score for knowledge, 106(62.0%) had poor knowledge while 65(38.0%) had good knowledge Table 3.

Variable	Category	n (%)
Heard of family planning	Yes	171 (96.6)
	No	5 (3.4)
	Total	176 (100.0)
Heard it from	TV/internet	6 (3.5)
	School	89 (52.0)
	Friends/relatives	35 (20.5)
	Health workers	41 (24.0)
	Total	171 (100.0)
Family planning	Terminating a pregnancy when it was not planned or still has a child less than 2 years	1 (0.6)
	Family bonding and taking full responsibilities of children needs	2 (1.2)
	Prevention of unwanted pregnancies and giving space between childbirth to prevent maternal and neonatal health risks	143 (83.6)
	What is done in order to have one's exact desired number of Children	25 (14.6)
	Total	171 (100.0)
Importance of family planning	Avoid pregnancy	149 (87.1)
	Prevent sexually transmitted diseases	9 (5.3)
	Reduces the rate of infertility	8 (4.7)
	Promote fidelity among spouse	5 (2.9)
	Total	171 (100.0)
Family planning methods	Natural method (by counting my menstrual cycle)	45 (26.3)
	Using condoms, injections, taking pills, intrauterine devices, implants	119 (69.6)
	Drinking whiskey or salt in water immediately after every sexual encounter	3 (1.8)
	Permanent method that is the removal of the fallopian tubes.	4 (2.3)
	Total	171 (100.0)
Use family planning	Yes	94 (55.0)
	No	77 (45.0)
	Total	171 (100.0)
Type of family planning used	Using condoms, injections, taking pills, intrauterine devices, implants	139 (81.3)
	Drinking whiskey or salt in water immediately after every sexual encounter	7 (4.1)
	Permanent method that is the removal of the fallopian tubes.	0 (0)
	Natural method	25 (14.6)

	Total	171 (100.0)
Side effects of family planning	Bleeding /spotting	29 (17.0)
	Weight gain	29 (17.0)
	Nausea and vomiting	13 (7.6)
	I don't know/ I don't have side effects	100 (58.5)
	Total	171 (100.0)
Source of family planning services	Pharmacy /Hospital/clinics	96 (56.1)
	Store	11 (6.4)
	Friends/ spouse/ relatives	39 (22.8
	No source	25 (14.6)
	Total	171 (100.0)
Number of times family planning is often used	As often as I have sex in a month	54 (31.6)
	Once in 3 months	12 (7.0)
	Safe/period/breast feeding	41 (24.0)
	None of the above	31 (18.1)
	Once in 5 years	33 (19.3)
	Total	171 (100.0)

Table 2: Knowledge on Family Planning Practices among Participants.

Variables	Category	n (%)
Level of knowledge	Mean Score+/- (SD)	5.13 +/-2.70
	Good knowledge	65 (38.0)
	Poor knowledge	106 (62.0)

Good=70-100% Poor=00-69%

Table 3: Knowledge Level amongst Participants.

An association between socio-demographic characteristic and knowledge level of participants was computed. A chi-square test was done between the knowledge of the participants and demographic variables, and there was no statistically significant association as shown in Table 4.

Characteristic	Variable	Knowledge category		Chi square	P-value
Age group		Poor knowledge	Good knowledge	4.951	0.079
	18-25	90(65.7)	47(34.3)		
	26-33	15(50.0)	15(50.0)		
	34-42	1(25.0)	3(75.0)		
Current Level of Education	Ordinary Level	2(100.0)	-		
	Advanced Level	16(64.0)	9(36.0)	1.316	0.702
	Tertiary Level	88(61.1)	56(38.9)		
Employment status	Student	75(67.0)	37(33.0)	3.416	0.181
	Employed	23(52.3)	21(47.7)		
	Applicant	8(53.3)	7(46.7)		

Table 4: Association between Socio-Demographic Characteristic and Knowledge Level of Participants.

Concerning the participants' attitude towards Family Planning (FP) practices, among the 171 participants who had heard of family planning, 110(64.3%) discussed FP with their spouse/ sex partners while 61(35.7%) did not, and 23(37.7%) reported reason of non-acceptance. One hundred and thirty (76.0%) reported greater than 2years interval before conception after previous delivery while 41(24.0%) said less than 2years. Seventy two (42.1%) were aware of traditional beliefs regarding FP with only 3(4.2%) believing in them Table 5. With respect to the participants' attitude regarding family planning, a cut off score of two was used to rate the attitude level of the study participants. The mean score was 2.58 +/- 0.97SD. Out of the 171participants who responded to the questions on attitude, 150(87.7%) had poor attitude towards family planning practices and only 21(12.3%) had good attitude Table 6.

Variable	Category	n (%)
Discuss family planning with spouse/sex partner	Yes	110 (64.3)
	No	61 (35.7)
	Total	171 (100.0)
No, because:	He is busy and there is no time	22 (36.1)
	I am shy	10 (16.4)
	He will not accept l	23 (37.7)
	His religion/ culture is against it	6 (9.8)
	Total	61 (100.0)
Duration after a previous birth	Less than 2years	41 (24.0)
	Greater than 2years	130 (76.0)
	Total	171 (100.0)
Heard traditional beliefs about family planning	Yes	72 (42.1)
	No	99 (57.9)
	Total	171 (100.0)
The traditional beliefs about family planning are true	Yes	3 (4.2)
	No	69 (95.8)
	Total	72 (100.0)

Table 5: Attitude Level towards Family Planning Among Study Participants.

Attitude levels and mean scores regarding family planning	Mean(+/- SD)	2.58 +/- 0.97	
	Poor attitude	150	87.70%
	Good attitude	21	12.30%
	Total	171	100

Table 6: Attitude towards Family Planning Among Study Participants.

A chi-square test and a cross tabulation was conducted to test the association between knowledge level of participants and their attitude towards family planning. More than half 91(60.7%) of the participants had poor knowledge and poor attitude while 59(39.3%) had good knowledge and poor attitude as shown in Table 7. Talking about the factors limiting Family Planning (FP) practices, 13(7.6%) of the participants reported that family planning practices are against their religion. Out of the 94 participants who said yes they have been using FP services, 60(35.1%) stopped at some point with a majority 20(33.3%) reporting an unsupportive partner as reason, 13(21.7%) said they stopped due to ineffectiveness of the method and 5(8.3%) said they had a fear of being judged. Eighty three (48.5%) did not practice FP as prescribed (Table 8). Practicing FP as prescribed was a significant factor associated with participants' attitude towards FP (p=0.001). All the other factors were not significantly associated with their attitude.

Practice Category	Knowledge category		Chi square	p-value
	Poor knowledge	Good knowledge	0.905	0.341
	N (%)	N (%)		
Poor Attitude	91(60.7)	59(39.3)		
Good attitude	15(71.4)	6(28.6)		

Table 7: Association between Knowledge and Attitude Regarding Family Planning.

Variables	Category	n (%)
Family planning is against my religion	Yes	13 (7.6)
	No	109 (63.7)
	I don't know	49 (28.7)
	Total	171 (100.0)
Stopped family planning at some point	Yes	60 (35.1)
	No	111 (64.9)
	Total	171 (100.0)
Reason for stopping family planning	Not effective	13 (21.7)
	Fear of being judged	5 (8.3)
	Costly	12 (20.0)
	Non supportive partner	20 (33.3)
	Fear of possible side effects	10 (16.7)
	Total	60 (100.0)
Practice family planning as prescribed	Yes	88 (51.5)
	No	83 (48.5)
	Total	171 (100.0)

Table 8: Factors Limiting Family Planning Practice Among Participants.

Discussion

This study aimed at investigating the knowledge, attitudes and factors influencing Family Planning (FP) practices among women of child bearing age. It is worth noting that proper education on FP will improve knowledge on the different methods of contraceptives and enhance positive attitudes towards FP practices [10]. This could reduce myths and misconceptions regarding FP, decrease unwanted pregnancies and abortions especially among youths. This may in turn curb morbidity and mortality among women of child bearing age. Hence, this study was carried out to provide information that could inform the designing and implementation of educational strategies on promoting the ultilisation of FP services in Molyko Health Area in particular, and Cameroon as a whole.

According to the findings of this study, more than three quarter of the participants were in the age group 15-25. This finding is similar to that of a study carried out by Ajang, et al. [22] in Cameroon, but different from that of Dadi, et al. [23] in India where a majority of the respondents were in the range 25-34. This difference may be due to differences in study area and setting. Also, majority of the respondents were single contrary to the study carried out by Nansseu, et al. [24] in Mbouda Health District Cameroon, where more than half of the participants were married. Again, this may be due to the difference in study area and settings. It is worth noting that even though majority of the respondents were single, more than three quarter of them were in the sexually active age group 15-25, which is similar to the findings of Humphries, et al. [25] who found that the age range of self-reported sexually active female students was 13–23 years.

Our study revealed that almost all of the participants reported having heard of Family Planning (FP) and a few could say what FP is. More than three quarter of those who had heard of family planning correctly defined it. This supports the finding of a study carried out in Nepal by Abinash, et al. [26]. A good proportion stated that FP is used

to prevent unwanted pregnancies, this finding concurs with the findings of studies conducted in Cameroon [27,28].

In general, more than half of the participants had poor knowledge on FP which is not so different from the findings of similar studies Khattak, et al. [10,29] conducted in Cameroon where almost all of the participants incorrect knowledge on FP. But our finding differs from that of Ali, et al. [30] carried out in Sudan where about three quarter of the participants had good knowledge. Our study showed that 5.7% of the participants had disabilities. A study conducted by Mekonnen, et al. [31] revealed that the knowledge, attitude and practice of persons with disabilities regarding FP methods were relatively low. It is worth mentioning that family planning (FP) prevents as many as one in every three maternal deaths, as it allows women to space birth, prevent unintended pregnancies and abortions. Hence, adequate knowledge regarding FP is mandatory. Associating knowledge and some demographic characteristics, we found that knowledge on FP was not statistically significant ($p>0.005$) with age, educational level and employment status implying the demographic characteristics of the participants had no association with the level of knowledge on FP practices. These findings are opposite to that of Genet, et al. [32] where age and educational level showed significant relationships ($p< 0.001$) with knowledge. This might be due to the differences in the sample size, data collection tool and scoring system.

Again, our study found that more than half of the participants had discussed Family Planning (FP) with their spouse/sex partners, this proportion is lower than that of Tilahun, et al. [33] in North West of Ethiopia. It was revealed that less than half of the proportion of participants who had not discussed with their spouse had as reason, the refusal of their partners to engage in FP. More than half of the participants had not heard of any traditional beliefs regarding FP. On a general note, majority of the participants had poor attitude towards FP. This is in line with the finding of a study conducted in Buea Health District in Cameroon by Layu, et al. [10]. In addition, our study revealed that only 12.3% had good attitude regarding FP. This finding is different from the finding in Southern Nigeria reported by Ofonime, et al. [34], where the majority of the study participants had good attitude.

Concerning factors limiting family planning, a minority of the participants reported that family planning practices was against their religion. This is similar to that of Genet, et al. [32] but different from the findings of Wwifan, et al. [35], where majority of participants voiced family planning was against their religion. Using Chi-square test to associate attitude with factors, we found that women who had poor attitude were less likely to correctly practice family planning as prescribed ($P=0.001$). This finding is similar to that of Genet, et al. [32]. The ineffectiveness of family planning methods, fear of side effects and lack of a supportive partner were possible barriers to the practice of family planning. This is contrary to the findings of Khattak, et al. [36] where factors found to limit family planning practice were traditional beliefs, religion and family type. Other known barriers are limited access to services, particularly among young, poorer and unmarried people. Also, there is fear or experience of side-effects, poor quality of available services, users' and providers' bias against some methods, and gender-based barriers to accessing services. Hence, proper and consistent use of family planning services could results in higher socioeconomic status, decrease maternal and neonatal mortality rates, decrease occurrence of teenage pregnancies, reduced rate of unsafe abortions, and curb the spread of sexually transmitted diseases [16].

Conclusion

It was found that the majority of the respondents were single and more than three quarter of them were in the sexually active age group. This study revealed that majority of WOCBA in the MHA had poor knowledge on Family Planning (FP) and similarly, majority of them demonstrated poor attitude towards FP. Some factors found to limit FP practices were ineffectiveness of FP methods, fear of side effects and the lack of a supportive partner. Few of the participants reported that family planning practices was against their religion. It is recommended that frequent sensitisation campaigns regarding FP services should be done to enhance knowledge and improve attitude towards the ultilisation of FP services. In addition, provision should be made to ensure that people with disabilities are well informed about family planning services as well, through information, education, and communication activities.

Limitations of the Study

Data was collected using questionnaire, which some participants might have given biased answers. Also, the extent of disclosure of the respondents may not have been total due to the sensitive nature of the topic. However, the purpose and benefits of the study was adequately explained which made the participants to freely give their responses.

Consent

It is not applicable

Ethical Approval

This study was authorised by the Department of Nursing, Faculty of Health Sciences, University of Buea, Cameroon.

Administrative authorisation was first obtained from the Regional Delegation of Public Health (No. 646/819) and then from the heads of the various quarters. Before responding to the questionnaire each respondent gave her consent by signing the consent form.

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Author's Contribution

All authors participated in all steps of the study from drafting to writing. That is, conception and design, acquisition of data, analysis and interpretation of data as well as drafting and revising or approving the final manuscript.

Competing Interests

Authors have declared that no competing interests exist.

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