

Original Research Article

Prevalence of Risky Sexual Behaviour and Associated Risk Factors Among Young Internally Displaced Persons in the Dschang Health District: A Mixed Method Study

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Article Information:

Received: 27 February 2026 | Revised: 30 March 2026 | Accepted: 27 April 2026 | Published: May 31, 2026

Cite this article:

Germaine Ndah Alombah, Djam Chefor Alain, Earnest Njih Tabah, Ange Ariane Ghomsi Tadie, Ifang Solomon Ndifon, Gabriel Tchatchouang Mabou, Noumedem Kenfack Jaures Arnaud (2026). Prevalence of Risky Sexual Behaviour and Associated Risk Factors Among Young Internally Displaced Persons in the Dschang Health District: A Mixed Method Study *Public Health Open Journal*. 11(1):519–530. <https://doi.org/10.17140/PHOJ.11.01.519>

Abstract

Background: Young internally displaced persons (YIDPs) face heightened vulnerability to risky sexual behaviours (RSB) due to displacement-related socioeconomic instability, disrupted education, limited access to sexual and reproductive health (SRH) services, and exposure to gender-based violence. Evidence on RSB among YIDPs in Cameroon remains scarce, particularly in humanitarian host communities. This study assessed the prevalence of risky sexual behaviours and identified associated factors among YIDPs aged 10–24 years in the Dschang Health District (DHD) in Cameroon.

Methods: A community-based cross-sectional mixed-methods study was conducted between January and July 2025. Quantitative data were collected from 276 YIDPs selected using stratified systematic sampling across seven health areas. Data were analysed using SPSS version 27, with bivariate and multivariate logistic regression to identify predictors of RSB. Qualitative data were collected through four focus group discussions and four key informant interviews involving YIDPs, parents/guardians, teachers, community health workers, and SRH service providers. Thematic content analysis was performed to present quantitative findings.

Results: The overall prevalence of RSB was 44.7% among all respondents and 90.4% among sexually active YIDPs. The most common RSBs were inconsistent or non-use of condoms (90.4%), unwanted pregnancy (47.3%), multiple sexual partnerships (35.6%), spontaneous sexual activity (33.3%), transactional sex, and substance use before sexual intercourse (26.7%). Multivariate analysis identified nightclub attendance more than once per month (aOR=5.01, p=0.001), psychoactive substance use (aOR=2.8, p=0.02), non-utilisation of SRH services (aOR=2.9, p=0.002), informal employment (aOR=2.2, p=0.03), and low economic status (aOR=2.5, p=0.038) as independent variables increasing the likelihood of RSB among YIDPs. Living with both parents reduced the likelihood of RSB (aOR=0.58, p=0.025). Qualitative findings highlighted peer pressure, economic difficulties, housing insecurity, misinformation about contraception, and coercion as key drivers of RSB.

Conclusion: Risky sexual behaviours are highly prevalent among YIDPs in Dschang, driven by structural, social, and behavioural factors. Integrated, youth-friendly SRH interventions addressing economic vulnerability, substance use, and access to services are urgently needed in displaced populations.

Keywords: Risky Sexual Behaviour, Young internally displaced persons, Sexual and Reproductive Health, Dschang health district, Cameroon.

BACKGROUND

Internally Displaced Persons (IDPs) are individuals or groups compelled to leave their usual habitations due to armed conflict, human rights violations, or disasters, but who remain within the borders of their country of origin [1]. According to Internal Displacement Monitoring Centre (IDMC) [2], there was a total of 83.4 million IDPs recorded by the end of 2024, representing a substantial increase compared to previous years. In Cameroon, more than 2.1 million people are displaced, with nearly 646,000 returnees [3]. IDPs encounter distinct and pressing public health challenges, notably a heightened susceptibility to high risky sexual behaviours (RSB) [4]. High RSB encompasses any sexual activity that elevates an individual's risk of acquiring sexually transmitted infections (STIs), including HIV/AIDS, experiencing unplanned pregnancies, undergoing unsafe abortions, or suffering psychosocial consequences [5,6]. Evidence from African settings indicates high and heterogeneous prevalence of RSB among young people, with rates exceeding 50% among out-of-school youths in Addis Ababa [7], and up to 78% among young female internal migrants in South Ethiopia [8]. The United Nations Population Fund (UNFPA) Cameroon Situation Reports (February and March 2025) [9] detailed the critical sexual and reproductive health (SRH) needs and challenges faced by young IDPs. Studies conducted among young people in non-humanitarian settings have documented wide variations in SRB, with reported prevalence ranging from 13.1% to 80.4% [10–12]. Inconsistent or non-use of condoms among unmarried youths ranges between 32.3% and 82%, early sexual debut before the age of 16 years between 32.6% and 80.4%, and multiple sexual partnerships affecting more than half of respondents in some studies [13]. The rates of unwanted pregnancies are between 20.7% and 30%, and STIs among youths have been reported at 5.8% to 8.3% [14]. A bulletin by the Cameroon Ministry of Public Health [15] reported that adolescent pregnancy rates in Cameroon fluctuate between 14% and 34%, with a high fertility rate, averaging 4.4 births per woman, and an annual population growth rate of 2.59% [15]. Young people in humanitarian and displacement settings face additional layers of risk that further exacerbate SRH vulnerabilities. These include disrupted access to education and health services, limited availability of contraception, entrenched gender inequalities, exposure to sexual coercion and gender-based violence, and harmful traditional practices such as early or forced marriage [16–18]. In Cameroon, particularly in the West and Littoral regions hosting displaced populations from the North-West and South-West crisis,

gender-based violence has been closely linked to housing insecurity, overcrowding, and lack of livelihoods among IDPs [19,20]. Increased rental costs have forced many displaced households into overcrowded living arrangements or exploitative hosting situations, heightening exposure to sexual violence and survival sex, especially among women and girls [20]. Despite growing recognition of these risks, research on the SRH of YIDPs in Cameroon remains limited. Existing studies have primarily focused on food security and nutrition [21], social integration and community solidarity [22], and mental health outcomes [23], with little attention given to the prevalence and determinants of RSB among displaced youth. Therefore, this study aimed to assess the prevalence of RSB and identify associated factors among YIDPs residing in the Dschang Health District, West Cameroon..

MATERIALS AND METHODS

Study Design and Setting

A community-based cross-sectional mixed-methods study was conducted from January to July 2025 in the Dschang Health District (DHD), located in the West Region of Cameroon. The district has an estimated population of 246,000 inhabitants and hosts more than 3,800 IDPs originating primarily from the North-West and South-West regions [24].

Study population

The study population consisted of young internally displaced persons (YIDPs) aged 10–24 years residing in the DHD for at least six months before data collection. Eligible participants included unmarried YIDPs who provided informed consent (≥ 21 years) or assent with parental/guardian consent (< 21 years). Individuals with severe cognitive impairments, minors whose parents withdrew their consent or they themselves withdrew their assent and married YIDPs were excluded.

Sample size

Sample size was determined using the Lorenz formula [25]

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

With p representing the expected prevalence expressed as a proportion, and d as the absolute precision. The result of a previous study conducted in Banjoun in the West region of Cameroon among young people [26] indicated an overall prevalence of RSB to be 13.1%. This prevalence was used as a proxy to determine the prevalence of RSB among YIDPS in the DHD. The calculation

employed an absolute precision of 5% (0.05) and a Z-value of 1.96, corresponding to a 95% confidence level which gave 174.9. However, considering that household survey coverage in Cameroon is approximately 80% [27,28], thus an anticipated non-response rate of 20%, the minimum sample size for the study was adjusted accordingly to 219 participants.

Sampling procedure

A stratified systematic sampling technique was used to select respondents age 10-24 years from the 7 health areas within the DHD. This was implemented as follows: Stage 1: Stratification and selection of primary sampling units. A comprehensive list of IDP household heads, family sizes, and neighbourhoods of residence classified in this study as Health Areas (HAs) was obtained from the Division of Social Affairs at the Office of the Senior Divisional Officer. In total, 3,800 IDPs were registered within Menoua Division, residing across 672 households. The identified Health areas included Fiala-Foreke, Fometa, Siteu, Fongo-Tongo, Mbeng, Fokoue, and Ndoh-Njutitsa. This list served as the sampling frame from which households were systematically selected for inclusion in the study. The total sample size of 219 was then proportionally allocated across each Health area based on their respective household counts. Stage 2: Determination of the total number of households to be included in the study in each health area and proportional allocation was done using the formula:

Total number of households included per HA =

$$\frac{\text{Total number of reported IDP households in HA}}{\text{Total number of IDP households in HD (672)}}$$

× sample size (219)

Determination of the Sampling Interval (k):

The sampling interval, denoted as k , was calculated using the formula:

$$k = \frac{N}{n}$$

where:

- N = total number of households in the HA
- n = desired sample size

For this study, the calculated value of k was 3.13 which was rounded up to 4. Selection of a random starting point: We used a simple lottery method to select a random integer between 1 and k (inclusive). Subsequent households were selected by adding the sampling interval (4) to the chosen number, then we selected every 4th household thereafter from the sampling frame until the desired sample size for each HA was reached.

Data Collection

Quantitative data were collected using a self-administered questionnaire adapted from the WHO/UNFPA Illustrative Questionnaire for Surveys with Young People [29]. The tool was pretested prior to use and administered in English or Pidgin English. Qualitative data were collected through four focus group discussions and four key informant interviews involving YIDPs, parents/guardians, teachers, community health workers, and SRH service providers.

Socioeconomic Characteristics

The poverty line in Cameroon is officially defined and regularly updated by the World Bank [30] and National Institute of Statistics (INS) [31]. According to the Fifth Cameroon Household Survey, ECAM5 by the INS [31], the national poverty line in 2022 was set at 813 CFA francs per person per day (IPPPD), which is equivalent to 24,724 CFA francs per month or 296,691 CFA francs per year. This threshold was used to classify individuals and households as poor if their daily consumption fell below this amount. Income per person per day (IPPPD) was determined by dividing the total household income by the number of household members.

Sexual health patterns of young IDPs

This encompassed a range of attributes related to their sexual behaviour such as:

Age of sexual debut: Defined as the age at which adolescents begin engaging in sexual activity. It was considered as early when the YIDP stated sexual activity at an age ≤ 16 [32,33]

Sexual activity patterns: Type of sexual activities respondent engaged in, including consensual or non-consensual behaviours, homosexual behaviours, spontaneous sex (unplanned sexual intercourse), transactional sex for accommodation or finances etc.

Unwanted pregnancy Rates after displacement: which was calculated using the formula below:

$$\frac{\text{Number of sexually active girls who became pregnant after displacement}}{\text{Total number of sexually active girls}} \times 100$$

Unwanted pregnancy Outcomes: Pregnancy outcomes were self-reported and included current pregnancy status, abortion, miscarriage, and live birth.

HIV testing rate: was estimated by the formula below:

$$\frac{\text{Total number of YIDPs who have been tested for HIV}}{\text{Total number of study participants (276)}} \times 100$$

Outcome description

Risky sexual behaviour (RSB) was the primary outcome, defined using indicators such as inconsistent condom use, multiple sexual partners, transactional sex, substance use before sex, and early sexual debut. The key areas assessed were developed based on guidance from systematic reviews [34,35]. Participants were asked: (1) if they ever had sexual intercourse (yes/no), (2) age of first sexual activity, (3) the type of sexual relationship within the last 12 months (monogamous/polygamous) (4) how frequent they used condom (always or irregularly/never), (5) if they engaged in sexual activity with partners of the same gender (6) if they engaged in spontaneous or unplanned sexual activity (7) if they used alcohol or psychoactive substances prior to sexual activity and if they have ever been tested for HIV/AIDS. These questions were categorized into 1 = yes and 0 = no, and regularity of condom use during sexual intercourse was divided into four categories (1 = always, 2 = most of the time, 3 = seldom and 4 = never).

Data analysis

Quantitative data were analysed using SPSS version 27. Bivariate and multivariate logistic regression analyses were performed to identify factors associated with RSB. Regarding qualitative data, interviews were audio-recorded and transcribed. Our team reviewed all transcripts, developed a codebook, and identified themes based on the literature, 'using an artificial intelligence-assisted transcription software called NoScribe. After this transcription, the qualitative data were analysed using the Atlas software. Thematic content analysis was employed to present the data.

Ethical consideration

Ethical approval was obtained from the West Regional Committee of Ethics and Research in Human Sciences (No. 387/26/03/2025/CE/CRERSH-OU/VP) and from administrative authorities in the Dschang Health District and Menoua Division (No. 000060/ACS/F.34/SAAJP). Written informed consent was obtained from participants aged ≥ 21 years, from legal representatives for those aged 10–12 years, and assent plus guardian consent for 12–20-year-olds, in line with Cameroon's National Ethics Committee (CNEC) guidelines. All participants and guardians were informed about the study objectives, assured of anonymity and data privacy, and were free to withdraw at any time without consequence.

Sociodemographic and socioeconomic characteristics of YIDPs in DHD

A total of 276 young internally displaced persons (YIDPs) participated in the study, yielding a response rate of 94.2%. The mean age of respondents was 18.7 ± 4.1 years. Participants aged 19–24 years constituted the largest age group (50.7%) meanwhile females represented 57.2% of the study population. Most participants had been displaced after the year 2000 and were predominantly Christians (65.2%). The majority lived below the national poverty line (62.3%), only 27.1% had higher education and 64.1% were unemployed. Alcohol consumption was reported by 38.4% of respondents, and 13.0% reported use of other psychoactive substances mixed in food or drinks. More than half of the participants lived with one or both parents (56.2%) (table 1).

Sexual behaviour patterns of Young Internally Displaced Persons

Table 2 presents the sexual behaviour patterns of YIDPs in the DHD. Most sexually active respondents were in monogamous relationships 77 (57.0%). Unplanned sexual encounters were reported by 29 (21.5%) participants. Same-gender sexual relationships were reported by a few participants: 2 females (1.5%) and 3 males (2.2%). Among sexually active females, 52 (47.3%) had experienced an unwanted pregnancy. Pregnancy outcomes included 25 (48.2%) live births, 19 (36.5%) abortions, 2 (3.8%) miscarriages, and 6 (11.5%) ongoing pregnancies. HIV testing rates were low, with only 45 (16.3%) of all respondents having ever been tested. Sexual assault was reported by 23 (17.0%) sexually active YIDPs, of whom 16 (69.6%) indicated that the assault involved a family member. The quantitative findings on assaults were supported by insights from individual interviews. According to one head of SRHS, he stated,

"I had a case here: a woman lived with her older sister, who was married. The older sister was never home, so the husband assaulted this young lady. During this time, he constantly threatened her not to tell anyone. She kept it to herself for a very long time. Until one day, she said she couldn't take it anymore. She finally packed her bags and came to the hospital. When we tried to question her, she started telling us all these stories."

Contraception use

Contraceptive use among sexually active respondents was suboptimal. Only 9.6% reported consistent use of contraception, while 90.4% reported inconsistent or no use. The most frequently reported methods were the safe period (47.4%), condoms (43.0%), and with-

RESULTS

Table 1. Sociodemographic and socioeconomic characteristics of YIDPs in DHD

Variable	Modality	Absolute frequency	Relative frequency (%)
Age	10-14	53	19.2
	>14-19	83	30.1
	>19-24	140	50.7
Gender	Female	158	57.2
	Male	118	42.8
Duration of displacement	≤ 4 years	177	64.1
	>4 years	99	35.9
Academic characteristics	None	5	1.8
	Primary	92	33.3
	Secondary	119	43.1
	Higher education	60	21.7
Social status	Worker	99	35.9
	unemployed	177	64.1
Socioeconomic status	Below poverty line	172	62.3
	moderate poverty	91	33
	no poverty	13	4.7
Take drugs or alcohol	Take alcohol	106	38.4
	Take other drugs in food or drinks	36	13
Living with others	Parents (father or mother)	155	56.2
	Guardian	64	23.2
	alone	57	20.7

ATR: African traditional religion

Table 2. Sexual behaviour patterns of Young IDPs

Variables	Modality	Frequency	Percentage (%)
Current sexual relationship	Monogamous	77	70
	Multiple partners	33	30
Risk perception during intercourse	Unplanned or spontaneous	45	33.3
	Planned	90	66.7
Sexual relationship with same gender	Females	2	1.8
	Mmales	3	2.73
Sexual assault (with family member)	Yes	16	69.6
	No	7	31.4
Frequency of contraception use	Always	19	17.3
	Sometimes	53	48.2
	Never	38	34.5
Unwanted pregnancy	Yes	52	47.3
	No	58	52.7
Pregnancy outcome	Currently pregnant	6	11.5
	Miscarriage	2	3.8
	Abortion	19	36.5
	Live Birth	25	48.2
Ever done HIV test	Yes	45	16.3
	No	231	83.7
Have already been rape	Females	7	6.4
	Males	0	0

drawal (27.4%). Use of modern hormonal methods was uncommon (figure I).

Misconceptions about contraception methods were reported during FGDs: "... I cannot use family planning

methods because they are not good. They have too much side effects like making a woman fat or bleed during menstruation. Some even cause menstruation to stop" (19 -year-old female). I don't want it at all, that it could affect my reproductive system in the fu-

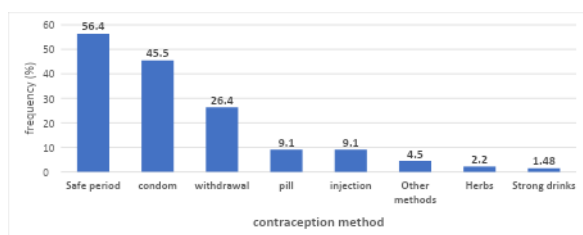


Figure 1. Most common methods of contraception used by YIDPs in DHD

ture. And make me not to deliver children” (16-year-old female) What about condom? Asked the interviewer “...My friend told me that it is like sucking bonbon in a paper, so I don’t like that method (17-year-old male). Additionally, during the FGD with parent/guidance of YIDPs, only 3 out of 12 parents/guidance supported the use of contraception. One parent remarked, ‘I cannot discuss pregnancy or STI prevention with my children who are not married. I myself don’t use those contraceptive methods, and for an unmarried child, what do they have to do with sex? their own is abstinence, it pleases God like that’.

Description of high-risk sexual behaviours observed among young IDPS in the Dschang health district

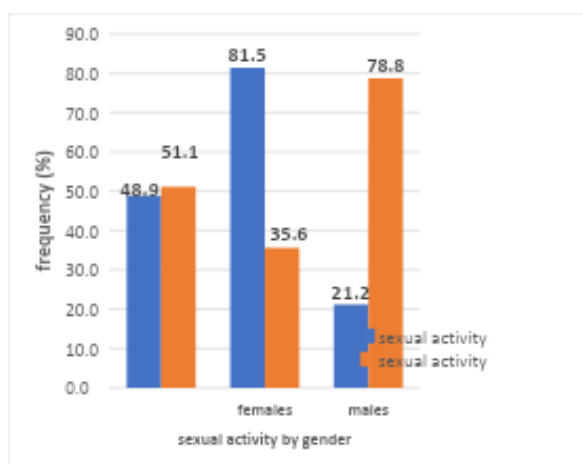


Figure 2. sexual activity by gender

Among the 276 respondents, 135 (48.9%) reported having ever engaged in sexual intercourse. The mean age of sexual debut was 19.7 ± 2.4 years among males and 16.6 ± 4.3 years among females. Early sexual debut (≤ 16 years) was reported by 27.3% of sexually active females and 16.0% of sexually active males (Figures IIa and IIb)

Prevalence of RSB among young IDPs in the DHD

Table 3 displays a range of high-risk sexual behaviours that were reported among YIDPs in the DHD. The overall prevalence of RSB among YIDPs in DHD was 44.7% and among sexually active individuals, the prevalence was 122 (90.4%). The most common RSB was inconsis-

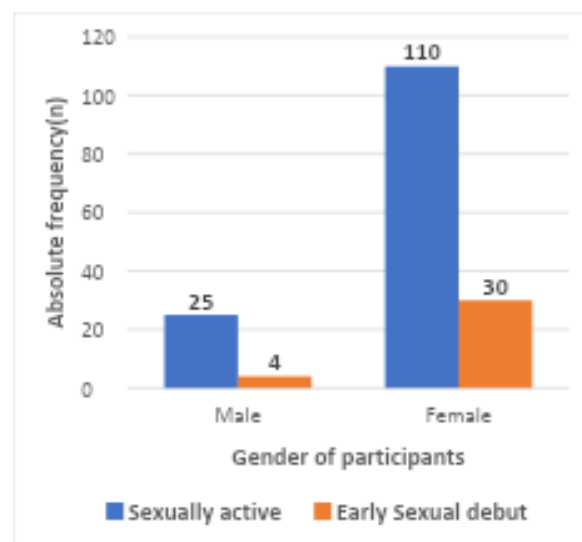


Figure 3. Early sexual debut by gender

tent or no condom use (90.4%) during first or subsequent sexual encounters, followed by unwanted pregnancy 52 (47.3%) and abortion 19(36.5%). Transactional sex (for financial incentives) was reported by 38 (28.1%) and for accommodation 27 (20.0%). Sex with a same-gender partner was reported by 5 (3.7%).

Reasons for engagement into risky sexual behaviour among YIDPS in the DHD.

The most common reason for engagement in RSB was peer pressure 64 (47.3%), followed by lack of information 48 (35.5%), financial incentives 41 (30.0%), desire for excitement 36 (26.4%), and accommodation needs 33 (24.5%) (figure III).

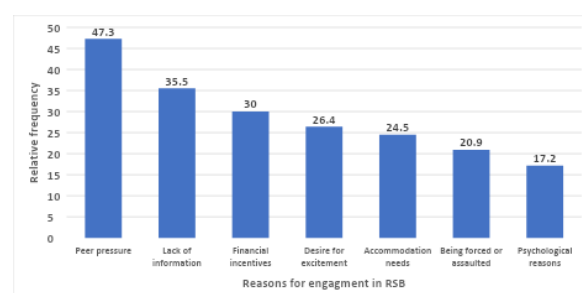


Figure 4. Reasons for engagement into RSB among YIDPS in the DHD.

To further complement the quantitative data, insights from YIDPs themselves revealed the complex realities behind certain behaviours. One participant shared: “Sometimes we are forced to do it. It’s not that we like this bad behaviour. If I don’t sleep with this man, how will I have money? My mother is sick and cannot take care of me and I must do all to survive. That’s the reason why we sometimes do prostitution” (18-year-old female). Again, it was reported that YIDPs were exposed to RSB, including unprotected sex and unsafe abortions, often due to precarious economic conditions. As one head of SRH service stated: “They take six

Table 3. Prevalence of risky sexual behaviours reported among YIDPs in the DHD

Variable	Modality	Numbers	Frequency(%)
Psychoactive substance use	Yes	36	26.7
	No	99	73.3
Multiple sexual partner	Yes	48	35.6
	No	87	64.4
Transactional sex (accommodation)	Yes	27	20.0
	No	83	80
Transactional sex (financial incentive)	Yes	38	28.1
	No	97	71.9
Inconsistent condom use	Yes	122	90.4
	No	13	9.9
Spontaneous sexual activity	Yes	45	33.3
	No	90	66.7
Unwanted pregnancy	Yes	52	47.3
	No	58	52.7
Pregnancy outcome (abortion)	Yes	19	36.5
	No	33	63.5
Sex with same gender	Yes	5	3.7
	No	130	96.3

YIDPs: Young internally displaced persons, RSB: Risky sexual behaviour

sachets of Lion d'or (hard drug) to cause an abortion (Head of SRHS). Drug and alcohol use, being influenced by peers frequently emerged as a common theme, suggesting that RSB is often influenced by peer pressure within this group. Two male participants recounted, "We always drank something called CHICHA" (referring to a psychoactive substance). They further explained, "Most of us take this after school, going to a particular house where in addition, we drink wine called EL VINO from a container." Another experience shared was, "Some of my friends even go as far as preparing what they call 'happy rice,' which is cooked with marijuana to energise themselves for sexual activity" (participants aged 15 and 17, both in-school males). They also described situations where "a girl might go out with a boy, and the boy would drug her, then invite his friends, leading to her being exploited sexually by many males" These were corroborated during the FGD with teachers of YIDPS, who frequently reported that the reason for RSB was due to peer pressure. "Displaced youths frequently face risky sexual behaviours such as unprotected sex and prostitution, often due to peer pressure or their circumstances" (higher institution lecturer T2). Another teacher noted that, "due to permissive environments and shared living spaces with parents, many young people are exposed to adult behaviours at an early age and later attempt to imitate what they observed" (Secondary school teacher T5).

Determinants of risky sexual behaviour

Bivariate analysis showed that substance use (cOR = 3.3, 95%CI: 1.38–7.9, $p = 0.005$), low economic status (cOR = 2.8, 95%CI: 1.1–7.1, $p = 0.02$), being a worker

(cOR = 3.8, 95%CI: 1.76–8.36, $p < 0.001$) and attending nightclubs more than once a month (cOR=4.8, 95%CI: 2.1– 11.0, $P=0.001$) were correlated with the act of engaging into RSB. Other factors linked to RSB are presented in table 4 below.

Multivariate analysis of factors predicting risky sexual behaviour among YIDPs

After adjusting for confounders, attending nightclub more than once per month (aOR=5.01 95%CI: 2.52-10.0, $p=0.001$;) substance use (aOR = 2.8, 95%CI: 1.2–6.5, $p = 0.015$); non-utilization of SRH services (aOR = 2.9 95%CI= 1.5–6.0, $p<0.002$); informal occupation (aOR= 2.2, 95%CI: 1.1–4.4, $p = 0.03$); living with both parents (aOR =0.58, 95%CI: 0.36-0.92, $p=0.025$); and economic status (aOR=2.5, 95%CI : 1.05-6.0, $p= 0.038$) remained significant independent predictors of RSB among YIDPs (table 5).

DISCUSSION

This study highlights a substantial burden of risky sexual behaviours among young internally displaced persons in the Dschang Health District, underscoring the combined effects of displacement, socioeconomic precarity, and limited access to sexual and reproductive health services. Almost half of the respondents reported being sexually active, and engagement in risky sexual practices was particularly high among those who had initiated sexual activity. The majority of YIDPs in this study were older adolescents and young adults aged 19–24 years, accounting for 50.7% of the sample, reflecting the protracted nature of displacement in the region. This age distribution aligns with global

Table 4. Bivariate analysis of factors linked to risky sexual behaviour.

variable	Modality	RSB		X2	cOR (95%CI)	P-Value
		Yes	No			
Sex of respondent	Females	19	139	2.9	0.57(0.3-1.1)	0.088
	Males	23	118			
Religious activities	Irregular	16	102	0.45	0.8(0.4-1.6)	0,05
	Regular	26	37			
Go to clubs	>once/ month	22	42	23.7	4.8 (2.1- 11.0)	0.001*
	1 /month	20	192			
Alcohol consumption	≥5 /month	9	19	20.7	1.3(0.5-3.2)	0.6
	<5 /month	22	59			
Substance use (Drug)	yes	9	27	7.87	3.3 (1.38-7.9)	.005*
	no	22	218			
Living alone	Yes	9	48	1.49	1.68 (0.7-3.9)	0.22
	No	22	197			
Non-utilization	No	23	69	19.89	3.4 (1.9 – 5.9)	0.001*
	yes	98	86			
Duration of displacement	4 years	16	161	2.4	0.56 (.26-1.1)	0.12
	>4 years	15	84			
Sexual debut	16	15	36	2.37	1.1 (0.49-2.57)	0.83
	>16	16	43			
Economic status	NPL	25	146	5.18	2.8 (1.1-7.1)	0.02*
	>NPL	6	99			
SRH knowledge	Low knowledge	16	85	0.571	0.57 (0.13-2.53)	0.75
	Good knowldege	26	148			
Educational Level	Primary	7	90	2.42	0.5 (0.2-1.2)	0.12
	≥Secondary	24	155			
Living with both parents	Yes	37	68	6.0	0.54 (0.33-0.89)	0.015*
	No	86	85			
Employment status	Worker	20	79	12.46	3,8 (1.76-8.36)	0.000*
	Non-worker	11	166			
Type of occupation	Informal	18	58	5.8	2.8 (1.1-7.1)	0.02*
	Formal	24	176			

ORc=crude Odd ratio, X2=Chi square, p=level of significance (p>0.05), RSB=Risky sexual behaviour, NPL: National poverty line.

displacement patterns reported by the Internal Displacement Monitoring Centre (IDMC) [36] underscoring the need for age-specific interventions targeting displaced youth. A substantial proportion of YIDPs lived in abject poverty (62.3%), with an additional 33.0% experiencing moderate poverty. This mirrors national poverty trends in Cameroon [31] but highlights heightened socioeconomic vulnerability among displaced youth. Limited access to basic needs such as food, healthcare, education, and income-generating opportunities may contribute to sustained deprivation and increased engagement in risky sexual behaviours. Sexual and reproductive health patterns revealed earlier sexual debut among females, with a mean age of 16.6 ± 4.8 years, and a higher prevalence of early sexual initiation compared to males. Nearly half of respondents were sexually active (48.9%). In contrast, a 2019 study conducted across six Divisions in the West Region [37] reported a much lower prevalence of 20.3% among in-

school adolescents aged 15–19 years. This difference may be explained by the broader age range included in this study and the protective role of school attendance against early sexual activity [38,39]. Although most sexually active YIDPs reported monogamous relationships, a significant proportion engaged in multiple partnerships and spontaneous sexual encounters. Irregular condom use and multiple sexual partnerships were markedly higher than those reported in non-displaced populations in the same region [37], with peer pressure, lack of information, and financial incentives identified as key barriers to contraceptive use. The prevalence of unwanted pregnancy among females (47.3%) was considerably higher than national estimates reported in systematic reviews [40-42]. Similar trends have been documented among displaced adolescent girls in other contexts, including Bogotá, Colombia [43]. These findings highlight the persistence of sexual activity and pregnancy during displacement and reinforce

Table 5. Bivariate and Multivariate analysis of factors predicting risky sexual behaviour among YIDPs in the DHD

Predictor variable	Modality	RSB		COR (95% CI)	p-Value	aOR (95% CI)	p-value
		Yes	No				
Religious activities	Irregular	16	102	0.8 (0.4-1.6)	0.05*	0.87 (0.7-1.5)	0.15
	Regular	26	37	1		1	
Go to clubs	>once/ month	22	42	4.8 (2.1- 11.0)	0.001*	5.01 (2.52- 10.0)	0.001*
	≤1/ month	20	192	1		1	
Living with both parents	Yes	37	68	0.54 (0.33-0.89)	0.015*	0.58 (0.36-0.92)	0.025*
	No	86	85	1		1	
Psychoactive substance use (drug)	Yes	9	27	3.3 (1.38-7.9)	0.005*	2.8 (1.3 – 6.6)	0.02*
	No	22	218	1		1	
Utilization of SRH services	No	23	69	3.4 (1.9 – 5.9)	0.001*	2.9 (1.5-6.0)	0.002*
	Yes	98	86	1		1	
Economic status	≤ NPL	25	146	2.8 (1.1-7.1)	0.02*	2.5 (1.05-6.0)	0.038*
	>NPL	6	99	1		1	
Type of occupation	Informal	18	58	2.8 (1.1-7.1)	0.02*	2.1 (1.1 – 4.0)	0.03
	Formal	24	176	1	1		
Duration of displacement	4 years	16	161	0.56 (.26-1.1)	0.12		
	>4 years	15	84				
Sexual debut	16	15	36	1.1 (0.49-2.57)	0.83		
	>16	16	43				
SRH knowledge	Low knowledge	16	85	0.57 (0.13-2.53)	0.75		
	Good knowledge	26	148	1	1		
Sex of respondent	Females	19	139	0.57 (0.3-1.1)	0.088		
	Males	23	118	1	1		
Living alone	Yes	9	48	1.68 (0.7-3.9)	0.22		
	No	22	197	1	1		
Alcohol consumption	≥5 /month	9	19	1.3 (0.5-3.2)	0.6		
	<5 /month	22	59	1		1	

cOR=crude Odd ratio, aOR= adjusted odd ratio, X²=Chi square, p=level of significance (p>0), NPL: National poverty line, 1=reference value

the importance of prioritizing family planning services alongside other humanitarian interventions. Evidence indicates that family planning services are both feasible and effective in crisis settings [44], yet remain insufficiently accessible to displaced youth. RSB was highly prevalent, affecting 44.2% of all respondents and 90.4% of sexually active participants. Independent predictors included substance use, frequent nightclub attendance, non-utilization of sexual and reproductive health services, informal employment, low economic

status, and not living with both parents. These findings are consistent with existing literature linking substance use and socioeconomic vulnerability to unsafe sexual practices among adolescents [45-48]. Qualitative findings further illustrated how economic hardship, peer influence, and coercion contribute to transactional sex, unprotected intercourse, and unsafe abortions. Overall, these results emphasize the need for integrated interventions combining substance use prevention, economic empowerment, and accessible, youth-friendly

sexual and reproductive health services to reduce sexual risk among YIDPs

STRENGTHS AND LIMITATIONS OF THE STUDY

This study has several important strengths. It focuses on young internally displaced persons, a highly vulnerable and under-studied population in Cameroon. In addition, the study examined a broad set of socioeconomic, behavioural, and service-related factors, enabling a multidimensional analysis of determinants of RSB. The integration of quantitative and qualitative findings further strengthened the interpretation of results. Despite these strengths, the study has some limitations. Its cross-sectional design precludes establishing causal relationships between identified exposures and risky sexual behaviours. Furthermore, reliance on self-reported data may have introduced recall bias and social desirability bias, potentially influencing the accuracy of participants' responses

CONCLUSION

This study provides important evidence on the magnitude and determinants of RSB among YIDPs in the DHD. RSB was highly prevalent, particularly among sexually active youth, with inconsistent condom use, unwanted pregnancies and abortions frequently reported. Multiple interrelated factors contributed to this high risk, including peer pressure and limited access to accurate sexual and reproductive health information. These findings highlight the urgent need for integrated, youth-friendly sexual and reproductive health interventions tailored to IDP settings. Such programmes should combine comprehensive sexuality education, accessible and confidential SRH services, substance use prevention, and socioeconomic and psychosocial support to effectively reduce vulnerability and promote safer sexual behaviours among displaced youth.

Competing interests: The authors declare no competing interests.

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