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Access to Healthcare vis-à-vis Women's Reproductive Health in Cameroon

By Michael Soh¹

Abstract

All over the world, several million women die each year, and 90% of them in developing countries from pregnancy and childbirth related causes (World Health Organisation Magazine on Women's Health, 1995). Nearly all of these are preventable, yet in Cameroon, this is far fetched. This study questions why women die from these causes? Is it due to government neglect, and / or women's callous attitude toward pregnancy and/or the patriarchal control of women? Are healthcare facilities lacking or rudimentary, inadequately staffed, and / or expensive? This study argues that limited access to healthcare facilities drains women's reproductive health down the spiral in Munyenge-Cameroon

Via open-ended semi-structured interview guide questions data was solicited from 40 pregnant women between 15-45 years (Denzin & Lincoln, 1998). Interviews followed a topic guide and exploited interviewees' different views focused on different themes to elicit reflective accounts which enabled respondents talked freely about highly personal issues which rekindled their memories on reproductive health problems due to limited access to healthcare facilities. All interviews were tape-recorded in 'Pidgin English' (a lingua franca) to eschew questions being misconstrued if asked in English, and this tremendously enhanced data reliability and validity. The data was transcribed into English to ease data interpretations, explanations, discussions and analyses. The findings provide a comprehensive picture of healthcare service mismanagement of facilities, men's control of women due to socio-cultural tenets, financial vulnerability of women hence limit their access to health care facilities.

Keywords: Access; Healthcare; Women's Reproductive Health, Cameroon.

Health is the aggregate of our successful attainment of a state of wellness, our acquired capacity to resist disease, our success in achieving the series of developmental tasks in the sequence of mental and social development at each stage of our life span (World Health Organization, 1958). But this cannot be achieved without health institutions and /or access to health institutions, able to provide adequate healthcare. Access to these services is fundamental in every country, as this reflects their socio-economic and political structure. The overarching question is: why do women have limited access to healthcare facilities in Munyenge-Cameroon?

Cameroon lately introduced healthcare policies via the Ministry of Health, intended to improve standard of health, which determines its development. Are these healthcare facilities adequate to prevent pregnant women from dying during pregnancy and/or childbirth? The major objective is to explore women's limited access to healthcare facilities. Because wellness is the physical, mental and psychological well-being and not the mere absence of disease or infirmities (World Health Organisation, 1958), women's reproductive health vary significantly across cultures. For example,

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- i. Socio-economic dependency particularly with men as ‘bread-winners’;
- ii. Patriarchal structures ensure men to subjugate women hence compromise women’s reproductive health;
- iii. Social welfare policies / health inequalities discriminates against women, a consequence of differentials of what social change does to people’s socio-economic circumstances;
- iv. Socio-epidemiology, relating to what people’s socio-economic circumstances do to their health for instance, job type and income level differentials.

Women’s physical and mental peculiarities are linked to their reproductive functions and their particular experiences of pathology define the norm of the female body legitimated by medical practice in the science of gynecology. Similarly, during puberty to menopause (women’s sexual activity peak), most women are vulnerable to gynecological complications, and after menopause, because they have less sexual activity and its many demands on the powers of their systems and health, suffer less from reproductive diseases and become more secure against extraneous battles. In this regard, studies focusing on access to healthcare provision are very important to women, since women as population multipliers need excellent health (Doyal, 1995; Yuval-Davis, 1997). This study thus explores healthcare facilities and pregnant women’s access to them in Munyenge to assess whether the government provides pregnant women the necessary healthcare facilities.

What is Healthcare?

Bernard (1991) views healthcare as ‘providing antenatal and postnatal services. This means providing women with healthcare services before and after pregnancy. Similarly, for Bencha (1993: 14) healthcare is “providing healthcare services during and after pregnancy at a moderate cost for all including the provision of necessary drugs”. The overarching emerging question is; does the Munyenge rural pregnant woman given her financial vulnerability have access to such services at the point of need? A major problem of rural poor pregnant women is often the lack of money to afford antenatal healthcare. Similarly, Oakley (1980: 45) defines healthcare to mean, “...sensitizing women on pregnancy related issues via health programmes and creating many healthcare institutions to attend to women in need”. Thus, educating women on pregnancy issues and available healthcare facilities is very important, though male dominance continues to exclude women from reproductive decision-making processes even when their health is at stake.

Also, Sundari (1992) defines healthcare as “accessibility to obstetric and maternal health services”. This view fails to identify anti-poverty strategies, which can facilitate access to adequate healthcare services to reduce maternal mortality for rural women in developing countries. Hopkins (1985: 11) also defines healthcare to mean “availability of information on healthcare to provide a healthy environment...” otherwise rudimentary healthcare and stressful environments expose women during pregnancy to health complications.

Review of Healthcare Situation in Cameroon

The Ministry of Public Health coordinates healthcare activities in Cameroon, though receives insignificant budget allocation each financial year, and coupled with misappropriation healthcare facilities are lacking and in most instances rudimentary. Government healthcare providers according to ...Stegmueller in "Unpaid Nurses Downs Tools", (2007) observed that the staff of Buea General Hospital like in Yaounde, Douala without salary become easily agitated and rude to healthcare users. On July 11, 2007, the worm has turned. Staff will no longer accept these untenable working conditions. They have painted protest signs with their demands on them and assembled before the hospital's gates.

The strike consisted of a small group of people dressed in their "whites," standing up for their constitutionally confirmed right to be paid in exchange for their labour. They were not demanding heaven on earth; all they wanted back was their legitimate property: the earned money every worker is entitled to receive at the end of each month, "or at least quarterly" as a nurse conceded. "No more promises" is written in big letters on one of the signs. This was not the first strike of this kind. All around Cameroon, in Douala, Yaoundé, Limbe, nurses and doctors have been on the warpaths. Buea was only part of a wider, national organised strike that takes place these days. "It is the same everywhere--go to Limbe, and you will find the same problems". A furious nurse observed: "Last time, the Minister of Public Health sent us a note that we should keep on working. Salary will be paid soon, but nothing happened". But what exactly are all these problems; the medical staff is complaining about? Well, there are various reasons for a strike; the loss of wages might be the most apparent, but not the only one.

An automatic advancement to avoid too many employees being retired prematurely is also as causing the quarrel as is the unfair recognition of different qualifications and therefore payments. Take for example the many voluntary workers who are an integral part of the hospital's daily operating. With the intention to be taken over later on as a civil servant, the qualified healthcare provider began working on a voluntary basis. Most of them, though, have not yet been integrated into public service and have been working for months, yet are unpaid healthcare assistants. Almost 70% of the staff in Cameroon is longing for their money. This exclusively pertains to the so-called "HIPC staff", staff that is employed as contract workers under the HIPC program, which was initiated and sponsored in 1996 by the World Bank and International Monetary Fund. The program originally aims to reduce the external debt of heavily indebted poor countries (HIPC), to sustainable levels by assistance and financial support for long-term development projects. The general hospital in Buea's glimmer of hope on the country's long walk to modernity seems bleak.

The nicely painted and relatively equipped hospital with its approximate 100 employees is deceptive. Behind the cream walls, in the hospital wards and even the doctor's office, one might find anger and, of course, hopelessness. A frightening percentage of all these thoughtful nurses and doctors have not been paid for fifteen months. Since April of last year, many healthcare services have been provided without salary for the personnel. This is not due to the staff's generosity, but rather compulsion: To have a proper job is a rare thing nowadays, and nurses prefer to wait instead to quit. They have no choice, for there is no real alternative. However, the HIPC staff is waiting,

waiting, and waiting. What matters is that 54 billion dollars that were spent for 27 countries so far within the framework of the program, among them Chad and Burkina Faso, if staff at the Buea General Hospital cannot "feed their families, their children, and take care of themselves". How then can they be polite and nice to healthcare users at the point of need? Apart from the obvious question: where did all that HIPC money go? More urgent is the immediate response to the staff's needs. For otherwise, the patients, particularly the vulnerable pregnant women have to pay with their health for the political failure.

As a result the needy populations rely on private healthcare providers who are somewhat handy though expensive. Since the 1970s, the government has been concerned about maternal health, thus maternal and child healthcare departments were established, but poorly equipped, despite its desire to train auxiliary paramedics including nurses and midwives to staff midwifery Centres (NAPWID, 1997). Regarding the private sector, religious missions retain attention due to their sizeable intervention and their special status as non-profit making organizations. In the traditional sector, traditional healers are most solicited because of the joint effects of the economic recession and some beliefs and customs, which are still deeply rooted. Given the economic recession, there is increasing recourse to traditional healers even in urban areas to mobilize and render sustainable the achievement in the health sector. International co-operation via national non-governmental organizations is also playing a significant role in health development in Cameroon. The World Bank, United Nations Population Fund, United Nations Children's Fund, German Cameroon Cooperation and World Health Organisation are financing health projects aimed at women and children's health, and overseen by the Health Ministry.

Following the ALMA-ATA Conference in 1978 in USSR, Cameroon ratified the Africa Health Development Charter, making primary healthcare an essential strategy towards "Health for all by the year 2000" (NAPWID, 1997: 59). Cameroon further took active part in the meeting of Health Ministers in Lusaka in 1986 of World Health Organisation Member States in Africa, which laid the bases for a health development to strengthen health care systems at all levels. Since the mid 1990s, the government has increased the budget of the Ministry of Public Health; yet such an increase has not only failed to meet the rising public demands for health services for women, but has also not specifically targeted women's reproductive health issues for proper solution. As a consequence, women continue to suffer disproportionately from many of the diseases such as pregnancy related complications including HIV/ AIDS, VVF, anemia, miscarriages, maternal mortality, and post parturition traumas that have become endemic to the nation and unique to women (NAPWID, 1997).

Later in 1996, a framework law in the area of health was enacted. This law No.96/3 of 4 January 1996 laid down the general framework of State action in the domain of health and the objectives of the national health policy in Cameroon. This law aims at giving a legal basis to partnership between the State and the Communities on the promotion of the health of the vulnerable and underprivileged groups especially women (NAPWID, 1997). In view of this, the political will of the government to improve on the healthcare situation of women took a challenging turn with the ratification of the Convention for the Elimination of All Forms of Discrimination against Women (Ministry of Women's Affairs, 1999), though frustrated by individuals misappropriating funds.

Nonetheless, to some extent, the government has been implementing programmes to educate women on reproductive health problems they face. In this light and in line with the World Health Organization's programme on women's health, though the Ministry of Public Health launched many health programmes aimed at improving women's health, yet the maternal mortality rate is high in most rural communities (Ministry of Public Health, 1999).

Currently, the government through the Ministry of Public Health has adopted a policy to ensure women's access to healthcare services by building healthcare structures all over the country, though concentrated in urban areas aimed at improving women's health via workshops and seminars on health (Ministry of Women's Affairs, 2000). In order to improve women's health, the government in 1997 initiated a programme to encourage girls to major in natural sciences, and today, Cameroon has a growing number of female medical doctors who can better understand the reproductive health problems of fellow women (Tumnde, 1998). In this regard, the government tries to improve the health of women, but a lot of pregnancy related health problems particularly in rural areas still exist due to limited access to health care facilities. There is need therefore for women's reproductive health needs to be made a national priority, since with the ineffective healthcare system maternal mortality continues to increase making it difficult for women to live a commendable reproductive life. There is need also to introduce alternative ways to finance healthcare such as anti-poverty strategies as to enhance the ability of women to have access to these critical healthcare services, since women represent the vulnerable groups in need of immediate healthcare intervention in the country.

Women's Reproductive Rights / Reproductive Health Needs in Cameroon

Are women and men treated differently in ways that objectively disadvantage them hence limit their access to healthcare facilities? How can if any discriminatory practices in healthcare access and provision be removed? If an equitable health care system is provided, will it treat both men and women in identical ways despite the patriarchal culture of control and domination of women by men? If equality of outcome is to be achieved, healthcare provision needs to be based on a clear understanding of the socio-biological differences between men and women vis-à-vis reproductive health care needs (Nana-Fabu, 2001).

Feminist critiques of medical practice often identify gender discrimination in healthcare systems and provision (Ferree, 1990). Though in many countries, women make up about 75% of healthcare workers and providers, and a majority of healthcare users, yet the power remains with senior medical professionals and managers; majority of who are males. Thus they tend to allocate scarce medical resources, and exercise significant degree of control of such medical resources in favour of men. This unavoidably affects the quality of treatment provided women who always have huge and complicated reproductive health needs (Stanley & Wise, 1983, Rubin, 1975). This paper questions whether patriarchal stereotype cannot be deconstructed considering gender dichotomy as it affects healthcare provision for women's complex health needs.

Reproductive healthcare needs, access and consent

Despite women's numerous reproductive health needs, they have less access via personal consent to healthcare provision. Most women particularly in patriarchal societies

(Doyal, 1995; Smyke, 1995) continue to experience discrimination in reproductive healthcare access, and their rights to make decision on whether to terminate a risky pregnancy is often denied them. Their right to an abortion is dependent on their husband's consent regardless of the wife's health needs. The society's message to these women is 'carry these unwanted pregnancies or risk your lives to end them' (Royston & Armstrong, 1989). Therefore, women in such patriarchal societies continue to have difficulty in obtaining appropriate care and these problems often result in huge maternal deaths, with complications ranging from VVF, miscarriages, postpartum parturition, and maternal deaths. Family planning services are always significantly lacking or reduced for women due to discriminatory and control tendencies of men. Even when women do receive family planning services, there is evidence that women generally experience specific problems ranging from care giving to communication, decision-making regarding type of service and method of service provided. Women always face difficulties relating with male health personnel due to their socialization and to the stereotypical views of patriarchal dictates. Generally, most male doctors in Cameroon are reluctant to let women speak for themselves and because of women's childhood socialization feel unable to assert their own reproductive rights and medical needs: typical in Munyenge. Poor women or the financially vulnerable are often treated by health workers as though they are less rational, less capable of making complex decisions regarding when to get pregnant, simply because cultural beliefs devalue their reproductive health (Petchesky, 1992; Doyal, 1995).

Women's own experiences are often devalued by comparison with male 'expert medical' knowledge and decision-making, and many male doctors are often reluctant to admit ignorance and uncertainties in handling and treating women's reproductive health problems, even if they are gynecologists (British Sociology Association, 1991). As a result, female patients may become the passive recipients of doctor's ministrations: as these episodes are so distressing and demeaning for women particularly those economically dependent. Mores seriously make patriarchal systems and structures to not respect women's autonomy over their fertility, and this represents a significant breach of medical ethics. For example, informed consent will have little reality in a situation where women's own beliefs and desires are required. These issues have thus generated keen concerns (to this researcher as a Medical Sociologist, Gender Health Practitioner and Social Policist) in the context of reproductive healthcare needs for women, where access to new reproductive technology (NRT) is denied women. Women seek to use modern contraceptives to control fertility or during risky sex, but must first negotiate with their partners, then with male doctors whose personal judgment about the appropriateness in particular may raise concerns and constrain the woman's own choices and desires to opt for specific therapy or abortion of risky pregnancies and/or surgery, or are denied the opportunity to participate fully in treatment decisions in Cameroon (Petchesky, 1992; Smyke, 1995; Doyal, 1995). Of course in Cameroon, individual women vary greatly in how active a part they play or wish to play, and in the case of hysterectomy, rural women still report lack of support in their attempt to make informed choices, while vasectomy remains a 'no-go' area dictated by traditional mores of polygyny.

Concerns about the quality of caring relationships continue to be high on the agenda of women's reproductive health around the world. It is clear that the development of modern contraceptive devices has influenced more effectiveness and cost criteria than

by concerns for women's health according to World Health Organization and International Women's Health Coalition (1991). In recent years too, it has become evident that problems linked with the quality of clinical care are not confined to specialists on women's health domains'. In the US for example, studies have revealed that even where women and men have the same health needs, women may be denied a fair allocation of clinical resources. For example, men on dialysis according to the US National Institute of Health are significantly more likely than women with the problem to obtain a kidney transplant. Also, a number of U.S. studies have shown that men with Cardiac symptoms are more likely than women to be given diagnostic catheterisation. Several UK studies are beginning to show similar trends. Men in the South of the Thames Region for example, are 60% more likely than women with the same condition to be offered coronary artery bypass operations or angioplasty (Koblinsky et al; 1993, Hearn, 1987). Such evidence thus highlights the ways in which differential treatment of men and women can sometimes lead to unacceptable outcomes. These genuine differences in terms of healthcare delivery, according to radical feminists rather should be equal at point of contact regardless of who delivers the service (Coveney, et al, 1984; Jones et al; 1988; Walby, 1990). Therefore, there is the need for healthcare policy change, in order to break sex/gender barriers in medical practice, provision and ministration

Location of case study area and its diversity

Munyenge is a village situated off Owe, Ikata and Bafia in the Southwest Province under Muyuka Sub-division in Cameroon. Its original inhabitants are part of Bakwerians from Bova. Munyenge has an estimated population of 1400, with women making 2/3 of the population despite the high incidence of maternal deaths. More than half of the populations are strangers from across the country: Banwas from Liebialem, the Mettas from Momo Division, the Akwayas from Manyu Division, the Esicmbis and some foreigners from Nigeria (Muyuka, Rural Council, 2005). Its inhabitants are mostly Christians from different denominations (Protestants, Catholics and Pentecostals), though with a few Moslems and atheists. Though religion may not seem a direct factor, indirectly they are influential and greatly limit women's access to healthcare facilities, as reported by some interviewees. Catholicism is critical of pregnancy outside of marriage, and not early pregnancy, though paradoxically it does not support the use of contraceptives (New Jerusalem Bible, 1990). The indigenous religious rites in this Anglophone region give some indication of the traditional importance of traditional birth attendance.

The main occupation of the inhabitants particularly women is agriculture with cocoa, as the main agricultural produce. Understanding their economic mainstay helps to understand women's financial situation linked to whether their failure to attend clinics during pregnancy is because of lack of money. Some of the women combine agricultural and non-agricultural activities such as petty trading, nursing, etc. All of these helped the researcher to understand the financial status of these women vis-à-vis their limited access to healthcare facilities. Their main language of communication is Pidgin English. Because of this, data was solicited in Pidgin English as to avoid questions being misconstrued (Kvale, 1996, Denzin and Lincoln, 2000).

Sample Selection method/rationale

The researcher knocked from door-to-door to select 40 monogamous married women relevant and interested in partaking in the study. The strategy of knocking at every door was a technique to avoid any bias based on the imposed criteria below and to ensure respondents' privacy. This way, every woman had an equal opportunity of being selected if in a monogamous marriage and interested (Kvale, 1996).

Imposed criteria for sample selection

- Only a married female pregnant member of monogamous household was selected. This was to understand why a monogamous husband should be unable to provide financial support to the wife during pregnancy;
- Each respondent had to have one or more dependent children. This was to examine the burden they may have in supporting such children. Do they deviate resources to care for the many than to attend to their pregnancy needs due to meagre resources?
- Both employed and non-employed respondents were selected. This was to explore the influence of 'money' and whether or not this affects women's attitudes towards attending antenatal clinics;
- Women from different religious denominations were selected. Though not predetermined, the sample had 25 Presbyterians (predominantly Presbyterian village), 8 Catholics, and 7 atheists. The choice of 40 women was driven by the researcher's capacity to handle the sample size, the time constrain and funds available to conduct the study.

Research design, Data collection method / Rationale

This study is designed from a feminist perspective, which takes as its starting point the need to create a common bond of interest between the researcher and the respondents (Stanley & Wise, 1983, Oakley, 1986). Each respondent was interviewed in-depth for 1 hour. They had the leeway to discuss at length in any chosen direction without deviation the phenomena investigated. The age range (18-45) was chosen to enable the researcher understand the different health problems faced by women of these different ages particularly when pregnant. Getting access was difficult as they spend most of their time on the farms and only returned home in the evening after 6pm. Fieldwork was during the rainy season and rain acted as a barrier hence limited time meant working with a larger population would have been difficult to manage.

Most of the women were aged 26 and 35 years (number=25). A further 10 were in the younger age group of between 18 and 25 years, while 5 were in the older age group between 36 and 46. Most were married women (30) living with their partner, while 10 were widows. A majority (25) were either on the sixth or seventh pregnancy, while 10 were at their second pregnancy, and 5 were with their first pregnancy, but fell under the older age group. Out of the 40 interviewees, only 10 had completed primary education and out of the 10, only 5 were employed, 2 teachers and 3 nurses. This analytical categorization helped to understand the knowledge of the respondents on the importance of seeking healthcare services when pregnant and whether their lack of access to such services is caused by their lack of education or otherwise.

Interviews were conducted between the months of May and June 2007 in two phases: phase one involved interviews with younger women during their first two pregnancies; and phase two involved interviews with older women during their sixth and

seventh pregnancies. This was so in order to understand the different health problems faced by pregnant women of different ages. Do younger pregnant women more than older pregnant women visit more healthcare facilities? This hypothesis was tested and analysis suggest that younger women visit healthcare facilities more due to anxiety, while with later pregnancies, clinic visits reduce significantly with their meagre finances committed to taking care of the many children usually without the husband's support. According them, later pregnancies are no longer perceived as dangerous, and they develop different coping strategies (e.g. using traditional birth attendance in order to cut cost). Though some are placed in a 'catch 22 situation': as they do not attend clinics; but they do know that it drains their health down the spiral (Family Planning Saves Lives, 1991).

Research ethics and confidentiality

Because the objects of inquiry in interviewing are human beings, extreme care was taken to avoid any harm to them (Denzin and Lincoln, 1998), since people's feelings can be hurt during and after the exercise. Linked to this, three ethical issues were considered viz:

a. Informed consent

All interviewees gave their verbal 'informed consent' to partake in the study, after the researcher gave elaborate explanations to them about the purpose and the benefits of the study. Also, the respondents were informed that they had the right to withdraw from the study at any time they wanted. This was done in order to counteract any potential undue influence or coercion, especially as the researcher was a male (Moustakas, 1994; Kvale, 1996). They also provided their consent for the researcher to use a tape recorder: to correct the natural limitations of human memories and the intuitive glosses placed on people during interviews, and it also freed the interviewer from doing several jobs (probing, prompting, listening and jotting notes), which could have hampered concentration hence impacts on data reliability (Bryman, 2001).

b. Confidentiality

In social research, there is often the tendency that researchers present 'subjects' and the findings in rather demeaning ways, which may not reflect them and their situations. Whyte's 'famous study' of Italian street corner men in Boston has come under severe scrutiny as the men were portrayed in demeaning ways (Denzin & Lincoln, 2000). Thus, pseudonyms have been used in reporting the data in this study to respect respondents' right of privacy and confidentiality in giving information.

Data Analysis, Findings and Discussions

The analysis describes attitudes of respondents towards pregnancy and establishes the link between limited access to healthcare services and the impact limited access has on women's reproductive health. The results identified factors restraining antenatal visit to healthcare facilities by the selected respondents. The data analyses provide intriguing findings and provide a representative picture of the existing situation in the study area in particular. Data is analyzed via interpreting respondents' responses based on questions asked them. The first section analyzed factors, which act as barrier to women's access to

healthcare facilities, and the second section analyzed the impact of limited access to healthcare services on women's reproductive health.

a. *Geo-social and economic factors*

Cameroon is a mosaic of differing cultures, languages and religions, united only by the accident of colonial history. There is great diversity in traditional attitudes towards women and girls. Linked to its regional diversity is the geographical aspect of the educational penetration of the country by the various Christian missions with their health Centre, and were keen first in developing boys' education and later that for girls, as the missions worked inwards from the coast. Cameroon's rural communities are underdeveloped with few healthcare units and fewer literate women (Education Research Paper, No. 09, 1993). Facets of this gender dichotomy affect the role; status and education of females and their desire for healthcare (Allen and Baber, 1994). Although this is in most parts of Cameroon, it is prevalent in rural areas. As participation in secondary schooling becomes strained, it is the poorer families whose girls lose out as the economic factor emerges. At primary level the potential problem of distance between home and health institutions normally arises and is indeed a major problem in the rural regions. There are arguments that Cameroonian women tend to consider traditional birth attendance as 'parallel' and/or 'complementary' in the provision of antenatal care. Early marriage is common in this rural area, and the tradition continues that marriage and early procreation is the only possible future for a girl. A girl is transitory within the family group (Rubin, 1975, Chow, 1999). The girl-child is regarded not only as a valuable asset but also for her work in the fields, her bride price and her high fecundity. There is a clear link between early marriage and early pregnancy resulting often in VVF without healthcare facilities when needed. Traditional non-formal education for girls in this area centres on preparing them to be good housekeepers and mothers. A satisfactory wife must have "un ventre de fécondité", a strong spine (for working), good cooking skills and good manners (Bankole & Singh, 1998; Speizer, I, 1995). Here, women always work extensively in the fields to exploit its huge volcanic fertile soils with obvious implications on their reproductive health. Given this diversity, some men fear the independence of women (Fanon, in Chow, 1999) that can come through education hence there is more pressure on women to conform to traditional norms of early pregnancy and childbirth via the use of traditional birth attendants (Mauldin, 1965; www.ippfnet.ippf.org/pub/IPPF_Regions).

Women play a central role in subsistence agriculture: they are the prime source of labour. Here, women rent fields and own storehouses for their produce. Their role in feeding the family has implications for their reproductive health (Berer, 1993; Smyke, 1995) as they have to work for long hours to learn the backbreaking subsistence agricultural skills they need in order to increase productivity; hence their clinical enrolment and attendance suffers. Their tasks are not any easier and coupled with frequent pregnancies, deliveries and poor nutrition drains their health down the spiral.

Cameroon had enjoyed something of a boom until the last decade, but now is experiencing rapidly deteriorating economic circumstances (Eloundou-Enyegue, 2000), with the severe economic climate affecting women's workload on the farms. The economy of monogamy is uneconomical in this area: "*le travail familial a besoin de bras*". Thus, women in monogamous marriages tend to have many children intended to

stop their husbands from being polygynists. The women prefer girls because more girls mean more labour for agricultural production hence more income. There is thus a rather utilitarian view of girls within the traditional economy: useful for house chores and farming; hence socialized for marriage and to undermine pregnancy as a reproductive health problems needing medical care. In marriage they tend to have a relaxed attitude toward clinical healthcare (Doyal, 1995). Respondents who were unemployed reported insolvency, hence their inability to attend clinics during pregnancy. For example, for Celine; “As a housewife, the little money my husband gives for the kitchen, I manage it to provide food on the table for a family of 7 children. When pregnant, my husband hardly gives me money to attend the clinic”. Most women (25 out of 40) depend on their husbands for money, but in response to the question; would the case be the same if they earn their own money? Mrs. Mbah said: “I am employed, but my husband controls the salary as the family head. I don’t decide how to use the money”. Similarly, for Mrs. Elloh: “I am a farmer on a very large estate. I grow cocoyams for the market. The income the farm generates, my husband controls it. If I do the contrary without his consent, he would dispossess the farm of me”. Thus, women lack access to and control of money and this limits their access to healthcare facilities (Pahl, 1989, Ferree, 1990, Volger & Pahl, 1994). Even those who earn money cannot control it. Contrary to the above, Ms. Bess a widow said: “I am a trader; I control my money the way I like. Nobody tells me what to do. I have a child I need to care for”.

b. Indifferent attitude

The nonchalant attitudes of women affect their reproductive health, despite government’s call to strengthen health education for the girl child, intended to emancipate women and to enable them have control over their sexuality and fertility as to minimize their reproductive health problems. Most women (28 out of 40) reported that they lack time to go for antenatal care due to their multiple chores. They conflate domestic and other chores hence tend to neglect their health matters, which they perceive as less important. For Ma Vero: “I rarely attend antenatal care except during the last month of pregnancy. I do farming, petty business and other donkey house chores. There is hardly any time available to visit the clinic, after all pregnancy is no illness” (Uchudi, 2001)

Ma Vero like most women in her situation rarely visit antenatal facilities given their preoccupation with farm and domestic chores to support their many children. Their lives are a resemblance of a beehive (Thompson and Walker, 1989). However, Mrs. Ngufor expressed an atypical view: “All I do is cooking. I have house help. My husband also gives me money each month for antenatal care”. Women like her expressed such one-off views because they have house help and much less workload; and their husbands provide money for antenatal care nonetheless (Renne, 1992).

Some women equally identified long distance and rudimentary transportation means between home and the clinic as limiting their access to healthcare facilities. For Mrs. Evelyn, “We use a ‘Ben Skin’ on the bad roads: it shakes you and the baby, which can cause a miscarriage. I attend antenatal clinic 2 months to delivery”. For her, motorbikes (Ben Skin), deters her frequent visits for antenatal care. According to her, the government health centre is not only far away, but also lack necessary and adequate medical facilities. For the richer women, they prefer private health centres though

expensive. For Mercy: “The government hospital is not only far away, but it is also inadequately equipped. I prefer the nearby private health unit though expensive”.

Male dominance also emerged as an important issue, which limits most respondents’ (25 out of 40) antenatal access (Bourdieu, 1989; Murray, 1995). For example, for Susana: “How can I go to the clinic without my husband’s consent? Even if I have the money, my husband’s consent is paramount; otherwise I will be accused of being a bad and disrespectful woman”. These issues bedevil women’s very existence, as they lack self-determination and rights over their sexuality and fertility (Bernhard, 1716, in Gray, 2000). Similarly, for Mrs. Maureen, “...my husband does not give me money for antenatal care because according to him it is waste of money since I cannot have male children useful in a patrilineal kinship system”. These issues underpin patriarchal practices, which subordinate women (Langness, 1972, Walby, 1990). Also, most women prefer traditional birth attendants because they charge less. For Azinwi,

“I prefer traditional birth attendants not only because clinic prices are scary, but also, the nurses are extremely rude, and the clinic understaffed: you must be extremely fortunate to be attended to during emergency. No emergency even if you can pay for, particularly in the government clinic”.

These numerous hurdles tremendously limit their access to healthcare facilities. The use of traditional birth attendant has huge implications on women’s health, for example, according to Mrs Ajeh: She is 35 years old. When she was born, her mother was malnourished, undernourished and over-worked. She was very low weight at birth and grew slowly. During childhood, she had little good food to eat even, less than her brothers. She could not go to school as her brothers could but remained at home with her mother to help with the housework and child minding. When she became an adolescent, her pelvic bones were misshapen and she was shorter in stature than might have been expected. As was the tradition, she was married early and had her first baby when she was 14 even before she had fully developed. It was a difficult birth, but she survived it. It was a painful event with her second pregnancy shortly after as it was aborted spontaneously. She was tired and weak afterwards. Her many subsequent pregnancies occurred as well, with little time between to recuperate or replenish her health. On one delivery, she had so much bleeding that every one was afraid she would never recover, and she had a high fever for days. She has been anaemic ever since, a condition aggravated by the hookworm she carries and the inimical environment rife with malaria.

During another pregnancy, she suffered a malarial fever and aborted. During later pregnancies, her nutritional state was very poor, and her fatigue was draining her. She had so much work with the children, keeping up the household, fetching water from far away, working all day long on the farms under the scorching sun, coupled with the petty trading of farm surplus that she began to dread the next pregnancy. When it happened, she went to a woman in the village for something to end it. She was very sick but it worked. She breastfed all of her eight children, but many times it was difficult and tiring. Once, in order not to stay off from her multiple activities, she bottle-fed her infant. She did not have enough money to buy enough powder so she diluted the little she had and her eldest daughter had the job of giving the bottle to the baby. The baby died at four months from diarrhea.

Like her mother before her, she never went to the health centre when she was pregnant. It was too far away and too foreign. She used the traditional birth attendant (TBA) who delivered her and who helped her sisters. The TBA, unaware of the importance of cleanliness used a bamboo blade to cut the umbilical cord, and her unclean hands to extract the placenta. Thus, she suffered serious infection. Though she survived those episodes, today at 35, she still feels dull pains and soreness in her 'belly', which flares up from time to time. During her rare menstrual periods, she does not experience too much pain, but she is anemic, and sometimes there is infection because she is not able to use clean enough protection. Also, after so many pregnancies, abortions, and miscarriages, her body has a partial prolapsed uterus, which often causes her strong discomfort, especially after a hard day's work. Despite all her long hours of hard work in petty trading and helping the family working in the fields, there is never enough food. She does all she can to prepare the family's meals all alone, but the husband and children must have the most, and she will manage. She is always malnourished and underfed.

She is a woman who cares desperately about her family and wants to limit her pregnancies. She heard about family planning from her sisters but was always too afraid of her husband who would never allow it. What would people think if she has no more babies, especially after her last son died lately? Despite these anxieties, she once got some contraceptive pills clandestinely, yet she felt so nauseated and had so many headaches (this was surely a punishment, she thought), that she stopped. Her next pregnancy was a disaster, an ectopic pregnancy that almost led to her demise.

These difficult situations bedevil the majority of women in Munyenge. At the centre of this fine labyrinth are the women whose reproductive deliberations take place within a particular set of beliefs and values about the nature of men and women, the purpose of sexuality and the meaning of marriage, sex, parenthood and family life. In this community, women experience powerful pressures to 'prove their femaleness' by becoming pregnant often. At the same time, women and their partners are influenced by the socio-economic reality of the world around them. Therefore, a woman does not simply get pregnant and give birth like the flowing tides and seasons. She does so under the constraint of material conditions that set limits on natural reproductive processes. For many women, the decision to have a large family is not from ignorance or religious obscurantism but also because children represent an important army of labour and a sign of social status aggrandizement and a source of material security in their old age. Decisions of this sort are invariably represented as belonging to couples or households, but it would seem most of these decisions in Munyenge are made in the context of gender inequality.

c. Legal Legacy

Although customary laws give almost all power to the male, on paper there exists, since independence the notion of equal opportunities. In practice, women make no reproductive decisions. Early marriage, which is a constraint on girls' education, while the minimum age for the girl is 18, lawyers often agree to legalize the union at much younger ages (as low as 12) provided that both sets of parents consent. This is not uncommon, especially amongst the rural poor and this leads to women's domination and control in marriage by men who exercise more power and control driven by traditional

mores. Thus, women are rarely allowed access to antenatal care, as most wives are usually younger than their husbands, and traditionally, seniority is power (Walby, 1990).

d. Political /Administrative challenges

The Ministry of Women's Empowerment and the Family created lately though with limited budget appear to boost equal gender roles and power despite the increasing number of qualified female healthcare providers without jobs in this province. The healthcare sector has come under immense financial crisis, especially in the rural regions due to government's misappropriation of state funds, hence women lose out. Aid agencies (e.g. Overseas Development Agency) do assist the health sector, though this remains an uphill task; due to traditional bureaucratic red-tape thus limiting funds and access to antenatal care. As a result, indigenous private healthcare facilities are helping to break these barriers via mass sensitization programmes and bringing the facilities nearer to users, though they charge more money.

Impact of limited access to healthcare facilities on women's reproductive health

Mother and child health centres are unevenly distributed at all levels of Cameroon's three tiered public health systems. Rural areas suffer most despite the government's apparent support for maternal and child health adopted in the 1992 National Population Policy (NAPWID, 1997; MINCOF, 1999). This policy, emphasizes 'responsible fertility decisions', commensurate with parents' financial and health situations. This means couples and not the government decides about family size, unlike the case in China (Davin, D. et al., 1985). Government's inadequate funding of health institutions, inadequate reproductive health staff training and facilities; and poor communication infrastructure seriously limit women's access to health care facilities.

Though health is important given its connection with the sexual dimension of youth culture, where sex education and the health of adolescent girls are matters of concern, the government is less involved in protecting maternal and child health (Doyal, 1995, Koblinsky et al, 1993). While the custom of bride price protects the health of young girls to some extent, early marriage and pregnancy militate against health and educational opportunity for girls. This permeates family structures in such rural areas with the least educated wives, without jobs dependent on their husbands, hence dominated and controlled. With such socio-cultural beliefs which legitimate women's subordination, this significantly reduces the average life expectancy in years for women to 56, often resulting from high maternal mortality rate due to pregnancy and / or childbearing complications (www.dfid.gov.uk/). In this regard, the women reported several reproductive health problems. For example, 15 out of 40 interviewees reported having had stillbirths, 10 with anemic cases due to poor nutrition and malaria during pregnancy. Miscarriage cases due to hard breaking domestic and farm chores without adequate medical care were also reported. Mrs. Marty reported VVF complication: "My first pregnancy at 13 resulted in a ruptured bladder and has since remained a scare on my mind. The gynecologist's diagnoses say I failed to attend antenatal care, and my condition was diagnosed very late". Such cases affect the very heart of a family's future survival and economy. The workload of women increases as the number of people to care for increases. This in many ways has a negative effect on the health of women, hence

detrimental to both their psychosocial and reproductive health. (www.usaid.gov/pop_health/pop/tiahrtpolicy.html),

Also, the frequent health problems during pregnancy vary according to the ages of the interviewees. A few interviewees (5 out of 40) from the ages of 18-25 complaint of miscarriages, while 15 between 26-35 years complaint of abdominal pains and usual bleeding, and anemia related to poor nutrition and malaria during pregnancy. Also, most women (35) had more complications during their fifth and sixth pregnancies than during their first two pregnancies. Maggi for example said: “I did not attend antenatal care with the first pregnancy. A traditional birth attendant helped me at home. With the sixth pregnancy, I bled and was anemic. The timely termination of it by a gynecologist saved my life”.

Conclusion

This study has explored the impact of limited access to healthcare facilities on women’s reproductive health in Munyenge and revealed intriguing findings that can be generalized to reflect similar situations in rural areas in Cameroon. The findings revealed the following:

- ◆ The government is to blame for women’s limited access to healthcare facilities;
- ◆ Health units are poor and under equipped;
- ◆ Rude medical personnel;
- ◆ Very expensive diagnoses and treatment;
- ◆ Poor road infrastructure;
- ◆ Patriarchal structures which subordinate women;
- ◆ Women’s lack of financial independence;
- ◆ Women’s callous attitude towards their own health matters;
- ◆ Women’s vulnerability and proclivity to remain under their husbands’ perpetual protection though traumatic.

To adequately understand these issues, the study traced the evolution of healthcare in Cameroon, revealing government’s policies that are more-or-less lip service unable to secure healthcare particularly for the rural poor women. The government needs to prioritize women’s reproductive health issues, as the present situation pushes a lot of pressure on women to increase population without adequate medical support for them. Not only because women lack control over resources such as money, but also the patriarchal culture subjugates them, hence they depend exclusively on their husbands for financial support. Their responses depict things would be different if they have financial autonomy via generating their own income and controlling it, and able to make decisions about when to visit the clinic for antennal care. The critical reproductive health problem most women face in Munyenge is high maternal mortality. More than 65% of women in Munyenge die each year during childbirth or pregnancy related problems. Indeed, the government’s slogan “health for all” seems a mere sham policy. The results reveal a pathetic situation that bedevils a majority of women in the rural communities of Cameroon, with similar socio-cultural and financial backgrounds.

Recommendations

In order to improve on women's reproductive health in rural communities in Cameroon via increase access to healthcare facilities:

- Firstly, Government Health Institutions should be increased, expanded and equipped and brought nearer to the users. With the advent of rural community radios and /or television, they constantly need to disseminate information to users at point of antenatal need;
- ◆ Secondly, the government should provide good roads to facilitate access to healthcare services especially in emergency cases;
- ◆ Thirdly, socio-cultural practices detrimental to women's reproductive health including beliefs that guarantee male dominance should be annihilated (Olusanga, 1969). Women need to be empowered and should have the right of self-determination and control of their sexuality, make decisions regarding whether or not go for antenatal care, underpinned by a legal and social workers' support scheme to ensure that women's reproductive rights are not interpreted as favours but as prerogatives;
- ◆ Fourthly, the medical personnel should be trained to be polite and tolerant, as patients sometimes are naughty particularly when in excruciating pregnancy related pains;
- ◆ Fifthly, the government should recruit and pay monthly healthcare providers particularly in such rural communities, to enhance efficiency in the delivery of healthcare services;
- ◆ Sixthly, the government should develop an anti-poverty strategy to alleviate poverty and to engage the rural poor women in self-sustainable income generating projects void of men's interference. Since poverty is one of the critical problems rural women face particularly when pregnant, they need to be educated on healthcare issues and why they should attend maternal health clinics (Christopher, 1980). Through these, women's chances of dying due to pregnancy related problems would be significantly reduced.

References

- Allen, K, R. & Baber, K, M. 'Issues of Gender' in Mckenry, P, C. & Price, S, J. (1994) Families and Change: Coping with stressful events. London: SAGE.
- Bankole, A. & Singh, S. (1998) "Couples' Fertility and Contraceptive Decision-Making in Developing Countries: Hearing the Man's Voice", International Family Planning Perspectives'. Vol. 24, No.1
- Bencha Yoddumern, (1993) Social Cost of Maternal Deaths, Thailand
- Bernard, J. B. (1991) Pregnancy and Malaria, Tanzania
- Bernhard, J. (1716) "Every Man is King in His House" in Gray (2000) Productive Men, Reproductive Women. Oxford: Bergbabn.
- Berer, M. (1993) 'Population and family planning policies: Reproductive Health Matters, No 1: 4-12
- Bourdieu, P. (1998) Masculine Domination, Paris: Seuil.
- British Sociology Association, (1991)
- Bryman, A. (2001) Social Research Methods, Oxford: OUP.

Cameroon Population Commission Report, March 2002

Chow, R. (1999) 'The Politics of admittance: female sexual agency, miscegenation, and the formation of community in Frantz Fanon', in A.Alessandrini (ed.) Frantz Fanon: Critical Perspectives. London: Routledge.

Christopher, E. (1980) Sexuality and Birth Control in Social and Community Work, London: Maurice Temple Smith Ltd.

Coveney, L. et al., (1984) The Sexuality Papers: Male sexuality and the social control of women, London: Hutchinson.

Crompton, R. (ed.), (1999) Restructuring Gender Relations and Employment, OUP.

Davin, D. et al., (1985) China's one child family policy, Basingstoke: Macmillan.

Denzin, N.K. & Lincoln, Y.S. (1998) Strategies of qualitative inquiry, London: SAGE.

Doyal, L. (1995) What Makes Women Sick: Gender and the Political Economy of Health. London: Macmillan.

Education Research Paper, No. 09, (1993)

Eloundou-Enyegue, P. (2000) 'Socio-Economic Context, Population and Demographic Change in Cameroon', in Child Policy Project, downloaded from www.rand.org/child/projects/html

Encyclopedia of Women's History in English and American Law.

Family Planning saves lives (FPSL), (2nd ed) (1991)

Ferree, M. M. (1990). Beyond separate spheres: Feminism and family research. Journal of marriage and the family; Vol. 52, 866-884

Gray, M.W. (2000) Productive men, Reproductive women: Oxford: Bergbavn Books.

Hearn, J. (1987) The Gender of Oppression: Men, Masculinity, and the Critique of Marxism, Brighton: Wheatsheaf.

Hopkins, E. (1985) Pregnancy: Women Speak Out about their Experiences, Oxford: Pergamon.

Jones, K. B., et al. (1988) The Political Interests of Gender: Developing Theory and Research with Feminist Face, London: SAGE.

Koblinsky, M et al, (ed.) (1993). The Health of Women: A global Perspective. Oxford: Westview Press.

Kvale, S. (1996) An introduction to qualitative research interviewing, Thousand Oaks, Calif: SAGE.

Langness, L. (1972) 'Ritual, Power, and Male Dominance in New Guinea Highlands', in Fogelson, R. D. & Adams, R. N. (ed.) (1977) The Anthropology of Power, London: AP.

Mauldin, W. P. (1965) Fertility Studies: Knowledge, Attitude and Practice, Studies in Family Planning: A Publication of the Population Council

MINCOF (1999) Rapport Initial du Cameroun sur la mise en oeuvre de la Convention sur L'elimination de toutes les formes de discrimination, MINCOF, Yaoundé

Moustakas, C. E. (1994) Phenomenological Research Methods, Thousand Oaks, Calif: SAGE.

Murray, M. (1995) The law of the father? : Patriarchy in the transition from feudalism to capitalism, London: Routledge.

Muyuka District Hospital, (2005)

Muyuka Rural Council (2005)

- Nana-Fabu, S. (2001) 'High fertility and development in Cameroon', in Journal of Social Development in Africa, 2001, 16 (1) pp 25-45
- National Plan of Action on the Integration of Women in Development (NAPWID): Sector-Based Analysis, April 1997).
- Neba and Chrystian (1991) Contraceptive use in Cameroon in 1991, Bamenda: Nooremac.
- Oakley, A. (1986) Women confined, Oxford, Martin Robertson
- Olusanga, P, O. (1969) 'Nigeria: Cultural barriers to family planning among the Yorubas', in Studies in Family Planning, Vol.24, no.6/ Part 1 Nov/Dec.1993.
- Pahl, J. (1989), Money and Marriage, Basingstoke: Macmillan.
- Petchesky, R. (1986) Abortion and Women's choice: the state, sexuality and reproductive freedom, London: Verso.
- Renne, E. P. (1992) 'Gender Ideology and Fertility Strategies in an Ekiti Yoruba Village', in Studies in Family Planning, Vol.24, No. 6 /Part 1.
- Royston, E. and Armstrong, S. (1989) Preventing Maternal Deaths, (Geneva: WHO).
- Rubin, G. (1975) The Traffic in Women: notes on the political economy of sex, in R. Reiter (ed) Towards an Anthropology of Women, New York: Monthly Review Press.
- Shiffman, J et al., (2002) 'Reproductive rights and the state in Serbia and Croatia', in Social Science and Medicine: an international journal, Vol.54, No.4. Pergamon
- Smyke, P. (1995) Women and Health: Women and World Development Series. London: Zed Books Ltd.
- Speizer, I. (1995) 'Men's desire for additional wives and children', in Social Biology, 42 (3-4): 199-213).
- Stanley, L & Wise, S (1983) Breaking Out: Feminist Consciousness and Feminist Research, London: Routledge
- Stegmueller, C. P. (2007) Unpaid Nurses Down Tools, Unpublished.
- Sundari, T.K. (1992) Women and Pregnancy, Kenya.
- The New Jerusalem Bible, (1990).
- Thompson, L., & Walker, A. J. (1989) Gender in families: Women and men in marriage, work, and parenthood. Journal of marriage and the family, Vol. 51, 845-871
- Trushen, M. (2000) African Women's Health, Africa World Press: Asmara
- Tumnde, M. (1998) The Participation of Women in Politics and the Democratization process in Cameroon
- Uchudi, J. M. (2001) 'Spouse's socio-economic characteristics and fertility differences in Sub-Saharan Africa: does spouse's education matter'? in Journal of Biosocial Science. (2001).
- Volger, C. & Pahl, J (1994) 'Money, power and inequality within marriage', Sociological review, Vol.42, no.2. P.263-288
- Walby, S. (1990) Theorising patriarchy, Oxford: Basil Blackwell
- World Health Organization (1958)
- World Health Organization and International Women's Health Coalition (1991)
- World Health Organisation Magazine on Women's Health (1995)
- <http://www.crtv.cm/Cameroon%20national%20population%20%25commission>
- www.dfid.gov.uk/
- http://www.ippfnet.ippf.org/pub/IPPF_Regions
- www.usaid.gov/pop_health/pop/tiahrtpolicy.html
- Yuval-Davis, N. (1997) Gender & Nations, London: SAGE.