Social Policy Research Network in West and Central Africa
The Cameroon Coordination Office

Women and Access to Health Services in Cameroon

Final Report

June 1997

Submitted to the SPRN Coordination Office
c/o IDRC Dakar, Senegal
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Acknowledgment

The SPRN of Cameroon gratefully acknowledges the financial and technical support provided by the IDRC Regional Office, Dakar. We are also most grateful to the Honorable Minister of Social and Women’s Affairs of Cameroon for her availability as well as to the Dean of the Faculty of Medicine who provided the much needed work space and showed keen interest in our work. We thank the staff of the Centre for the Control and Study of Communicable Diseases at the Faculty of Medicine for their exemplary service. We acknowledge the collaboration of our colleagues in the field and gratefully remember the kindness of all of those whom we interviewed. We hope that these findings will result in the betterment of the health of our women.

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EXECUTIVE SUMMARY

Given that the woman plays an important role in the socio-economic life of a country and that her health status is an important variable in the development process, a study was carried to evaluate the level of access they had to health services in Cameroon as well as the determinants of this access. The study set out to determine the nature of access to health services by the Cameroonian woman. Specifically, the study aimed at determining and analyzing the characteristics of the proportion of women with satisfactory access to health services in both rural and urban settings, identifying the key factors that determine access to health services (at societal, institutional and family levels), identifying the coping mechanisms adopted by women regarding their health and consequently providing guidance to government in social policy matters as well as further research.

The study was principally participatory and observational aiming at obtaining both qualitative and quantitative data. It was carried out in five of the ten provinces of Cameroon. The provinces were chosen to reflect the ecological, social and religious diversity in Cameroon. Qualitative data was obtained with the use of a focus group discussion guide which was administered to groups of women aged 15 and above. The quantitative data was obtained with the use of structured questionnaires. There were three types of questionnaires which were administered: one at the community level, one at the level users of the health services and one at the level of health workers. A total of 1362 respondents were interviewed in the five provinces of the country (Centre, East, Far North, South West, North West). In each province interviews and focus group discussions were conducted in both the urban and rural areas.

We obtained the following results:

- Overall health services are solicited and used by most of the women interviewed (85-95%)

- About half of the women are able to satisfactorily access health services.

- The four most cited obstacles to the use of health services are high cost of services, poverty, poor patient-staff relations and discrimination from health staff in order of importance.

- Men are still the principal decision makers and still pay most of the health bills, although most women with satisfactorily access are engaging in income generating activities like farming and trading in order to be more financially independent.

- Culture does not constitute an obstacle to women's attitudes to the health services.

- The most important obstacle to health care delivery are lack of equipment and inadequate staffing of health units which has resulted from the economic crisis.
The following are needed in order to improve access of women to health services:

- Reduction in the cost of health services.
- Availability of more staff in health units.
- Equipment of health units with basic materials.
- Creation of more health units and participatory management of these.
- Education of women in services available in health units.
- Education of health workers in professional ethics and improvement of services offered.
1.0 INTRODUCTION: STATEMENT OF THE PROBLEM

It is now generally accepted that health is a pre-requisite for development since unhealthy people cannot constitute an adequate force to initiate or maintain economic growth. It is equally accepted that women have a key role to play in development since they interact with the social web in diverse and intricate ways. Thus a healthy woman is primordial for a development. However, the situation of women in relation to the health care systems and therefore how they access it, appears to be dependent on variables such as women's statuses in the specific culture and society to which they belong. Therefore questions related to gender and control of decision making, their socio-economic situation, the degree of social investment of women, their position in the labour force and in some instances their ethnicity become of key importance in determining the health of the woman.

Social policies in Cameroon have been instituted since independence in an unstructured manner. Basic indicators of well being have been reported to be improving up till 1990, Thus the human development index changed from 0.228 in 1970 to 0.310 in 1990. In 1993, the population was estimated at 12.2 million, the growth rate at 3.0, the crude birth rate at 41, the mortality rate at 12, the fecundity index at 5.7, and the life expectancy at 56 years. The urban population constituted 53% of the total and had a growth rate of 5.3%. Yaounde the capital city had 17% of the national population.

The economic situation in Cameroon is changing. The annual growth rate of the GNP between 1970 and 1980 was 7.2% and between 1980 and 1991 it was 1.4%. Economic dependence was 84% in 1970 and 93% in 1990. In 1985, the proportion of the population below the poverty line in urban and rural areas was 15% and 40% respectively.

Education-wise, between 1986 and 1992, the enrolment rate for boys in primary school was 82%, and that for girls 71%. In secondary schools it was 32% and 23% respectively the literacy rate for men was 66% and for women 43% during the same period. Health-wise, 41% of the population has access to health services (44% urban and 39% rural); 50% has access to potable water (urban 57, and rural 43); and 74% has access to sanitation schemes (100% urban, 64% rural). Antenatal care services were assessed as follows: ATT vaccination 36%, use of family planning services 16%.

The situation of the woman has been assessed as follows between 1980 and 1993: life expectancy 53.3 years fecundity rate 5.8% follow up of pregnancy, 56%, access to health 25%, maternal mortality rate 430 per 100,000, literacy 43%, enrollment to primary schools 93%, enrollment to secondary schools 26%. In Cameroon, a woman's health is related to the national health status. Thus, although traditional health indicators (i.e infant mortality rate, maternal mortality, life expectancy) have improved over all, inequalities are apparent when incorporating into the analysis socio-cultural variables such as class, ethnicity, demographic and epidemiological information such as age, risk exposure and incidence of some illnesses, and conditions. Hence, the Cameroonian woman is greatly disadvantaged regarding her access to health. One may argue that this is also true of children. Although this may be so to a large extent, the driving force toward a reversal of the process would be more easily mobilized among women than among children.
A certain number of events have influenced the overall standard of living in Cameroon, whose effects negatively influence the access to health care of the populations. These are the economic crisis, the devaluation of the CFA franc and the structural adjustment programme set up by the Bretton Woods institutions. Indeed the social services have been drastically cut as result of the necessity to improve economic growth. Thus fees are required both for attendance of schools and for accessing health services whereas they were substantially subsidized in the past. In addition, there is an accompanying reduction in workforce in the civil service, with most people being informed on the spur of the moment that they are out of job.

Women and children have traditionally suffered most from unhealthy social policies. The inadequate access to health services is an expression of inequity that is unavoidable. Equity objectives are directly related to those of access and availability of health services to all. Thus, in considering gender differences and women's disadvantaged position in society, the object of achieving equity in health constitutes a challenge to achieve.

It is conceivable that inequities would occur even among the women folk. We do not know what proportion of the women do actually have adequate access to health care. Also, we do not know what coping mechanisms have been adopted, if any, to allay the ill effects of the inequity in social services regarding the women. An appraisal of the coping mechanisms adopted by the more equal women would help in the understanding of the key factors that need to be taken into consideration as we plan issues for development, including those related to health.

The analysis of the issues related to access could be viewed from the societal macro level, the institutional level and the individual/family level. The societal level will consider issues related to the style of development, macro - economic policies, political orientation, the statues of women, work/employment conditions, health policies, self - help systems and social support networks. The institutional level will review the structure of the health system (available, affordability and quality) as well as the behaviour of the health professionals accommodation and acceptability). Regarding the individual and family level one will study the characteristics of the clients to determine the affordability of the services as well as their behaviours to determine the acceptability of these services.

Thus, this study on the access to health services by the Cameroonian woman identifies both the weak points of the health system as well as the coping mechanisms that have adopted that could be proposed to men and children in similar situation as the women. Also, the information obtained will be used to advice government action regarding development and policy social issues.

Our working hypothesis is that the majority of the Cameroonian women have unsatisfactory access to health care as a result of the poor health system and institutional organization. Some women, both in the rural and urban areas have developed coping mechanisms which could be adopted to other women and men.
2.0. RESEARCH OBJECTIVES

The general objective of the study was to determine the nature of the access to health services by the Cameroonian woman. The specific objectives were:

1. To determine and analyze characteristics of the proportion of women with satisfactory access to health services in a rural and urban setting in Cameroon.

2. To identify the key factors that determine access to health services by the Cameroonian woman in relation to societal, institutional and family levels.

3. To identify the coping mechanisms adopted by women regarding their health.

4. To identify a framework for providing guidance to governments in social in social policy matters as well for further research.

3.0 RESEARCH METHODS.

The overall methods were observational and participatory and resulted in the obtention of quantitative and qualitative data. Five study sites were chosen namely the Centre, the East, the Extreme North, the North West and South west provinces. These represent the major ecologial and cultural zones within the country. In each site interviews and focus group discussions were conducted. Respondents were selected randomly from an urban area and a rural area where farming is the predominant socioeconomic activity. Although these results may eventually not be generalisable to all women, they generally represent women in the urban and rural setting.

The study population of women in both rural and urban areas was a mix of adolescent, adult and elderly women as well as working, housewife, and petty traders.

The population of women with satisfactory access to health care was determined by subjecting the selected women to a questionnaire. In essence "satisfactory health care" is defined as a woman being able to obtain health services from a trained practitioner, with a time frame that is not considered excessive by both the client and the interviewer.

3.1 Data collection

The key factors that determine health care was obtained by observation, interview and focus group discussions. These are related to the societal, the institutional and the individual/family levels. Data was collected by members of the research team.
or their assistants after validation of the verification of the relevant instruments both at the instructional and field levels. Questionnaires were prepared to permit verification of results obtained. The instruments strived to obtain data about three levels of study: society, institutional, individual/family.

i) The societal level considered issues related to development, macro-economic policies orientation, the status of women, work/employment conditions, health policies, self-help system and social support networks.

ii) The object of study on the institutional level are on the one hand to determine availability, affordability and quality, and on the other hand to determine the accommodation and acceptability.

Regarding availability, affordability and quality, the following was studied in order to assess the structure of the health systems:

- Cost of services
- Prevalence of western medical culture
- referral patterns
- professional recruitment
- staff training
- class structure of health system
- fragmentation
- inability to diagnose certain ailments
- profit orientation of the medical system
- provider-consumer relationships
- site of the service relationships
- hours of operation

Regarding accommodation and acceptability the following were studied in order to assess the behaviour of the health professionals:

- feelings towards poor women
- prevalence of western medical culture
- referral patterns
- professional recruitment
- staff training
- class structure of health system
- fragmentation
- inability of diagnose certain ailments
- profit orientation of medical system
- provider-consumer relationship
- site of service
- hours of operation

Regarding accommodation and acceptability the following were studied in order to assess the behaviour of health professionals:

- feelings towards poor women
- beliefs about women's status
discrimination on the basis of ethnicity
do not speak language of clients
awareness of disparities in the provision of health services
position on reproductive issues
position on expansion of sex roles

iii) The individual/family level measures affordability by studying the characteristics of clients and acceptability by studying the behaviour of clients.

The characteristics of clients studied are:
- ability to pay for services
- etiological beliefs
- levels of education
- residential segregation
- lack of health insurance
- do not speak language of providers
- ability to identify health problems as problems
- homeless, battered, imprisoned, elderly, adolescents, nomads

The behaviour of clients studied are:
- limited participation in decision making
- the role of traditional medicine in their health
- delayed health seeking behaviour
- perception of severity of situation
- perception about the ability of services to solve the problem
- previous negative experience with the service
- fear

3.2 Data analysis

Data analysis was carried out in two steps. First there was the verification and sorting of the manual records. Secondly data was analyzed to obtain central tendencies (means and standard deviation), as well as associations using univariate and multivariate analysis assisted by an SPSS software was used in order to determine key factors that influence access to health care. The chi-square distribution test was used to test variation between trends in the urban and rural areas. In order to see whether responses varied according to province we simply inspected the cross tabulations according to province.

3.3 Complementary activities

The team comprises researchers in the social, Biological, Epidemiological, Communications and behavioural sciences. The research results will be disseminated through the media (written, radio and television). And through seminars and workers to be held with interested parties concerned sector and representatives of the women). Educational materials will subsequently be made to the women.
4.0 FINDINGS

The following sections present the findings of the study. We start by presenting the sample and the medical personnel knowledge of health facilities and the quality of services provided, then move on to explore women’s knowledge of services available, health seeking behaviour, the use of available services, their appreciation of those services, the cost of services as seen by the users and the health workers, accommodation and accessibility, individual and family factors that influence women’s access to health care and institutional factors affecting health care delivery. We then examine whether this varied according to area of residence or province.

This led to us examining proposal from the respondents on how to inform the respondents on how to improve health care delivery and women's access to health services.

4.1 The Sample

Some of the socio-demographic characteristics will be presented here. We are looking at the characteristics of the focus group discussion participants (age) and the informants of the survey such as residential area (urban, rural), marital status, and age group. The variables, level of education/literacy, religious groups and socioeconomic activities are relevant only for the non-hospitalized informants.

The study combines both qualitative and quantitative methods. Quantitative data was obtained through focus group discussions. A total of 50 groups were selected from the five sites visited. Focus Group Discussion sessions were held with 6 groups in the Centre province, 12 in the Far North Province, 8 in the North West province, 12 in the East, 12 in the South West. These groups were constituted according to the following age groups: 15 - 25 years, 26 - 35 years, 36 - 45 years, and 46 years and above. The number of respondents per group ranged between 7 and 12.

Quantitative data was obtained with the use of a structured questionnaire. A total of 1362 informants were interviewed. Of this number 81 were medical personnel, 493 persons seeking treatment at health units and 788 persons contacted within the community.

Table I shows a distribution of respondents according to province.
Table I: Distribution of Respondents according to Province

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>TYPE OF INFORMANT</th>
<th>Medical Personnel</th>
<th>Hospitalized</th>
<th>Non hospitalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre</td>
<td></td>
<td>14</td>
<td>148</td>
<td>164</td>
</tr>
<tr>
<td>Far North</td>
<td></td>
<td>19</td>
<td>100</td>
<td>102</td>
</tr>
<tr>
<td>East</td>
<td></td>
<td>15</td>
<td>156</td>
<td>178</td>
</tr>
<tr>
<td>North West</td>
<td></td>
<td>13</td>
<td>—</td>
<td>165</td>
</tr>
<tr>
<td>South West</td>
<td></td>
<td>20</td>
<td>89</td>
<td>179</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>81</td>
<td>493</td>
<td>788</td>
</tr>
</tbody>
</table>

We have to note that there is missing data for hospitalized respondents in the North West province because the questionnaire for non-hospitalized respondents was equally served for the hospitalized.

Table II: Distribution of Respondents according to Residential Area

<table>
<thead>
<tr>
<th>Residential Area</th>
<th>Type of respondent</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical personnel</td>
<td>60</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Hospitalized</td>
<td>398</td>
<td>95</td>
</tr>
<tr>
<td></td>
<td>Non - Hospitalized</td>
<td>518</td>
<td>270</td>
</tr>
</tbody>
</table>

Table III: Distribution of Respondents according to Marital status

<table>
<thead>
<tr>
<th>Type of Respondents</th>
<th>Marital Status</th>
<th>Single</th>
<th>Married</th>
<th>Free union/colabritio n</th>
<th>Widow</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical personnel</td>
<td></td>
<td>45</td>
<td>13</td>
<td>10</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Hospitalized</td>
<td></td>
<td>115</td>
<td>305</td>
<td>15</td>
<td>34</td>
<td>17</td>
</tr>
<tr>
<td>Non Hospitalized</td>
<td></td>
<td>249</td>
<td>408</td>
<td>47</td>
<td>48</td>
<td>26</td>
</tr>
</tbody>
</table>
Table IV: Distribution of Respondents according to Age Group

<table>
<thead>
<tr>
<th>Type of Respondents</th>
<th>Marital Status</th>
<th>15 - 25</th>
<th>26 - 35</th>
<th>36 - 45</th>
<th>46 - 55</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical personnel</td>
<td></td>
<td>1</td>
<td>35</td>
<td>27</td>
<td>8</td>
</tr>
<tr>
<td>Hospitalized</td>
<td></td>
<td>186</td>
<td>176</td>
<td>78</td>
<td>38</td>
</tr>
<tr>
<td>Non Hospitalized</td>
<td></td>
<td>273</td>
<td>290</td>
<td>156</td>
<td>68</td>
</tr>
</tbody>
</table>

Table V: Distribution of Respondents according to Level of education and literacy

The majority of the non-hospitalized respondents (83.7%) had attended school. The following table shows the distribution of this sample according to level of education:

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>195</td>
</tr>
<tr>
<td>Secondary</td>
<td>381</td>
</tr>
<tr>
<td>University</td>
<td>77</td>
</tr>
</tbody>
</table>

A greater proportion of the sample could read a newspaper although 23.6% said they could only do so with difficulties.

Distribution of Respondents according to Religious Affiliation

More than three quarter of the informants were Christians (86.6%) divided mainly into Catholics (41.2%) and Protestants (45.4%). Muslims constituted 8.2% of this sample.

Socioeconomic Activities

The following income earning activities were reported by the non-hospitalized respondents: housewife (73%), office work (51.6%), sole entrepreneur (44.2%), work on farms (77.3%) and others (16.2%). This implies that respondents were engaged in more than one economic activity. Questioned about their main occupation the following responses were given: student (20.9%), housewife (29.4), farmer (15.3%) and others (26.9%); 7.6% said they were jobless.

An identification of such personal characteristics will also enable us establish whether they are important in women's access to health care services.
4.2 Services

4.2.1 Medical Personnel Knowledge of Health Facilities

Table VI shows health facilities mentioned by health personnel:

Table VI: Health Units identified by Medical Personnel

<table>
<thead>
<tr>
<th>Health Facilities</th>
<th>Frequency of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health post</td>
<td>37.5%</td>
</tr>
<tr>
<td>Health centre</td>
<td>50%</td>
</tr>
<tr>
<td>PMI</td>
<td>21.3%</td>
</tr>
<tr>
<td>Clinics</td>
<td>18.8%</td>
</tr>
<tr>
<td>Dispensary</td>
<td>22.5%</td>
</tr>
<tr>
<td>Private maternity houses/ Dispensary/clinics hospital</td>
<td>46.3%</td>
</tr>
<tr>
<td>Public hospital/clinics</td>
<td>51.3%</td>
</tr>
</tbody>
</table>

4.2.2 Medical Personnel in the Service

Table VII shows the quality of personnel in the health as reported by the medical personnel.

Table VII: Categories of Medical Personnel in services identified by medical personnel

<table>
<thead>
<tr>
<th>Medical Personnel</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctors</td>
<td>80.2%</td>
</tr>
<tr>
<td>CESSI</td>
<td>37%</td>
</tr>
<tr>
<td>Staff Nurse IDE</td>
<td>88.9%</td>
</tr>
<tr>
<td>Infriminier breveté</td>
<td>93.8%</td>
</tr>
<tr>
<td>Nursing Aid</td>
<td>93.8%</td>
</tr>
<tr>
<td>Fille/garçon de salle</td>
<td>75.3%</td>
</tr>
<tr>
<td>Nursing agent</td>
<td>37%</td>
</tr>
</tbody>
</table>

4.3 Women and the Health Services

4.3.1 Women's knowledge of health services available

The majority of the hospitalized respondents (88.5) knew about the modern health services in the area which they resided. They cited the following services in descending order of importance as provided in these health
facilities: paediatrics (88.3%), gynecology (86.2%), surgery (74.9%), ENT (75.3%)
laboratory tests (75.3%) ophthalmology (48%), cardiology (22.3%) neurology (19.9%).
The majority of these respondents had been visiting the health services for
consultation (45.3%). The others had either been making prenatal visits (17.3%)
or laboratory tests (10.2%). They had either known about these centres from
family members (38.6%) or neighbours. A small minority had been referred to
the centres.

On their own part non hospitalized respondents for the most part (83.4%) also
mentioned paediatrics as a services rendered in the health services. This was
followed by surgical services (78.6%), gynecology (70.7%), family planning
(47.7%), ophthalmology (43%) care of handicap (22.1), endocrinology (20.1%)
orthodopodist (19.5%), and neurology (15.7%). Other significant proportion (17%)
mentioned unspecified other services.

These trends points to the fact that health care services are perceived by
women in an essentially feminine framework. Most women find health services as
essentially providing mainly services related to their functions as child bearing
gynecology, Family planning) and mothers paediatrics). Besides they are only
considered as providing complicated operations (surgery). Other services come
only in a second position.

4.3.2 Health seeking behaviour

Most of the hospitalized patients (95.3%) said they sought treatment in the
hospital when they were sick. When it was a neighbour or family members who
was sick they sought for help with traditional healers (31.6%) pharmacist
(37.1%), drug dealers (34.2%) and other sources (54.4%).

Non hospitalized respondents for the modern health services when they were
sick. They also preferred to take relatives to such services (87.6%) rather than
to other services: traditional healers(9.9%) and drugs dealers (10.3%). When they
were sick they would also prefer to visit the health centres/hospitals for the
most part (87.7%) although a substantial proportion mentioned traditional healers
(16.7%) pharmacist (13,2) and drugs dealers (10,2%). Self medication was also
mentioned by 9.4% of the respondents. Choices were largely influenced by the
type of the illness (70.2%) financial status (30.6%) and proximity (17.5%).

Hospitalized respondents preferred the modern health services because of
efficiency (83.7%) and to a lesser extend because of accessibility (22.1%) and
cheap cost (11.8%). The non hospitalized respondents said they preferred such
facilities because they could diagnose diseases before treatment (38%) and
because of efficiency

4.3.3 Availability and use of services

The following services were identified by non - hospitalized respondents as
existing within their vicinity: health centres (80.9%), clinics (54.5%),general
hospitals (52.9%) and subdivisional hospitals (44%) A high proportion of
respondents (82%) declared that they used these services with a majority of the
women (78.7%) declaring that they had their last delivery in the hospital.
The most cited cause of not using these services were high cost of services (65.4%), bad behaviour of staff (31.6%) lack of equipment (39.7%) and far distances. Nearly equal proportions of the respondents said they had either been referred (50.1%) or were been referred to a mission or private hospital (13.8%). Most had been referred because of specialist services (62%), lack of equipment (36.3%) and inability to diagnose diseases (22.5%).

Most respondents (59%) said they could visit the health services at any time of the day while 38.7% could visit these services from morning to afternoon.

4.3.4 Judgment of services provided by health facilities

Most of the respondents had a positive appreciation of the health services. A majority (60.2%) of the hospitalized patients said they were treated well while a substantial proportion (24%) declared they were treated very well during their last stay within the health institution. Only a very small proportion had a poor judgment of these services. The same situation is observed with non hospital informants who for the most part (79.19) declared they had been treated well by Doctors/nurse during their last stay in a health institution.

An immense majority of the hospitalized informants (90.1%) said they will visit the hospital next time they were sick. Reasons advanced were: good services (56%), good treatment (45.9%), and attitude of staff (35.2%). Patient who would not want to return to the services cited cost (48.9%), bad treatment (21.3%) and attitude of staff (38.3%). If we put bad treatment and attitude of staff under the same category we see that the most likely obstacle to women's use of health services would be experience with hospital staff.

The non hospitalized respondents were nearly equally divided into a category of satisfied (51.5%) and not satisfied (48.4%). Reasons advanced for satisfaction were good services (30.1%), efficiency (28.2%) and good results (27.2%) Most significant reasons advanced for lack of satisfaction are high cost of services (19%). Poor behaviour of staff (15.2%), poor reception (12.7%) lack of qualified medical personnel (14.4%) and lack of equipment. If we put poor behaviour in staff and poor reception together this would corroborate an observation concerning women's use of services mentioned above.

The majority of respondents (61.8%) declared they had not encountered problems during their last delivery. Those who accepted having encountered problems (32.4%) mentioned bleeding vesico vagina fistula, recto vagina fistula and caesath the women had delivered in the hospitals. The principal reason for resorting to hospitals was security. Most women who delivered at home mentioned lack of means and the impromptu nature of the labour. A majority of the respondents (90%) found family planning clinics helpful.

4.3.5 Cost of services.

Table VIII shows hospitalized respondents assessment of cost of services.
Table VIII: Cost of Services as reported by hospitalized respondents

<table>
<thead>
<tr>
<th>Appreciation</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>31.5%</td>
</tr>
<tr>
<td>Normal</td>
<td>24.5%</td>
</tr>
<tr>
<td>Expensive</td>
<td>22.4%</td>
</tr>
<tr>
<td>Very expensive</td>
<td>16.7%</td>
</tr>
</tbody>
</table>

If we classify normal and moderate under the same category, and expensive and very expensive a on the other side then we can say respondents assessment tilt towards the normal/moderate category. However 48.9% of respondents who would not visit a hospital next time advanced costs as a reason. On the contrary most hospitalized respondents judged costs as too expensive i.e 59% as against 29% who thought it was moderate and 9% normal. The following costs were cited for some services solicited.

Table IX: Cost of last delivery cited by hospitalized respondents

<table>
<thead>
<tr>
<th>Amount</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;6000</td>
<td>11.8%</td>
</tr>
<tr>
<td>6000 - 10000</td>
<td>35%</td>
</tr>
<tr>
<td>11000</td>
<td>21.5%</td>
</tr>
</tbody>
</table>

Most cited cost of consultation: 600.
Range of cost of transport :< 1500 - >1000
Most cited cost of transport: 150 - 300 (38.9%)..
It is worth while comparing this with authorized cost of consultation and cost of services on reported by medical personnel.

Table X: Authorized cost of consultation in CFA according to Medical Personnel

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>≤2235</td>
</tr>
<tr>
<td>Children</td>
<td>100 - 2235</td>
</tr>
<tr>
<td>Aged/Handicapped</td>
<td>≤ 2235</td>
</tr>
</tbody>
</table>

Table XI: Authorized cost of service in CFA according to Medical Personnel

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory exams</td>
<td>300 - 25000</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>300 - 2000</td>
</tr>
<tr>
<td>Surgical Operation</td>
<td>300 - 40000</td>
</tr>
<tr>
<td>ENT</td>
<td>200 - 1250</td>
</tr>
<tr>
<td>Gynecological</td>
<td>300 - 80000</td>
</tr>
<tr>
<td>Laboratory test</td>
<td>500 - 7250</td>
</tr>
<tr>
<td>X-rays</td>
<td>500 - 25000</td>
</tr>
<tr>
<td>Hospital bed/night</td>
<td>225 - 2500</td>
</tr>
<tr>
<td>Grad price (min) (max)</td>
<td>5 - 1700, 5000</td>
</tr>
<tr>
<td>Dental</td>
<td>600 - 26000</td>
</tr>
<tr>
<td>Normal delivery</td>
<td>600 - 12000</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>≤ 6000</td>
</tr>
</tbody>
</table>
4.4.3 Assistance obtained by informants

Husbands declared alone. Concerning husbands. Most linguistic/ethnic way of long, 78.7% nurses looked low on them, 67.2% the rich were shown respect (67.2%), given prompt attention (65.2%) and priority treatment.

On the other hand nurses were observed to be discriminatory by the majority of non-hospitalized respondent (69.3%). The most cited case of discrimination were preferential treatment to the rich (60.9%) and fellow women of the same linguistic/ethnic group (60.5%). On the contrary 55.8% of these respondent declared that patient were treated on an equal basis while 22.7% said clients were treated on a first-come-first-served basis.

4.4 Individual / family factors that influence women's Access to health care.

4.4.1 Decision Making

Most of the decision making concerning health issues is in the hands of the husbands. A quarter of the respondent declared they took decisions alone. Concerning the number of children most of the respondent (53.4%) declared they took decision jointly with the husbands while only 19.8% said husbands took decisions alone.

4.4.2 Health Bills

Husbands were cited by most of hospitalized (55%) and non hospitalized respondent as paying health bills for the family. A substantial proportion of hospitalized respondent got money from farming (33.5%) and family members (28.7%). This was also observed for non hospitalized respondent where 20.8% of informants obtained assistance from family or were obliged to provide it themselves (27.2%). About half (50.3%) of the respondents generally received assistance from family members as against a nearly equal number which did not receive such assistance (49.7%). The principal reasons advanced for not receiving assistance from family members was the latter's poor situation.

Persons who received assistance from relatives said they did not so rarely (34.7%), monthly (23.7%) and yearly (10%)

4.4.3 Difficulties encountered by family members in seeking for services

Most of the respondents (74.1%) were of opinion that family members encountered problems when sick. The most frequently mentioned problem was lack of money (89%). Distance, accessibility and poor reception were also mentioned by accessibility and poor reception were also mentioned by most of the respondents.

4.5 Cultural Factors

Most of the respondents (83.9%) did not see culture as an impediment to persons attending hospitals. The same is true of religion which was observed by 97% of the informants as not constituting any special obstacle to people attending health centres. However, some respondents felt it on the nature of the health services depending on the nature of the disease.
4.6 Institutional factors affecting health care delivery

4.6.1 Difficulties encountered by medical personnel.
Most medical personnel declared they had problems at work. The majority of medical personnel interviewed (89.7%) mentioned lack of equipment as a major problem. Most also pointed to inadequate staffing (79.5%). Other difficulties mentioned are heavy patient load (26.9%), long working hours (21.8%) and language (21.8%).

4.6.2 Patient - staff ratio and relations
The medical personnel reported they received between 1 and 87 patients per day in the health facilities in which they served. Most respondents (69.1%) found the behaviour of the respondents treated were sober and miserable. Some respondents found them difficult (48.1%), and (32.1%) and cranky (24.7%).

4.6.3 The economic crisis and access to proper quality health care
The most cited consequence of the economic crisis on the quality of health care was a decrease in motivation (87.7%) and a decrease in the number and quality of staff (65.4%). A substantial proportion of the respondents (28.4%) mentioned over - loading of staff.

4.6.4 Influence of traditional medicine on services provided in the hospital
Questioned on whether traditional medicine influenced services provided in the hospitals a majority of the health personnel interviewed (61.3%) though the influence was negative; 22.5 % of this category of respondents thought they was no influence while 20% thought the influence was positive.

4.6.5 Services provided by the private sectors to empower women
A number of services were mentioned as provide by both the private and public sectors to empower women. The most mentioned was the Njangi or women's group (77.9% of non hospitalized respondents). Women's centres, home economic centres and self help programmes were also mentioned by a substantial proportion of the non - hospitalized respondents.

4.7 Proposals for improving access to health services
Hospitalized respondents proposed the following measures for improving access to health services:
- reduction of cost of health services (35.6%)
- provision of necessary equipment (16.8%)
- house to house sensitization (17.3%)
- provision of free products (11.1%)
- health education through the media (17.1%)
In order to improve the quality of care they proposed:
- an increase in the number of nurses (53.7%)
- an increase in the number of doctors (47.6%)
- provision of free drugs (47.6%)
- Equipment of health facilities (56.8%)
The non hospitalized informant mentioned:
- reduction of cost (19.4%)
- reduction of cost of drugs (19.9%)
- creation of new hospitals (21%)
health education through women's houses and family planning clinics (19.7%)

increase the number of medical personnel available (19.7%)
equipment of hospitals (12.1%)
The medical personnel suggested that in order to improve their working conditions the following should be done:
  increase in salaries (88.9%)
  reduction of work load (19.8%)
  increase of staff (77.8%)
In order to improve health services they suggested the following:
  binging services closer to patients (70.4%)
  decrease cost of cost services (79%)
  improve quality of services (65.4%)

4.8 Disparities According to Residential Area

We set out to see whether the differences between respondent in rural and urban centres were significant or not. We noted the following significant differences.

4.8.1 Health Units, Services Provided, Use and Appreciation

We found significant differences in non hospitalized patients Knowledge of health units available within the community (hospitals, clinics, health centres) and the type of services provided therein, their judgement of the treatment offered and the male - female ratio of workers in these units.

The following table shows their knowledge of health structures available within the community.

Table XII: Health structures available within the community according to Residential Area

<table>
<thead>
<tr>
<th>Health structure</th>
<th>Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
</tr>
<tr>
<td>General hospital</td>
<td>67.5%</td>
</tr>
<tr>
<td>Sub-divisional hospitals</td>
<td>46.9%</td>
</tr>
<tr>
<td>Health centres</td>
<td>77.6%</td>
</tr>
<tr>
<td>Clinics</td>
<td>62.8%</td>
</tr>
<tr>
<td>Others</td>
<td>12.8%</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 57.9 \text{ df}=4 \text{ p}=0.0000001 \]

We find that more structures were reported in the urban in the rural areas for the most part.
By inspection we find that more services were reported to be provided in the urban than in the rural area.
Table XIII: Services provided in hospitals according to Residential area

<table>
<thead>
<tr>
<th>Service</th>
<th>Residence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>No response</td>
<td>3.4%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Gynaecological</td>
<td>49.5%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Surgical</td>
<td>80.6%</td>
<td>74.6%</td>
</tr>
<tr>
<td>Ophthalmological</td>
<td>61.4%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Endocrinological</td>
<td>27.3%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Care of handicap</td>
<td>30.9%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Neurologist</td>
<td>22.2%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>85.3%</td>
<td>79.6%</td>
</tr>
<tr>
<td>Orthopodist</td>
<td>28.3%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Family planning</td>
<td>62%</td>
<td>20%</td>
</tr>
<tr>
<td>Others</td>
<td>15%</td>
<td>19.6%</td>
</tr>
</tbody>
</table>

It would imply that rural women's knowledge of services rendered in health services is limited to Gynecology, Surgery and Paediatrics. Family planning is known but to a very limited extent. There was also a significant difference in the use of services between the rural and urban areas. More rural women reported using the health services than the urban women i.e 87.7% as against 78.5% (chi square = 11.45 df=1 p=0.0007).

4.8.2 HEALTH SEEKING BEHAVIOUR

There was some differences in the health units respondents preferred to seek for treatment when sick and what influenced them. However, the degree of disparity is not very high (Chi - Square = 9.82 df = 5 P = 0.081 for preferred areas of treatment, and Chi - Square = 29.38 df = 3 P = 0.00000019 for the influences).

4.8.3 Referral

A significant different was observed in the place where respondent were referred to when they visited a health unit (Chi - Square = 8.23 df = 3 P = 0.04). The same was observed with the reasons for referral (Chi - Square = 8.76 df = 3 P = .033).

4.8.4 Delivery

There was a slight different in the places women were reported to deliver. The proportion of the women in the rural areas who reported delivering in hospitals was greater than in the urban area (79.7% against 87.4%). The reverse was true for women who delivered at home (7.8% for urban and 3.1% for rural). ( The Chi - Square value was 5.5% at a degree of freedom of 2, P = 0.061. )

This shows a reversal in the trends especially when we know that the ratio of health units in the urban area is greater than in the rural areas.

We did not test the reasons for such preferences statistically but if we examine the principal reasons given, we can observe the disparity too.
Table XIV: Reasons for Delivering in Hospital

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
</tr>
<tr>
<td></td>
<td>274</td>
</tr>
<tr>
<td>Security/avoidance of sick</td>
<td>59.5%</td>
</tr>
<tr>
<td>Quality of Personnel/services</td>
<td>17.2%</td>
</tr>
<tr>
<td>Insurance</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

From this we can say that the disparity in the respondents' use of these services would be explained in terms of the confidence that they have in the services. It is important to note that a very high proportion of the urban respondents who had delivered at home mentioned lack of means: 28 out of 39 for the urban areas as against 6 out of 12 for the rural area.

There was also a significant difference in the place of last delivery. Although most of the respondents in both areas had their last birth in the modern health units (79.1% for urban and 77.9% for rural) we find that when it comes to delivery in the home, there is a greater number from the rural areas (14.3% against 8.9%). (The Chi - Square value was 6.73, df = 2 and P = 0.03). Hence we find that there is a difference between what is declared and what is the practice. Rural women may prefer the modern health services but the practice may differ due to other factors.

We also find that there were some differences in the problems mentioned as occurring after the last delivery (Chi - Square = 5.92 df = 6  p = 0.43).

4.8.5 Family Planning

The proportion of persons who had heard of Family Planning was not significantly higher in the urban than in the rural areas (87.8% as against 81% Chi - Square = 6.09 df = 1 p= 0.014). However, knowledge of services provided in the Family Planning centres was significantly higher among urban respondents than in the rural area as the table below would show.

Table XV: Knowledge of Health Services according to Residential Area

<table>
<thead>
<tr>
<th>Services provided in the FP Centres</th>
<th>Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
</tr>
<tr>
<td>No knowledge</td>
<td>10.7%</td>
</tr>
<tr>
<td>Counselling on spacing</td>
<td>81.8%</td>
</tr>
<tr>
<td>Counselling on contraception</td>
<td>72%</td>
</tr>
<tr>
<td>Laboratory test</td>
<td>21.2%</td>
</tr>
<tr>
<td>Pap smear</td>
<td>20.7%</td>
</tr>
<tr>
<td>Others</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

Chi - Square = 28.08  df = 5  \( p = 0.000035 \)
As one would find the proportion of ignorant women is nearly equal in the rural and urban groups. The same ratio is maintained concerning counseling and spacing and reduces when it comes to contraception. The differences becomes acute when it comes to laboratory test and pap smear.

We do not find significant differences in the judgement of these services. Most respondents in the rural and urban areas found these services very helpful (89.3% and 90.6% respectively, Chi - Square = 0.55 df = 2  p =0.75). However we find a significant difference in the mode of transport in these areas.

Table XVI: Mode of Transport to Family Planning Clinics

<table>
<thead>
<tr>
<th>Mode of transport</th>
<th>Residential Area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
</tr>
<tr>
<td>Trekking</td>
<td>22.3%</td>
</tr>
<tr>
<td>Taxi /Car</td>
<td>70.2%</td>
</tr>
<tr>
<td>Others</td>
<td>7.5%</td>
</tr>
</tbody>
</table>

Chi - Square = 127.22  df = 2  P = 0.0000001

We find that while the predominant mode of transport is the taxi or car in the towns and city, in the rural areas it is trekking.

4.8.6 Cost

On the whole no significant differences were observed in patients judgment of cost of treatment whether it was too expensive or okay.

Table XVII: Judgment of cost of services according to Residential Area

<table>
<thead>
<tr>
<th>Cost of services</th>
<th>Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
</tr>
<tr>
<td>Too expensive</td>
<td>60.4%</td>
</tr>
<tr>
<td>Moderate</td>
<td>28%</td>
</tr>
<tr>
<td>Okay</td>
<td>9.3%</td>
</tr>
<tr>
<td>Others</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

Chi - Square = 2.12  df = 3  P = 0.55

There were also no significant variations between rate of cost of delivery. However, transport fare quotations varied considerably between the rural and urban areas (Chi - Square = 167.27 df = 5 P = 0.00000001). The same is true of rate of consultation (Chi - Square = 79.77 df = 1 P < 0.0000001).

4.8.7 Institutional Factors, Accommodation and Acceptability

From the data there was a significant difference in reports about staff - patients relations.
The point of view of medical personnel is represented in the following table.
Table XVIII: Medical Staff Assessment of Behaviour of Patients Treated

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
</tr>
<tr>
<td>Cranky</td>
<td>21.7%</td>
</tr>
<tr>
<td>Difficult</td>
<td>48.3%</td>
</tr>
<tr>
<td>Rude</td>
<td>21.7%</td>
</tr>
<tr>
<td>Sober and miserable</td>
<td>65%</td>
</tr>
<tr>
<td>Other</td>
<td>36.7%</td>
</tr>
</tbody>
</table>

Chi - Square = 5.59 df = 4 P = 0.23

The only observation that holds true for both rural and urban areas is difficult behaviour. It is worthy to note that the rural women are observed to be both more sober / miserable and rude than the urban women.

On their own part the non hospitalized respondents' report about discrimination suffered differed significantly between urban and rural areas. While there were no significant differences in saying whether there was a difference in the way the rich and the poor were treated (Chi - Square = 6.63 df = 1, P = 0.036) or treatment reserved for the poor (Chi - Square = 6.21, df = 3, P = 0.10) and the rich, there was a significant difference in the type of attitudes identified as discriminatory (Chi - Square = 24.15, df = 3, P = 0.000023).

We can say that the most glaring indicators of discriminatory practices are use of ethnic language in urban areas (45% of the urban respondents as against 19.3% rural). Attitudes towards the rich was observed in nearly equal proportions in both rural (60.5%) and urban (61%) areas.

4.9 REGIONAL DISPARITIES

We also sought to know whether our findings varied according to regions studied. If we look simply at services sought in the health services, who pay for services, difficulties encountered by family members who seek services and financial assistance from family relations we observe some significant variations according to region studied.

Although consultation constitutes the most solicited service in all the sites it is significant to note that less than 40% of the respondents for the East province were seeking for such services. We can also note the low level of prenatal visits for the South West province as against a substantial proportion seeking delivery services. Again, although pediatrics was mentioned by the majority of the respondents in all provinces, the North west province is a deviation from the global trend where gynecological service are cited as the services provided in hospitals. Here pediatrics and surgery were only mentioned in second and third places respectively. Family planning services were cited by a very small proportion of the respondents in both the North West and South West provinces. Judgement of services was on the whole positive in all the provinces.
When it came to sources of income for paying hospital bills although the majority of respondents mentioned husband, although a significantly small proportion of the respondents in the Centre (29.1%) pointed to this source. Figures for the far North (77.1%) North West (71.9%) and East (69.1%) are significantly high and point to the degree to which women depend on husbands in this areas. We may also note that women in the East where to a large extent self sufficient since we find up to 50.3% mentioning income from farming as used in paying bills.

The majority of the respondents in all provinces mentioned financial problems as being the most frequently encountered problem but we also find that substantial amount of respondents in the far North (48.2%) pointed to distance while access road was a problem in the East (25.7%). Poor reception was also a major problem in the East (38.1%). This points to the generally enclave nature of this province.

5.0 Conclusions and Recommendations

We can draw the following conclusion from our study:

Cameroonian women, whether they live in the towns/cities or villages know existing health structures within their communities. However more health units are reported in the urban areas. Rural women's knowledge of services provided in the health units is also very limited.

Health structures are solicited and used by most women although rural women appear to use this services more than the urban women.

The greatest deterrent to use of these services is cost (expressed in terms of lack of money by the users). And the thorny relations between the health staff and patients. Poor women suffer from discrimination at health units.

Barely half of the users are satisfied with the services.

Men still take the decisions in terms of health care and pay the health bills although women are increasingly taking care of themselves.

Culture does not constitute an obstacle to women's attitudes towards modern health services.

The most acute obstacle to health care delivery are lack of equipment and inadequate staff at health units. There has been a decrease in staffing and staff motivation as a result of the economic depression.

In order to assist women gain greater access to health services the following measures are recommended:

Reduction of Cost of Services

This will include cost of drugs, consultation and other specific services. Since the economic crisis set in leading to the structural adjustment programme with its correlates of privatization and reduction in public spending the state has ceased to subsidies health services. This has resulted in high fees for almost all services solicited and in some cases where fees were not charged fees are now charged.
It may be difficult subsidizing as such but specific programmes such as GTZ sponsored special funds for health operational in some provinces may be a model to follow. These funds have reduced the cost of drugs while at the same time providing essential drugs to most rural areas. It may be worth while extending them to all provinces in the country and the urban areas as well.

Increase of Staff (Nurses, Doctors) in the Health Units.

For some time now the state has not been training auxiliary and mid-level staff. This may explain why there is an acute shortage of staff at the health units. A special scheme may be initiated to revive the training of these staff. Medical Doctors should also be trained and made available to rural areas.

Equipment of Health Units

A fall in state revenue has also affected the way health units are equipped. Some of the essentials are still lacking. It would be necessary for the state to institute a scheme, probably of a participatory approach, to finance the equipment of health units.

Creation of New Health Units

It may not be economical multiplying health units especially when existing ones are poorly staffed and poorly equipped but these could be done in a context where communities are active participants in design, funding, planning and management.

Sensitization of Women on services available and need to use them

This is of crucial importance in the rural areas and enclaved parts of the country. Where some of the services exist (e.g. Family Planning) the women may be ignorant of them. The women need to be sensitized in this direction, hence the need for health education.

Education of Health Workers on the need to stick to work ethic

Deteriorating economic and social conditions may account for a fall in ethical standards in some health units. Health staff need to be sensitized on the need to abide by the code of conduct expected of health workers. In this regard seminars and refresher courses need to be organised for staff. A community based or participatory approach also helps in bridging the gap between health workers and their clients.
APPENDIX I: FIELD REPORTS
CENTRE PROVINCE
RAPPORT DE MISSION
ACCESS DES FEMMES AUX SERVICE DE SANTE
PROVINCE DU CENTRE - DU 16 AU 30/12/1996

L’enquête s’est effectivement déroulée pendant une dizaine de jours selon la programmation suivante:

16 Décembre : prise de contact auprès des responsables des hospitaux suivants:
  *Cité Vert : refus de collaboration
  *Djoungolo : rendez-vous donné pour le 17/12, par le Directeur de l’Hopital pour obtenir L’autorisation de travailler.

17 Décembre :
  *Prise de contact à l’Hopital de Biyem - Assi et second refus essuyé ;
  *Départ pour Eséka (Departement de Nyong et Kellé)
  *Recrutement de deux (2) enquêteurs pour faire accélérer les travaux.

Au niveau de la ville d’Eséka (du 18 au 20 décembre)

85 questionnaires individuels ont été posés dont 31 pour les personnes au sein des structures de santé (patients), 49 personnes hors des structures de santé et 5 personnes des services médicaux. Trois (3) focus groupes ont également été réalisés.

Au niveau du village d’Elanga (21 - 22/12)

27 questionnaires ont été posés dont 10 pour les personnes au sein de la structure de santé, 15 personnes hors structure et 2 personnes parmi le personnel médical. Deux (2) focus groupes ont également été réalisés.

22/12/96 : Retour sur Yaoundé et mise en ordre des instruments de travail.
27/12/96 : Reprise des activités par des contact avec les responsables des structure de santé suivantes : Hopital Central, Dispensaire de Messa; CBC Etoug - Ebé ; PMI Centrale de Ydé. Recrutement et formation de trois enquêteurs et début des enquêtes individuelles.

28 - 29 - 30 Décembre 96 :
Poursuite des enquêtes individuelles et réalisation de quatres (4) focus groupes.
Les résultats obtenus sont représentés dans le tableau suivant.

Résultats de L’équipe de la province du Centre

<table>
<thead>
<tr>
<th>Centre Urbain de Yaoundé</th>
<th>PERS.AU SEIN DES STRUCTURE DE SANTE</th>
<th>PERS.EN DEHORS DES STRUCTURE DE SANTE</th>
<th>PERSONNEL MEDICAL</th>
<th>TOTAL</th>
<th>FOCUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>105</td>
<td>100</td>
<td>08</td>
<td>213</td>
<td>04</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Niveau du Département Eseka</th>
<th>31</th>
<th>49</th>
<th>05</th>
<th>85</th>
<th>03</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Niveau du village (Elanga)</th>
<th>10</th>
<th>15</th>
<th>02</th>
<th>27</th>
<th>02</th>
</tr>
</thead>
</table>

| Total                     | 146| 164| 15 | 325| 09 |

Difficultés Rencontrées

Le questionnaires définitif n'a pas pris en compte les apports du MINASCOF notamment au niveau de la forme et de l'identification des individus et des structures.

Des répétitions qui alourdissent le document ont été déplorées tout comme certaines questions telles que “avez - vous été à l’école, à adresser aux médecins et infirmiers”.

Des imprécisions ont été relevés surtout la version française ce qui rendait parfois la tâche très difficile à l’enquêteur.

Le temps de sensibilisation ou d’information du public - cible (les soignants et responsables des structures de santé notamment ) n’était pas prévu et les blocages divers enregistrés témoignent de cette négligence.

Plusieurs rendez - vous non honorés par les personnels de santé.

Enfin la période du déroulement de l’enquête n’était pas très propice à cause de l’approche des fêtes de fin d’année et du déroulement de plusieurs congrès politique, notamment celui du RDPC.
Certaines personnes enquêtées (individuellement) réclamaient soit une motivation soit des médicaments “échantillon” ou de l’argent pour s’acheter des remèdes.

Pour la réalisation des “focus”, les appareils utilisés n’étaient pas performants et la transcription ne sera pas facile.
1.0: INTRODUCTION.

This report is a brief summary of the activities of the team composed of Francis Nfor Kimeng and Mrs Ana Awah who travelled to the East Province from December 15 - 23 to conduct a survey on the topic:

"Women and Access to health services in Cameroon"
The terms of reference for the research were as follows:

* to collect Data in urban and rural areas of the east in order to determine the nature of access to health services by the Cameroonian woman.

*Specifically the team was to use THREE sets of questionnaires as well as conduct 12 Focus Group Discussions (F,G,D) based on age ranges both in urban and rural settings in order to elicit information on women with particular reference to:

1) The proportion of women with satisfactory access to health services in the two setting;
2) The identification of key elements within the Eastern society, health institutions, individual and family that determine access to health services by the woman.
3) Finally, the identification of coping mechanisms adopted by the woman in the East.

It is noteworthy that the questionnaires were targeted at medical personnel, hospitalized patients and out of hospital setting women. On the other hand, the 12 F.G.Ds were meant for age ranges 15 - 25; 26 - 45 and 46 years of age and above.

This report, therefore is a brief summary of the work methodology, adopted for the survey and the results accomplished.

2.0: WORK METHODOLOGY

The nature of the survey necessitated a holistic approach to data collection. This comprised of contacts with medical and administrative authorities, selection of research sites, training of research assistants, administration of questionnaires and conduct of Focus Group Discussions.

2.1: Contacts with Medical and administrative authorities.

On arrival, it was imperative that the team needed to contact the Provincial Delegate of Public Health for the East in order to obtain a written authorisation to facilitate its field work. Our initial contact with the delegate on December 16, 1996 proved difficult. He complained that he had not been informed of our mission by the Minister of Public Health and further more, that our letter was not signed by the Dean of the Medical School as expected. Finally on pleading, he gave in and gave us written note of service addressed to all health officials in the province. It was this note that permitted the team to contact health officials and through them, to meet administrative authorities in Doume Sub - Division.
2.2: Selection of research sites
   For the urban setting, Bertoua, the Province Headquarters of the East was chosen. Given the lack of patients in most health centres and the provincial hospital Bertoua; it was deemed necessary to cover all the health structures in Bertoua municipality. For the rural setting, Doume Sub - Division in the Haut Nyong was selected on the basis of its remoteness - over 100 kms from the specialised facilities in Bertoua Provincial Hospital were all sampled.

   As to the selection of neighbourhood areas, homes, markets, bus stops and villages for administration of 178 of the out of hospital women, the random sampling technique was used. For the medical personnel questionnaire, this was distributed to heads of health institutions and sections or unit heads in the respective hospitals and health centres. In Doume Sub - Division, 4 villages were randomly selected ranging from 02 - 07 kms from Doume. Considering the immense distances in the East, the rough earth roads, lack of a means of transport for the team, Doume offered the best option given also the time contraints.

2.3: Recruitment and training of research assistants.
   Given the need to use resource persons, the magnitude of the work to be accomplished within eight days; the team decided to recruit 5 research assistants/interpreters. These were trained on the job through teaching and observation. Some of them recruited women for focus group discussions as well as facilitating penetration into the society by team members.

2.4: Administration of Questionnaires.
   Questionnaires were administered by team members and research assistants both in urban and rural areas. For detail see Appendixes II and III herewith attached. Total number administered in the East 365.

   Globally speaking, 178 out of hospital questionnaires were administered in the province. In the municipality of Bertoua, inside shops, homes, bus stops, markets and the neighbouring area of Yademe, Mukolo 1, Haousa, Nkol-Bikon, Meteo, Antennae Radio, Ekombitie and Tigaza; a total of 138 questionnaires were administered.

   On the other hand, 40 questionnaires for out of hospital women were administered in the villages of Sibita, Doume Central, Mbama I, Mbama II and Mbama III of the Doume Sub - Division in the Haut Nyong Division. With reference to hospitalised patients, a total of 163 were administered in P.M.I Bertoua, Centre de Santé Catholique de Tigaza, and the Provincial Hospital Bertoua.

   Meanwhile, for the rural setting; a total number of 11 questionnaires were administered to hospitalised patient in Centre de Santé Catholique de Doume and Doume District Hospital.

   As regards questionnaires for medical personnel, a total of 11 personnel were reached: 9 in the Bertoua Municipality and 2 in Doume health institutions.

2.5: Conduct of Focus Group Discussions.
   A total of 12 Focus Group Discussions were held during the survey: 6 F.G.Ds were in the Bertoua municipality, while the others 6 F.G.Ds were held in the villages of Doume Sub- Division representing urban and rural setting respectively.

   Of the 6 groups held in Bertoua urban area: 3 were with English-speaking women, while 3 were with French - speaking women. Whereas the Baptist and Presbyterian christn women groups fell within the age range 26 - 46, the Catholic women were in the age group 46 years and above.

   Meanwhile, of the 03 French - speaking F.G.Ds, one group constituted the age range of 15 -
25 and the other two ranged from 25 - 45 years of age.

In the rural setting, the 06 F.G.Ds varied in composition. There was an exclusive group of Moslem women within the age range 15 - 25 that held at the Haousa Quarters, Sibite village. Meanwhile, another F.G.D was held at the chief’s residence, Sibita of women within age range 26 - 45. In Mbama III village, 02 F.G.Ds were held: one for age group 46 years and above and the other for range 26 - 45 years of age. Discussions in these groups were free, frank and very lively.

2.6: CONCLUSION.
In spite of some difficulties encountered because of the lack of personal means of transport, time constraints and limited financial resources, the survey was properly conducted to the best ability of team members who worked averagely 8 hours daily to accomplish their mission.

It is strongly recommended that for future surveys, enough time and financial resources should be budgeted in order to ensure effectiveness and reliability of data collection.

Possible areas of future investigation on the topic will include: research into the efficacy of the new policy of decentralized drugs management by local health committees currently in use in the East province and the need for any other supplementary information that might arise from the analysis of data already collected.
### Administration of Questionnaires: Urban Setting

<table>
<thead>
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<th>Number</th>
<th>Type of Instrument</th>
</tr>
</thead>
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<td>P.M.I Bertoua</td>
<td>021</td>
<td>Hospitalised Patients</td>
</tr>
<tr>
<td>16/12/96</td>
<td>Provincial Hospital Bertoua</td>
<td>006</td>
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</tr>
<tr>
<td>16/12/96</td>
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<td>Medical Personnel</td>
</tr>
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<td>Provincial Hospital Bertoua</td>
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<td>Medical Personnel</td>
</tr>
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<td>17/12/96</td>
<td>Yademe</td>
<td>004</td>
<td>Out of Hospital Patients</td>
</tr>
<tr>
<td>17/12/96</td>
<td>Mokolo I Haoua Nkol-Bikon</td>
<td>015</td>
<td>Out of Hospital Patients</td>
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<td></td>
<td></td>
<td>020</td>
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<td></td>
<td></td>
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</tr>
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<td>17/12/96</td>
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</tr>
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<td>17/12/96</td>
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## Administration of Questionnaires: Urban setting

<table>
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<th>Type of Instrument</th>
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</tr>
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</tr>
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<td>Nkol-Bikon</td>
<td>004</td>
<td>Out of Hospital Patients</td>
</tr>
<tr>
<td>18.12.96</td>
<td>Mokolo I</td>
<td>010</td>
<td>Out of Hospital Patients</td>
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<td>Antenne Radio</td>
<td>024</td>
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<tr>
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<td>Haousa</td>
<td>011</td>
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</tr>
<tr>
<td>18.12.96</td>
<td>Meteo</td>
<td>033</td>
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<td>017</td>
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<td>Antenne Radio</td>
<td>017</td>
<td>Out of Hospital Patients</td>
</tr>
<tr>
<td>19.12.96</td>
<td>Ekombitié</td>
<td>008</td>
<td>Out of Hospital Patients</td>
</tr>
<tr>
<td>19.12.96</td>
<td>Meteo</td>
<td>005</td>
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<td>19.12.96</td>
<td>Yademe</td>
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</tr>
<tr>
<td>19.12.96</td>
<td>Haousa</td>
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<td>Out of Hospital Patients</td>
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<tr>
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<td>Out of Hospital Patients</td>
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### Administration of Questionnaires: Rural Setting

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<td>20.12.96</td>
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<td>20.12.96</td>
<td>Village Mbama I</td>
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<td>Out of Hospital Patients</td>
</tr>
<tr>
<td>20.12.96</td>
<td>Village Mbama II</td>
<td>004</td>
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<td>Out of Hospital Patients</td>
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<tr>
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<td>Village Sibita</td>
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<td>Out of Hospital Patients</td>
</tr>
<tr>
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<td>Out of Hospital Patients</td>
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<tr>
<td>21.12.96</td>
<td>Village Mbama I</td>
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<td>Out of Hospital Patients</td>
</tr>
<tr>
<td></td>
<td>Grand Total</td>
<td>053</td>
<td></td>
</tr>
</tbody>
</table>

Report humbly submitted by:

Francis Nfor Nkimeng  
Team leader for the East Province
SOUTH WEST PROVINCE

Report on the study of women and access to Health care services in the South West Province

A quantitative and qualitative study was carried out among the target groups of 15 - 25 yrs, 26 - 35 years 36 - 45 years and 46 years and above in the South west Province and women on access to health care service.

The study tools consisted of questionnaires and Focus Group Discussions. Questionnaires were filled for three groups of female respondents:

i) Hospitalized
ii) Medical personnel
iii) Non - Hospitalized

Data was collected at three levels: provincial, divisional and village. At each level respondents from the above three groups were interviewed.

At the hospitals, female respondents were interviewed from the maternity, female medical ward, female surgical ward, and the children's ward. Female medical personnel (Doctors, Nurses, Midwives) were interviewed. The non -hospitalized patients were interviewed from the market places, homes, schools offices and the streets.

The sample sized consisted of 355 respondents per province and 12 Focus Group Discussions. The sample size was distributed as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical personnel</td>
<td>20</td>
</tr>
<tr>
<td>Hospitalized patients</td>
<td>155</td>
</tr>
<tr>
<td>Non - hospitalized women</td>
<td>180</td>
</tr>
<tr>
<td>Focus Groups Discussions</td>
<td>4 each per province, division and village, giving a total of 12 FGD</td>
</tr>
</tbody>
</table>

Complete data was collected from the medical personnel and non - Hospitalized respondents, while only 97 questionnaires out of 155 were completed from the hospitalized respondents. This was mainly because it was the Christmas season and the patients asked to be discharged. This information was given to us by medical personnel.

The variable in the study fell under three themes namely:

i. Societal factors influencing access to health care services.
ii. Institutional factors
iii. Family/individual factors influencing access to health care.
Societal Factors

Elements under this section included self help systems, support network and health policies.

Institutional level

The variables included:
- Availability
- Affordability
- Quality
- Acceptability.

Individual/Family Level

The variables included:
- Culture/beliefs
- Ability to pay
- Level of education
- Age
- Marital status/parity.

The results of the study are intended to be utilized for recommendations that will influence health policy changes and improve women's access to health care services.

Problems Encountered

1. The administration took long to visa the letter of introduction requesting permission to carry out the study in the province.

2. Motivation for participants at Focus Group Discussions was considered as 'Nyongo' (secret society) money at the Molyko vicinity. After presenting the authorisation letter which was signed by the Governor of the South West Province and the Provincial Delegate for Public Health, the villagers permitted us to carry out the Focus Group Discussions (F G D).

They explained that their apprehensions stemmed from past experiences especially as it was Christmas season. In the end we bought drinks for the women participants and some men (village counselors and their quarter head).

This was an isolated incident because in all other places participants were very happy about the motivation gestures.
Recommendations

1. More time should be allocated for contacting the administration prior to future studies.
2. Future studies should not be rushed, but should be allocated more time as the sample size indicates.
3. Copies of letters of introduction signed by the administration of a given area be given to the quarter heads or chiefs at least a day prior to the FG D session.

Researchers for the South West Province

1. John Akuri
2. Justine Ayafor
NORTH WEST PROVINCE
SOCIAL POLICY NETWORK, CAMEROON DATA
GATHERING FIELD REPORT FOR THE STUDY;
WOMEN AND ACCESS TO HEALTH SERVICES
IN CAMEROON

A team of researchers made up of Dr. Emmanuel Yenshu and Mrs. Grace Tima was designated by the national coordinator of the network to collect data on the research on Women and Access to Health Services in Cameroon in the North West Province. This exercise which lasted from the 23rd to the 31st of December 1996 was done with the use of three instruments targeting three categories of respondents namely a questionnaire for hospitalized and non hospitalized respondents, a questionnaire for health personnel and a focus group discussion guide for respondents categorized according to four age groups. In all we interacted with 160 hospitalized and non hospitalized individual women in three localities (Bamenda central, Belo and Fundong) in Mezam and Boyo Divisions. Focus group discussions (FGD) were held with eight groups of women categorized according to their ages in the three localities.

These groups were made up of 7-12 women selected in the following manner.

**Bamenda Central (Nsoh, Bafut)**

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<tr>
<td>26-35</td>
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<tr>
<td>36-45</td>
<td>7</td>
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<tr>
<td>&gt;46</td>
<td>10</td>
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**Belo**

<table>
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<th>Number</th>
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</thead>
<tbody>
<tr>
<td>15-25</td>
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<tr>
<td>26-35</td>
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</tbody>
</table>

**Fundong**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>36-46</td>
<td>7</td>
</tr>
<tr>
<td>&gt;46</td>
<td>7</td>
</tr>
</tbody>
</table>

Total 67

We also interviewed 13 health personnel. The total number of persons with whom we interacted is 240.
Apart from the researchers, three research assistance were hired to take part in administering the questionnaires under the supervision of the former. The focus group discussions were conducted by the researchers.

At this stage it would be hazardous to advance any preliminary results since the data needs careful treatment. We would propose that while the data obtained from focus group discussions is being analysed by the researchers to bring out result of qualitative nature, the data from the structured questionnaire should be entered and treated with use of an appropriate computer programme (SPSS, EPI-INFO, Dbase IV) to bring out quantitative analysis. After this exercise both quantitative and qualitative analysis can be merged in a complementary manner.

The exercise suffered from a series of problems:

- Inappropriate timing
- Difficulties in getting respondents, whether it was the F G Ds of the interviews
- Difficulties in constituting focus groups.
- The tape recorder obtained for recording the F G Ds was defective in recording and so we had to rely only on recording responses by way of note taking alone.

Emmanuel Yenshu
Grace Tima
EXTREME NORTH PROVINCE

RAPPORT DE MISSION
*************************************************

OBJET : Collecte de données sur l’accès des femmes aux services de santé au Cameroun

DUREE : du 15 au 22 décembre 1996

LIEU : Extrême-Nord.

Dans le cadre de la Recherche sur l’accès des femmes aux services de santé au Cameroun, objet du protocole d’accord signé le 2 Octobre 1996 entre le Ministère des Affaires Sociales et de la Condition féminine et le CRDI, une mission composée du Dr. T. Tchombe et de M. Akono Ndo a séjourné du 15 au 22 décembre 1996 dans la province de l’Extrême-Nord en vue de collecter les données sur ce thème suivant la méthodologie arrêtée par l’équipe centrale de la Recherche à savoir :

- questionnaire en direction des populations, des malades hospitalisées et du personnel médical ;
- "Focus-Group" avec des femmes au niveau de la province, du département et du village (12 groupes au total).

Le présent rapport rend compte de manière synthétique du déroulement de la mission, des difficultés et des résultats obtenus.

1. DEROULEMENT DE LA MISSION

Trois temps forts ont marqué la mission:
- Les travaux préparatoires;
- L’administration des questionnaires;
- Les évaluations journalières.

1.1 Les travaux préparatoires. Ils se sont déroulés au niveau délégation Provinciale des Affaires Sociales et de la Condition Féminine de L’Extrême - Nord à Maroua. Ils ont été faits à travers les séances de travail et les contacts directs avec des personnes - ressources.

1.1.1 La séance de travail du 16 décembre 1996 a réuni autour du Délégué Provincial:

- deux chefs de service Provinciaux de la Délégation,
- trois animatrices dont une Technicienne Supérieure de la Santé
Les deux membres de la mission.
Elle a permis à la mission d'informer l'assistance sur la recherche, au-delà de l'aspect ponctuel et d'exprimer ses attentes à savoir :

- appui en matériel et en personnels en vue l'exécution de la recherche;
- identification des zones d'application de l'enquête;
- organisation pratique de la collecte des données.

Sur le premier point, les Délégués a mis à la disposition de la mission :

- un véhicule administratif;
- un chauffeur;
- deux enquêteurs par site au moins.

Sur le deuxième point, les villes de Maroua, Mora (60 km de Maroua) et Yagoua (200 km de Maroua) ont été retenues, de même que le village Gonya (20km de Yagoua, frontalier entre le Cameroun et la Tchad).

Ce choix s'est justifié par la prise en compte des grandes tendances socio-culturelles de la province: Maroua avec les Fulbé; Mora avec les Montagnards, Arabes choas; Yagoua avec les peuplement des zones frontalières. Sur le dernier aspect, des équipes englobaient en vue de l'administration des questionnaires: un chef de service et deux animatrices à Maroua, la mission, le Délégué Provincial, le chef de secteur Départemental des Affaires Sociales et de la condition Féminine, un animateur à Yagoua.

Avant la descente proprement dite, le Délégué Provincial s'est fait le devoir de :

- donner les instructions aux services départementaux concernés sur l'application de l'enquête dans chaque site (la sensibilisation du personnel médical; la constitution des groupes pour le Focus - group);

- informer les autorités préfectorales des sites.

1.1.2 Les contacts avec les personnes - resources.

Au niveau des départements notamment, l'équipe de recherche rendait systématiquement une visite de courtoisie aux autorités administratives et aux médecins - chefs des hôpitaux ciblés. Cette démarche était faite dans le but de susciter l'adhésion au projet et de minimiser les obstacles éventuels à notre travail.

1.2 Administration du questionnaire:

1.2.1 Le questionnaire adressé au personnel médical a été remis aux intéressés qui l'ont rempli de manière satisfaisante. A Mora par exemple, le Médecin - chef lui-même a rempli une fiche et s'est chargé de la ventilation du questionnaire auprès de ses collaborateurs.
1.2.2 Celui adressé aux malades hospitalisés a été administré par les enquêteurs à leur chevet.

1.2.3 Enfin, le questionnaire adressé aux femmes non hospitalisées a été remis à celles connues sachant lire et écrire parfaitement le français. Aux autres, il a été administré par enquêteurs.

1.2.4 En qui se concerne le Focus - Group, il a été conduit par les animatrices en langues locales dans la plupart des groupes; une traduction simultanée permettait à l’équipe de suivre l’évolution de la discussion et de donner une signification aux messages non - verbaux.

1.2.5 Evaluations Journalières

A la fin de la journée de travail, les membres de la mission se réunissaient pour faire le point et préparer l’activité du lendemain. Pour notre part, ces évaluations devaient renforcer la cohésion de l’équipe et l’efficacité du groupe dans son ensemble.

II DIFFICULTÉS RENCONTREES

Les difficultés rencontrées peuvent être ramenées à deux grandes catégories.

2.1 L’insuffisance des moyens matériels et financiers

L’organisation du travail sur le terrain a fait coïncider des discussion de groupes dans deux sites la même journée avec deux équipes distinctes. La mission n’avait qu’un seul enregistreur; il a fallu en emprunter un qui, malheureusement n’a pas bien fonctionné pendant l’activité.

Les facilités accordées à la mission par la Délégation provinciale n’ont pu être compensées que de manière symbolique.

2.2 Les difficultés rencontrées lors de l’administration du questionnaire

Les barrières linguistiques ont étiolé la compréhension des messages. Ceci a rendu nécessaire l’introduction d’interprètes tout au long de la communication dans certains sites (Mora - Yagoua). Les lieux d’administration du questionnaire retenue par les structures de terrain en accord avec la mission pour des raisons pertinentes étaient très éloignés les uns des autres. La mission a dû couvrir pendant le séjour près de 1000 km de routes bitumées et quelques 60 km de routes non bitumées. Le questionnaire adressé aux femmes non hospitalisées très dense dans sa formulation, nécessite de leur part disposibilité et abnégation; caractères qui ne sont pas toujours présents chez des personnes engagées dans d’autres créneaux (commerce, hospitalisation d’un membre de la famille, soins pré-nataux...). Pour remplir à 100% ce questionnaire, il fallait plus de personnels, option que ne pouvions retenir, faute de moyens.
III RESULTATS OBTENUS

Les résultats que l'amiission présente ci-après sont en rapport avec:

-Le volume de travail réalisé;
  Les premières observations qui découlent des données collectées et des contacts directs avec le terrain.

3.1 Le travail en terme de volume

-Nombre de fiche remplies auprès du personnel médical: 20
-Nombre de fiches remplies auprès des malades hospitalisés: 97
-Nombre de fiches remplies auprès des personnes non hospitalisées: 104
-Total des fiche remplies : 221
-Nombre de Groupes animés: 12

3.2 Commentaires

3.2.1 D’une manière générale, la mission a atteint les 100% des prévisions en ce qui concerne les travaux de groupes; par ailleurs, les % des fiches ont été remplies. Le taux de réalisation de la mission serait donc autour de 85%.

3.2.2 Le personnel médical contacté a été enthousiaste pendant l’activité.
  Le survol des fiches laisse apparaître une connaissance approximative des coûts des présentations de santé, une démotivation persistante du fait du bas niveau des salaire, la pauvreté des malades qui influence l’efficacité de leur action (pas de médicaments), la vétusté et le sous-equipement de certains hôpitaux (More par exemple), le manque de spécialistes.

Des programmes de réhabilitation des formations hospitalières de cette partie du pays devraient donc être envisagés pour ces lacunes, sauf si les résultats de la recherche en disposent autrement. Ils engloberaient la formation et le recyclage des personnels, le réaménagement des infrastructures et leur équipement, l’affectation de spécialistes et la mise en œuvre de stratégies opérationnelles au niveau de la base.

3.2.3 Au vu des données statistiques, l’on penserait que les femmes de Maroua, Mora et Yagoua et leurs environs se portent relativement bien car toutes celles qui étaient hospitalisées lors du passage de la mission dans ces localités ont été interviewées; exception faite de quelques rares cas difficiles. Mais l’on s’interroge sur cette hypothèse quand on sait que la santé de la femme dans ce contexte est conditionnée par les avis du mari, les préceptes culturels et, souvent, une interprétation des prescriptions religieuses, musulmanes notamment. Dans cette logique, de nombreux actes médicaux nécessaires lui sont prohibées, explicitement ou tacitement à l’exemple des explorations menées par des personnels médicaux de sexe masculin, au demeurant les plus nombreux et qualifiés dans la région.
3.2.4 À ces considérations, il faudrait ajouter le crédit accordé à la Médecine traditionnelle tante en milieu urbain qu’en zone rurale. Le recours aux tradi-praticiens est encouragé par leur disponibilité, le faible coût de leurs actes, les facilités de paiement et, dans certains cas, leur efficacité. Dans la pratique, les malades associent la médecine traditionnelle et la médecine moderne. La recherche devrait alors se pencher sur cette question dans la proposition des stratégies de prise en charge des malades, surtout ceux des zones reculées.

3.2.5 Les discussions en groupes ont repris toutes ces préoccupations. Les femmes ont d’ailleurs proposé des solutions à leurs problèmes: sensibilisation des femmes et des maris, augmentation de leurs revenus pour un re-investissement dans la santé, bon accueil dans les hôpitaux....

3.2.6 Les populations installées au niveau des frontières éprouvent de sérieuses difficultés à se faire soigner. Des cas de tuberculose, de malnutrition, de grossesses non suivies, de mal propreté y ont été décelés. Il faudrait donc prendre en compte, dans le cadre d’une politique des frontières plus globale, la santé de ces personnes; ceci cultiverait en elles le sentiment d’appartenance à la Nation et les fixeraient sur le territoire au lieu de privilégier la fréquentation des formations sanitaires des pays voisins.

DR T. TCHOMBE

E. EKONO NDO
APPENDIX II: INSTRUMENTS

SOCIAL POLICY RESEARCH NETWORK CAMEROON

WOMEN AND ACCESS TO HEALTH SERVICES IN CAMEROON

QUESTIONNAIRES FOR FEMALE HOSPITALIZED AND NON-HOSPITALIZED PARTICIPANTS

INTRODUCTION:

The government in collaboration with the Social Policy research Network in Cameroon wants to find out what difficulties women encounter in obtaining health services in Cameroon. This will enable the government seek ways of improving health services of women in particular and their families as a whole.

You are kindly requested to answer all the questions as objectively as possible. Please be assured that all the information you provide will be kept confidential and only the purpose of the study.
Part I

IDENTIFICATION:

Date: ________________________________

Interviewer’s name: ________________________ Interviewee N° ________________________

1. Province: ________________________________

2. Division: ________________________________

3. Sub - Division: ________________________________

4. Site: ________________________________

5. Residence (urban/rural): ________________________________

6. Quarter : ________________________________


8. Comments and signature of the supervisor:

________________________________________

________________________________________

________________________________________

SOCIO - DEMOGRAPHIC CHARACTERISTICS

1. How old are you ?
   1. 15 - 25
   2. 26 - 35
   3. 36 - 35
   4. 46 - 55

2. What is your ethnic (tribe) group?
   1. Bantu (Sawas, Beti, Bassa)
   2. Semi Bantu (grasslanders,Tikar,Bamileke, Bamoun)
   3. Nilo Sahelian (Fulbes, Hausa, Toupouri, Mundang)
   4. Others
3. What is your marital status?
   1. Single
   2. Married
   3. Free union/cohabitation
   4. Divorced/separated
   5. Widow

4. If married, state the marital regime:
   1. Polygamous
   2. Monogamous

5. Number of persons in household.............

6. Have you ever attended school?
   1. Yes
   2. No

   If no, go to 9.

7. What is your level of education?
   1. Primary
   2. Secondary
   3. University

8. Can you read a newspaper?
   1. Easily
   2. With difficulties
   3. Not at all

9. What is your religion?
   1. Catholic
   2. Protestant
   3. Moslem
   4. African traditionalist
   5. Others (specify)

10. What is your main occupation?
    1. None
    2. Student
    3. Housewife
    4. Farmer
    5. Others (specify)

11. What is your monthly income (in CFA francs)?
    1. None
    2. < 10,000
    3. 10,000 - 30,000
    4. 31,000 - 50,000
    5. > 50,000
    6. I don't know
PART II

A. SOCIETAL FACTORS WHICH INFLUENCE WOMEN ACCESS TO HEALTH CARE

1. What services are rendered by health centres in your community? [ ] [ ] [ ] [ ] [ ] [ ]

   Spontaneous [ ]

   Prompted [ ]

   1. None
   2. Gynaecological
   3. Surgical
   4. Ophthalmological (eye specialist)
   5. Endocrinological (diabeti)
   6. Care of handicap
   7. Neurologist
   8. Paediatrics (children doctor)
   9. Orthodopodist
   10. FP (bone Doctor services)
   11. Others (specify)

2. Are you satisfied with the services provided? [ ]

   1. Yes
   2. No

3. If no, why (specify)

4. If Yes, explain

5. What is the population of female workers compared to men when you last visited the hospital/health centre [ ] [ ]

   Spontaneous [ ]

   Prompted [ ]

   1. I don't know
   2. More men than women
   3. More women than men
   4. Others (specify)

7. In your opinion, are they satisfy with their job conditions? [ ] [ ] [ ] [ ]

   1. Yes
   2. No

8. If no, Why

9. If Yes, explain
10. What are some services provided by the public/private sectors that help to empower the women (provide training, create awareness, give support) [ ] [ ]

Spontaneous [ ] Prompted [ ]

1. Women’s centre
2. Home economic centre
3. Self help programmes
4. Njangies/women’s group
5. Adult centres
6. Others

11. What are some difficulties that prevent you from earning an income? [ ] [ ] [ ] [ ] [ ]

1. I did not go to school
2. I don’t have a capital
3. I don’t own land or property
4. Others

B. INSTITUTIONAL FACTORS THAT INFLUENCE WOMEN’S ACCESS TO HEALTH CARE

1. What are some health structure available in your community? [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Spontaneous [ ] Prompted [ ]

1. General hospitals
2. Sub-divisional hospitals
3. Health Centres
4. Clinics
5. Others

2. Do you use the services provided in the health centre/hospitals? [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

1. Yes
2. No

3. If no why? [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

1. Cost of service is too high
2. The hospital/health centre is too far
3. The medical staff are rude and uncaring
4. The institution lacks equipment
5. My religion doesn’t permit
6. Tradition doesn’t permit
7. Other (specify) ____________________________

4. I yes, how much does it cost for consultation? [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

1. Below 600F
2. 600F
3. < 3000F
4. 3000 - 5000
5. Have you ever been asked to go to another hospital or Doctor for treatment/consultation? [ ]
   1. Yes
   2. No

5. How much do you pay to go to the hospital/ health centre/clinic? [ ]
   1. < 150 F
   2. 150 - 300 F
   3. 300 - 500
   4. 500 - 1000 F
   5. > 1000 F
   6. Others (specify) ______________________________________________________________________

7. Where do you prefer to go to when you are sick? [ ]
   1. Health centres/hospital
   2. Traditional doctor
   3. Pharmacy
   4. Street drug sellers
   5. Auto-medication
   6. Other (specify) ______________________________________________________________________

8. What influences where you go to for treatment? [ ]
   1. Proximity
   2. Financial status
   3. Types of illness
   4. Others (specify) ______________________________________________________________________

9. Which of the answer(s) in the above question do you prefer? [ ]
   Why? ________________________________________________________________________________

10. Where did you have your last baby? [ ]
   1. At home
   2. At the hospital/health centre/clinic
   3. Others (specify) ______________________________________________________________________

11. How do you find the cost of health services in you community? [ ]
   1. Too expensive
   2. Moderate
3. Okay
4. Others (specify)

12. How much did you spend for your last delivery? [ ]
   1. Below 6000
   2. 6000 - 10,000
   3. 11000 - 20,000
   4. 21000 - 30,000
   5. 31,000 - 40,000
   6. Above 40,000
   7. Others (specify)

13. Did you have any problems after your last delivery? [ ]
   1. Yes
   2. No
   3. Does not apply

14. If yes, what was the problem? [ ]
   1. Episiotomy
   2. Bleeding
   3. VVF (vesico vagina fistula)
   4. Recto vagina fistula
   5. Caesarian
   6. Still birth
   7. Others (specify)

15. How did the nurses or doctors treat you during your last stay at the hospital? [ ]
   1. Well
   2. Badly
   3. Others (specify)

16. Have you ever been referred to another hospital for services (consultation, laboratory test, etc. to see a specialist)? [ ]
   1. Yes
   2. No

17. If no go to question 19

18. If yes, where? [ ]
   1. General hospital
   2. Referral hospital
   3. Mission/Private hospital
   4. Others (specify)

19. Why were you referred to another service (Doctor/hospital/clinic/health centre)? [ ]
   1. Inability to diagnose ailment
   2. To see a specialist
3. The health centre did not have equipment
4. Others (specify)

20. When can you go to the nearest health centre around you?

1. Anytime
2. Only from morning to afternoon
3. Others (specify)

21. Do nurses/Doctors discriminate in the way they deliver patient care?

1. Yes
2. No

22. If yes, what make you think that they do?

Spontaneous [ ] Prompted [ ]
1. They talk to their vernacular to women of their area
2. They attend to women who speak their language first before attending to others
3. They attend to the rich and well to do politely and well
4. Others (specify)

23. If no, explain

24. How are the poor treated?

Spontaneous [ ] Prompted [ ]
1. They are allowed to wait for too long
2. Nurses look low on them
3. I do not know
4. Others (specify)

25. How are the rich treated?

Spontaneous [ ] Prompted [ ]
1. With respect
2. Prompt attention is given them
3. They are given priority treatment
4. I do not know
5. Others (specify)

C. INDIVIDUAL/FAMILY FACTORS THAT INFLUENCE WOMEN'S ACCESS TO HEALTH CARE

1. Who takes major decisions on health issues in your family?

1. Wife
2. Husband
3. Oldest son
4. Oldest daughter
5. Others (specify)
2. In your family who makes the decision about how many children you are to have?
   1. My husband
   2. My husband and I
   3. In-laws
   4. Others (specify)

3. Have you ever heard of family planning centres?
   1. Yes
   2. No

4. If yes, what services are provided in these centres?
   1. I don't know
   2. Counseling on spacing
   3. Counseling on contraception
   4. Laboratory test
   5. Pap smears
   6. Others (specify)

5. What is your opinion about services provided in the family planning centres?
   1. They are very helpful
   2. They are not good
   3. Others (specify)

6. How do you go to the nearest family planning centre from your home?
   1. If Friends/family work
   2. By taxi/car
   3. Others (specify)

7. How many times have you been pregnant?
   Parity Abortion Death Living children

8. Where did you deliver?
   1. Hospital
   2. Home

9. Why?

10. How old is the baby?

11. How old is the last but one baby (birth date)

12. Who pays for your hospital bills?
   1. Self
2. Husband
3. Family (parents/brothers/sisters)
4. Insurance
5. Job offers free hospitals care
6. Others

13. Does your culture prevent you from going to the hospital? [ ] [ ] [ ] [ ] [ ]
   1. Always
   2. Sometimes depending on the nature of the disease
   3. Never
   4. Others (specify) ________________________________

14. Do you or your family members have difficulties when you or they are sick? [ ] [ ] [ ] [ ] [ ]
   1. Yes
   2. No

15. If yes, what are these difficulties? [ ] [ ] [ ] [ ] [ ]
   1. Lack of money
   2. Distance
   3. Lack of roads
   4. Poor reception and treatment
   5. Others (specify) ________________________________

16. Do you receive any financial assistance from family members significant others? [ ] [ ] [ ] [ ] [ ]
   1. Yes
   2. No

17. If no, why? [ ] [ ] [ ] [ ] [ ]
   1. I don’t have a family
   2. Family is poor
   3. Family conflicts
   4. Others (specify) ________________________________

18. I yes, how often? [ ] [ ] [ ] [ ]
   1. Weekly
   2. Monthly
   3. Rarely
   4. Yearly
   5. Others (specify) ________________________________

19. Do your religion belief prevent you from going to a health centre when you or a member of our family are sick? [ ] [ ] [ ] [ ] [ ]
   1. Yes
   2. No

20. If yes, why? ________________________________
What do you think could be done to improve women's access to health care services in your community?
MEDICAL PERSONNELS

1. What are the health facilities available in your community?
   1. ____________________________
   2. ____________________________
   3. ____________________________

2. What is the authorized cost of consultation in your hospital? [ ] [ ] [ ]
<table>
<thead>
<tr>
<th>Old case</th>
<th>New case</th>
<th>Card</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aging/handicap</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. What is the authorized cost of the following services in your hospital? [ ] [ ] [ ] [ ] [ ] [ ]
<table>
<thead>
<tr>
<th>Old case</th>
<th>New case</th>
<th>Card</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthalmologist (eye Dr)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT (ear, nose, throat)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynaecological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory test (all)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals-bed/night</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug-price range per hospitalization/illness (common)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery: normal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization: private semi private single room</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. What is the quality of medical personnel in your service? [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
   | 1. Medical Doctor | | | |
   | 2. CESSI | | | |
   | 3. Staff nurse IDE | | | |
   | 4. Infirmier breveté | | | |
   | 5. Aide soignant - nursing aid. | | | |
   | 6. Fille de salle/garçon de salle | | | |
   | 7. Infirmier décisionnaire - nursing agent | | | |

5. Do you have any difficulties at work? [ ]
   1. Yes
   2. No
6. If yes what? [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

1. Not enough staff
2. Lack of equipment
3. Patient load is heavy
4. Working hours are too long (> 8)
5. Language
6. Others (specify) ____________________________

7. What are some things that will help improve your conditions of work? [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

1. Increase salary
2. Reduce work load
3. Increase staff
4. Others (specify) ____________________________

8. What could be done to improve the use of health services by women? [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

1. Bring services close to them
2. Decrease cost of services
3. Improve quality of services
4. Others (specify) ____________________________

9. What is the behaviour of patients you treat? [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

1. Cranky
2. Difficult
3. Rude
4. Sober and miserable
5. Others (specify) ____________________________

10. How many women do you receive per day? ____________________________

NOTE: Circle service at which questionnaire was administered

(a) Maternity
(b) Vaccination
(c) Female ward

11. Does the political system practiced in Cameroon facilitate or enhanced your access as a woman to high quality and appropriate health services? [ ]

1. Yes
2. No

12. If no, specify ____________________________
13. How has the economic crisis affected your access to proper quality health care?
   1. It hasn't
   2. It has decreased the number and quality of staff
   3. It has decreased motivation
   4. Over-loading staff
   5. Others (specify) __________________________

14. What do you know about health policy concerning women?
   1. I don't know
   2. __________________________

15. How does traditional medicine influence the services provided in your hospital?
   1. It doesn't
   2. Negatively
   3. Positively
   4. Others (specify) __________________________

16. What do you think could be done to improve women’s access to health care in your community?
HOSPITALIZED PATIENTS

1. What made you come to the hospital today/this time? 
   - Spontaneous
   - Prompted
     1. Prenatal visit
     2. Medical consultation
     3. Laboratory tests
     4. Delivery (already delivery)
     5. Surgery
     6. Others (specify) 

2. How did you know about the services provided in this hospital/health centre?
   1. My family told me
   2. My doctor referred me
   3. I heard my neighbours talking about it
   4. Others (specify) 

3. How were you treated during your stay in the hospital?
   1. Very poorly
   2. Poorly
   3. Very well
   4. Well
   5. Others (specify) 

4. How did you find the cost of services?
   1. Very expensive
   2. expensive
   3. Moderate
   4. Okay
   5. Others (specify) 

5. What do you think could be done to improve the quality of care?
   1. Increase number of nurses
   2. Increase number of doctors
   3. Provide free drugs
   4. Equip the hospital
   5. Others (specify) 

What do women do to raise money to go to the hospital? 

1. Money is provided by husband
2. Money is provided by family
3. Money is got from farming
4. Others

What do your neighbours family do when they are sick?

1. Nothing
2. See traditional doctor
3. Buy drugs in pharmacy
4. Buy drugs in quarters
5. Others (specify) 

In your opinion what is the best thing to do when you are sick?

1. Go to the hospital
2. Go to a traditional doctor
3. Go to the pharmacy
4. Go to the quarter drug store
5. Others (specify) 

What makes you think that your choice is best?

1. Cheap (affordable)
2. Accessibility
3. Effective
4. Others

How do you rate the cost of consultation and treatment in this hospital/health centre?

1. Expensive
2. Moderate
3. Others (specify) 

Would you come to this hospital the next time you are sick?

1. Yes
2. No
If no why? [ ] [ ] [ ] [ ]

1. Nursing/Drs don’t care
2. I was not well treated
3. Services are too expensive
4. Others (specify) ________________________________

If yes why? [ ] [ ] [ ] [ ]

1. Services where good
2. I was well treated
3. Nurses/Drs really care
4. Others (specify) ________________________________

12 Do you know other hospital/clinics/health centres around here? [ ]

Spontaneous

1. Yes
2. No

Prompted

If yes, what services do they provide? [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

1. Paediatrics
2. Gynaecology + delivery
3. Surgical
4. Laboratory (all) + X-ray
5. ENT (ear, nose, throat)
6. Ophthalmology (eye)
7. Neurologist (nerve)
8. Cardiology (heart)
9. Neurology (kidney)

13 What is the behaviour of most of the staff of the hospital? [ ] [ ] [ ]

1. Polite/serviable
2. Rude and uncaring

14 What do you think could be done to improve women’s access to health care in your community? ________________________________
PROTOCOL FOR FGD

Part I Introduction and greeting

1. Thank participants for coming introduce yourself, the notetakers and any observers

2. Explain the purpose of the meeting and what you will be discussing

3. Describe what it will take. Taping will be done so as not to miss out the important things being said, for there are no wrong or right answers.

4. Outline some general rules to follow during the session
   * Everyone should have a chance to speak and state their opinions
   * People should feel free to comment on what others say
   * There are no right or wrong answers
   * It is useful to have different points of view.

5. Explain that all names and answers will be kept confidential.

6. Note taker should take note of participants age, level of schooling, gender, marital status, place of residence, with whom they live (immediate family, extended family, primary language).

PROBE QUESTIONS FOR FOCUS GROUPS

Probe is a special kind of question. It's used when you feel you've received an inadequate response. The response may be incomplete, too general, or usually vague some examples of probes are:

- remaining silent or rephrasing the question
- Why? Why do you say that or think that?
- Can you tell me more about that? Can you please explain that to me?
- What do you mean by that?
- What makes you feel that way?
- Can you think of an example of that?
- I'd like to know more about your thinking on that issue
- I'm not sure I understand how you are using the word
- What are some of your reasons for feeling as you do?
- You seem to feel strongly about this. How do you think other people might feel about this? (example of third-person probe).
- Use the mirror technique. Restate what the respondent has just said (this idea is based on Rogerian counselling techniques).
- Confront the respondent to clarify a position. "I'm a little confused. Earlier you said 'X' Now you are saying 'Y'."
- What does the (message) say for you? What do you see in this (message)?
- What does it say to you personally?
- What were you thinking as you were watching it?
- What stood out in your mind? What other things made an impression?
- You started to say something about...
- You mentioned something about...
- Did you get any new insights about... from the...?
- What words would you use to describe...?
FGDG

themes:

I. SOCIETAL

Societal factors that influence the use of Health Services

1.1 What do women in the community do to generate income?
1.2 What difficulties in the society hinder women from generating income?
1.3 What impedes or prevents women from using health services?
1.4 What other alternatives are opened to you when you do not use the health services?
1.5 What makes you go to the traditional doctor for consultation?
1.6 If you had to choose between modern and traditional medicine which one would you choose.

II. INSTITUTIONAL

II. Factors that prevent adequate use of Health Structures/Services

2.1 What are the health institutions in your community?
2.2 What services are provided in these institutions?
2.3 Do you use the services provided in these institutions? If not, why?
2.4 Have you ever been asked to go and see another Doctor or go to another hospital for consultation? If yes, when and what for?
2.5 Where is the referral hospital in your area?
2.6 When someone in the village is very sick what do you do? (referral systems (Probe))
2.7 How much do you pay to go to the nearest institution?

C. FAMILY/INDIVIDUAL

III. Factors that influence family and individual the use of Health Services

3.1 What determines your use of a health service?
3.2 What do you do when you have difficulties going to the hospital?
3.3 What could be done to improve quality of services in these institutions?
   a) Modern medicine
   b) Traditional medicine
3.4 What can be done to improve the use of health services by women?
3.5 How many persons live in your home? (children, husband and others included).
PATIENTS HOSPITALISÉS

PARTIE I: IDENTIFICATION

Nom de l'intervieweur: ____________________________ N° de l'interviewé: __________
Province: ______________________________________
Arrondissement: __________________________________
Résidence: [ ] 1. Urbain 2. Rural
Site de l'étude: ____________________________________
Quartier: _______________________________________
Code de la province ex: CP001
À quelle tranche d'âge appartenez-vous? [ ]
1. 15 - 25
2. 26 - 35
3. 36 - 45
4. > 46
Quelle est votre situation matrimonialement? [ ]
1. Marié
2. Divorcé
3. Célibataire
4. Veuf
Combien d'enfants avez-vous?
Combien de personnes habitent chez vous?
Résultat de l'interview [ ] 1. Complet 2. Incomplet
Superviseur: ______________________________________
Commentaire: _____________________________________
Signature: ________________________________________
PARTIE II

1. Pourquoi êtes-vous à l'hôpital aujourd'hui? [  ][  ][  ][  ][  ][  ][  ][  ]
   1. Visite prénatale
   2. Consultation médicale
   3. Les tests au laboratoire
   4. Accouchement
   5. Chirurgie
   6. Autres (Spécifiez)__________________________________________

2. Comment avez-vous été informée de l'existence de cet hôpital/centre de santé? [  ][  ][  ][  ][  ][  ]
   1. Ma famille m'a dit
   2. Mon docteur m'a dit
   3. J'ai entendu mon voisin en parler
   4. Autres (spécifier)__________________________________________

3. Comment êtes-vous traité durant votre séjour à l'hôpital? [  ][  ][  ][  ][  ][  ][  ][  ]
   1. Je suis très mal soignée
   2. Je suis mal soignée
   3. Je suis très bien soignée
   4. Je suis bien soignée
   5. Autres (spécifiez)__________________________________________

4. Comment trouvez-vous le coût des services? [  ]
   1. Très cher
   2. Cher
   3. Modéré
   4. Normal
   5. Autres (spécifiez)__________________________________________

5. Selon vous, qu'est-ce qui peut être fait pour une amélioration de la qualité des soins?
   [  ][  ][  ][  ][  ][  ][  ][  ]
   1. Accroître le nombre des infirmiers
   2. Accroître le nombre des docteurs
   3. Donner les remèdes gratuits
   4. Equiper l'hôpital
   5. Autres____________________________________________________

6. Que font les femmes pour avoir de l'argent pour leurs soins? [  ][  ][  ][  ]
   1. Mon mari me donne de l'argent
   2. Ma famille me donne de l'argent
   3. Autres____________________________________________________

7. Que font les voisins/membres de la famille quand ils sont malades? [  ][  ][  ][  ][  ][  ][  ]
   1. Rien
   2. Consultent le guérisseur traditionnel
   3. Achètent les remèdes à la pharmacie
   4. Achètent les remèdes dans la rue
   5. Autres____________________________________________________

8. Selon vous quelle est la meilleure chose à faire lorsqu'on est malade? [  ][  ][  ][  ][  ][  ]
   1. Aller à l'hôpital
   2. Consulter un guérisseur traditionnel
   3. Aller à la pharmacie
   4. Acheter les remèdes dans la rue
   5. Autres____________________________________________________
9. Qu'est-ce qui vous fait croire que ce choix est le meilleur? 
   1. le coût
   2. l'accessibilité
   3. l'efficacité
   4. Autres __________________________

10. Comment trouvez-vous les coûts des consultations et des soins dans cet hôpital? 
    1. Elevés
    2. Modérés (abordables)
    3. Autres __________________________

11. Viendrez-vous dans cet hôpital la prochaine fois que vous serez malade? 
    1. Oui
    2. Non

    Si non, pourquoi? __________________________
    a. les infirmières ne prennent pas soins des malades
    b. je n'ai pas été bien soigné
    c. les services sont très coûteux
    d. autres __________________________

    Si oui, pourquoi? __________________________
    a. les soins sont bons
    b. j'ai été bien traitée
    c. on prend réellement soin des malades
    d. autres __________________________

12. Connaissez-vous d'autres hôpitaux/cliniques/centres de santé dans les environs? 
    1. Oui
    2. Non

    Si oui, quels sont les services qui y sont offerts? __________________________
    a. Pédiatrie
    b. Gynécologie + accouchement
    c. Chirurgie
    d. Laboratoire + Radiographie
    e. ORL (Ortho Rhino Laryngologie)
    f. Ophtalmologie
    g. Neurologie
    h. Cardiologie
    i. Autres __________________________

13. Comment se comportent la majorité des personnels de cet hôpital? 
    1. Poli/serviable
    2. Sévère et inattentionné
    3. Autres __________________________

14. Selon vous, que peut-on faire pour améliorer l'accès des femmes aux services de santé dans votre communauté? 
    1. __________________________
    2. __________________________
    3. __________________________
    4. __________________________
PERSONNEL MEDICAL

Quels sont les autres services sanitaires que vous connaissez dans votre communauté?
1. 
2. 
3. 

Quel est le coût légal de consultation dans votre hôpital?
Les nouveaux les anciens patients carte
1. Adultes
2. Enfants
3. Handicapés

Quel est le coût légal des services suivants dans votre hôpital?
Les nouveaux les anciens patients carte
1. Examens au laboratoire
2. Ophtalmologie (les yeux)
3. Chirurgie
4. ORL (Oreille, nez, gorge)
5. Gynécologie
6. Tests aux laboratoires
7. Rayons - X
8. Hospitalisation
9. Remèdes - variation des prix par hospitalisation pour les malades les plus fréquents
10. Soins dentaires
11. Accouchement normal
12. Hospitalisation: privée, semi-privée, chambre pour 1 seule personne

Quelle est la qualité des personnels médicaux dans vos services?
1. Docteur en médecine
2. Technicien supérieur des soins infirmiers
3. Infirmier diplômé d'Etat
4. Infirmier breveté
5. Aide soignant
6. Fille de salle/garçon de salle
7. Infirmier décisionnaire

Avez-vous des difficultés dans vos services?
1. Oui
2. Non

Si oui, pourquoi?
1. Pas assez de personnels
2. Manque d'équipement
3. La demande des patients est énorme
4. Les heures de travail sont très long (> 8)
5. Language
6. Autres

Qu'est-ce qui peut vous aider à améliorer vos conditions de travail?
1. Augmentation de salaire
2. Réduire la charge du travail  
3. Accroître le nombre de personnel  
4. Autres ____________________________

Qu'est-ce qui peut être fait pour les femmes dans le but d'améliorer pour celles-ci l'utilisation des services sanitaires?
1. Rapprocher les services sanitaires auprès d'elles  
2. Réduire le coût des services  
3. Améliorer la qualité des services  
4. Autres ____________________________

Quel est le comportement des patients que vous soignez?
1. Pâle  
2. Difficile  
3. Rude  
4. Sobre et misérable  
5. Autres ____________________________

Combien de femmes recevez-vous par jour?
a) Maternité _____________  
b) Vaccination _____________  
c) Pavillon féminin ____________

Est-ce que le système politique au Cameroun facilite-t-il l'accès de la femmes aux services de santé de bonne qualité et appropriés?
1. Oui  
2. Non  

Si non, spécifiez ____________________________

De quelle manière la crise économique a-t-elle affecté votre accès à une bonne qualité de soins de santé?
1. Elle ne nous a pas affecté  
2. Elle nous a améné à diminuer le nombre et la qualité du personnel  
3. Elle a réduit la motivation  
4. Autres (spécifiez) ____________________________

Qu'en est-il de la politique de santé à propos de la femme camerounaise?
1. Je n'en sais rien  
2. ____________________________

Comment la médecine traditionnelle influence-t-elle les services fournis dans votre hôpital/centre de santé?
______________________________

Selon vous, qu'est-ce qui peut être fait pour améliorer l'accès des femmes aux soins de santé dans votre communauté?
______________________________
**IDENTIFICATION**

Nom de l'intervieweur: ____________________________ N° de l'interiewé: __________

Province: ____________________________

Arrondissement: ____________________________

Résidence: [ ] 1. Urbain
          2. Rural

Site de l'étude: ____________________________

Quartier: ____________________________

Code de la province ex: CP001

À quelle tranche d'âge appartenez-vous? [ ]
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2. 26 - 35
3. 36 - 45
4. > 46

Quelle est votre situation matrimonial?
1. Marié
2. Divorcé
3. Célibataire
4. Veuf

Combien d'enfants vez-vous? ________________

Combien de personnes habitent chez vous? ________________

Résultat de l'interview [ ]
1. Complet
2. Incomplet

Superviseur: ____________________________

Commentaire: ____________________________

Signature: ____________________________
ENTRAINEMENT

Le guide du groupe de discussion

RAPPELS ET INTRODUCTION

- Saluer les participants
- Vous présenter à ceux-ci et ensuite celui qui prend les notes
- Demander aux participants leurs noms et les écrire dans un endroit et selon le sens qui peut vous permettre mieux les diagnostiquer.
- Leur expliquer le bienfait de l’enregistrement et des notes que vous allez prendre.
- Leur demander de vous permettre cet enregistrement.
- Leur expliquer les règles du jeu :
  - l'utilisation des noms
  - le fait de laisser apporter une seule personne à la fois
  - chacun doit participer.
- Demander à chaque participant de raconter aux autres quelque chose d'une grande importance pour lui.
- Ouvrir la discussion

Thème I: quels sont les facteurs sociaux responsables de l'utilisation des services de santé chez les femmes dans votre communauté?

1.1 Que font les femmes de votre communauté pour avoir de l'argent?
1.2 Quels sont dans les obstacles qui empêchent les femmes d'avoir de l'argent votre communauté?
1.3 Qu'est-ce qui empêche les femmes d'utiliser les services de santé dans votre communauté?
1.4 Lorsque vous n'utilisez pas les services de santé de votre communauté, quelles autres alternatives vous sont offertes?
1.5 Qu'est-ce qui vous pousse à aller consulter un médecin traditionnel?
1.6 Si l'on vous demandait de choisir, laquelle entre la médecine traditionnelle et la médecine moderne choisiriez-vous? Pourquoi?

INTITUTIONNEL

Thème II: Facteurs ne permettant pas aux femmes d'utiliser de manière adéquate les services de santé.

2.1 Quelles sont les structures de santé (hôpitaux, cliniques, dispensaires, centres de santé) qui se trouvent dans votre communauté?
2.2 Quels sont les services que vous fournissez ces structures (quel genre de travaux font les docteurs et infirmiers ces hôpitaux?)
2.3 Est-ce que les membres de votre famille ou vous-même utilisez les services de ces institutions?
   1. Oui
   2. Non
   Pourquoi?

2.4 Vous a-t-on demandé ou à un membre de votre famille d'aller consulter un autre docteur? Si oui, quand et pourquoi?
2.5 Où allez-vous souvent avec vos malades (du village à l'hôpital général/hôpital référence).
2.6 Quand est-ce que l'hôpital le plus proche de votre communauté peut-il traiter ou soigner un patient?
2.7 Combien payez-vous pour aller à l'hôpital le plus proche?
Les facteurs qui influencent aux niveaux familial et individuel l'utilisation des services de santé dans la communauté.

Qu'est-ce qui détermine l'utilisation des sources de santé qui sont dans votre communauté?

Quelles sont les difficultés que vous rencontrez lorsque vous voulez vous rendre dans une institution de santé?

Quels sont les services fournis dans une institution de santé? (citez et décrivez les).

Selon vous, qu'est-ce qui doit être fait pour améliorer les soins qu'on vous fourni dans ces institutions?

a) Médecine moderne

b) Médecine traditionnelle

Selon votre opinion, qu'est-ce qui doit être fait pour améliorer l'accès des femmes aux services de santé dans votre communauté?