Reproductive health experiences among women with physical disabilities in the Northwest Region of Cameroon

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Abstract

Objective: To investigate the reproductive health experiences among women with physical disabilities in the Northwest Region of Cameroon. Methods: Data were collected in the city of Bamenda through semi-structured interviews with women with mobility impairments, discussions with healthcare providers, hospital observations, and field notes. Interviews were transcribed verbatim, coded, and analyzed for key themes. Results: The 8 participants included in the study had limited understanding of reproductive health and many had not received basic reproductive health education. Unplanned pregnancy was common and pregnancy was often feared. Respondents reported both positive and negative responses from family, community members, and healthcare workers regarding reproductive health. Most healthcare centers were physically and financially inaccessible. Conclusion: Women with disabilities need greater education on reproductive health and improved access to health care.

1. Introduction

The World Health Organization reports that 600 million people worldwide are living with some form of disability, with 80% living in low-income countries [1]. Women in low- and middle-income countries account for up to 75% of this population [2]. Reproduction, birth, and postpartum health are as important for women with disabilities (WWD) as they are for other women, yet these issues are often not addressed sufficiently by health services. We are not aware of other research that has explored this in-depth in low- and middle-income countries.

The Republic of Cameroon recently implemented changes in healthcare provision and services by decentralizing the national health system and, in 1996, increased the proportion of the national budget allocated to health services. However, despite Cameroon’s documented commitment to improving health care, many WWD in the Northwest Region have unmet reproductive health needs.

Disabled people in low-resource countries experience barriers to accessing health information and services. Barriers arise from restrictive cultural norms, service limitations, lack of mobility aids, poor communication skills of staff, inaccessible buildings, marginalization in the community, illiteracy, lack of education, and gender inequality [3]. In terms of women’s reproductive health, family, caregivers, institutions, and even healthcare professionals often overlook the needs of WWD because of the perception that they are “asexual” and therefore do not require sexual health information. Research in other areas of the world contradicts this perception. People with disabilities can have healthy sexual lives; however, women with disabilities are more likely to be victims of rape, sexual abuse, and domestic violence than their nondisabled peers [3]. It is not known whether these findings are applicable in Cameroon. The aim of the present study was to examine the reproductive health experiences of WWD in the Northwest Region of Cameroon.

2. Materials and methods

This was a phenomenological research study approved by the University of Toronto Research Ethics Board and the National Ethical Review Committee of Cameroon. The aim was to better understand the reproductive health experiences of WWD by focusing on the perspectives of individual women and the effect of the experiences on their lives [4,5]. The methods used privileged the experiences of women in their own words.

As a first step, the researchers examined their own perspectives on reproductive health and reproductive health among the group—a necessary step to assist in recognizing how preconceived questions and discomforts can influence the study. This was done through individual reflection and writing, as well as research team meetings to discuss shared and disparate conceptions. Through informal discussions with healthcare providers in the city of Bamenda and observation in the Bamenda Provincial Hospital, the first author was able...
to gain an appreciation of the delivery of reproductive health care in Bamenda.

Data were collected through semi-structured key informant interviews lasting 45 minutes to an hour, which were conducted and tape-recorded in the presence of an interpreter when necessary. Pilot interview questions were outlined prior to data collection and minor changes were made as the project unfolded. Menopause was not discussed since none of the participants had experienced it. Participants were asked to describe their experiences regarding their reproductive health and their understanding of the situation for other women. Following transcription of each interview, thematic analysis was performed by the primary researcher with discussion and interpretation from other members of the research team [4]. A composite description was returned to the participants for review and discussion. Coding and analysis was done by hand, without the use of a software package.

Participants were women aged between 27 and 45 years with physical disabilities that affected mobility who resided in Bamenda in the Northwest Region of Cameroon. If there was any doubt about a participant’s competency to provide consent, they were not eligible to participate in the study.

Recruitment was done by contacting leaders in the disability community and attending disability group meetings to explain the nature of the study. Following the presentation, volunteers who were available within the study timeframe were requested. Word-of-mouth and the snowball technique of sampling, where existing study participants recruit future participants from among their acquaintances, were used in recruiting additional participants. Informed consent was acquired prior to conducting the interviews, and participants gave themselves pseudonyms to ensure confidentiality.

3. Results

The basic demographic characteristics of the 8 participants included in the study are shown in Table 1.

The participants’ understanding of reproductive health was limited and only consisted of their health during pregnancy and childbirth. One participant said, “information flow about reproductive health is not that good in our society” (Ato). Reproductive health experiences were unique, influenced by each individual’s health education, romantic relationships, social support network, feelings about their reproductive health, and community perceptions of WWD. These influences are discussed in the context of the common themes that emerged from their experiences.

In Cameroon, the basic biology of menstruation is taught in primary school and methods of contraception and sexually transmitted infections (STIs) are taught in secondary school. However, many girls rely on their mothers or sisters to teach them about the connection between menstruation, pregnancy, contraception, and STIs. One participant explained, “[my mother] told me that I am matured and that if I play carelessly I will be contracted an illness or a child” (Ceye).

Some WWD may not have access to reproductive education. Many girls with disabilities do not attend secondary school or complete primary school because of financial constraints or physical inaccessibility of schools. Some grow up without mothers or older sisters, or their family does not consider that they may be sexually active. Others delay starting school because of time spent in health and rehabilitation centers and may be sexually active before receiving reproductive health education. Some learn about the connection between menstruation and pregnancy after becoming pregnant. One participant stated, “I did not really know much, I just learnt about [pregnancy] when it happened. It was after I put to birth that they explained that to me” (Vero).

In the general population in Cameroon, knowledge about contraceptive methods is 90% [6]. However, contraceptive use in Cameroon is low, with a rate of 26% for all methods and 13% for modern methods. Although 20% of women express a need for contraception, only 56% of the potential demand for family planning is being satisfied [6]. In the present study the participants’ contraceptive method of choice was the rhythm method, with condoms or the withdrawal method used during the “unsafe period.” As a result, there were unplanned pregnancies. Although abortion is not legal in Cameroon, women discussed crude methods of abortion and were aware that some WWD undergo illegal abortion.

Two of the women interviewed had tubal ligations; one after her third child as a means of family planning and the other after her first child because of her sick mother’s concerns. “At first when mother told me, I refused, but the way she explained, I cannot even fetch water alone or cook or anything, except if I have somebody to assist me, so if I deliver now again I will really suffer with the children, so I had to accept” (Ceye).

WWD had varied experiences with healthcare workers and healthcare centers. In general, they received adequate care if they were able to pay the medical fees and communicate their needs. Some experienced extra attention, encouragement, and support at the prenatal clinic during their pregnancy because of their disability. Others found that healthcare workers were not knowledgeable in disability issues, nor sensitive to their needs. Some participants felt that healthcare workers did not appreciate that WWD could have boyfriends or be sexually active, and as a result neglected to educate them or inquire about their reproductive health.

Most healthcare centers were inaccessible, which led to feelings of shame: “Can you imagine a mature woman like myself being carried to enter the doctor’s office because I want to receive medical care? Very very disgraceful and challenging!” (Florence).

Participants relied on taxis for transportation but taxis were often unwilling to carry them, making it more difficult to access services. “If you get a taxi they will just look at you and think that you will inconvenience them so they just go” (Helen).

In addition to physical inaccessibility there were also financial barriers to reproductive health services. Earning an income was difficult. Inability to afford the cost of transportation to health centers

### Table 1
Demographic characteristics of the 8 participants.

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age, y</th>
<th>Employment</th>
<th>Impairment/disability</th>
<th>Level of education attained</th>
<th>Relationship status</th>
<th>No. of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ato</td>
<td>28</td>
<td>Shop owner</td>
<td>Physical disability, poliomyelitis</td>
<td>University diploma</td>
<td>Single</td>
<td>0</td>
</tr>
<tr>
<td>Ceye</td>
<td>45</td>
<td>Market vendor</td>
<td>Physical disability, poliomyelitis</td>
<td>Primary school diploma</td>
<td>Single</td>
<td>1</td>
</tr>
<tr>
<td>Grace</td>
<td>35</td>
<td>Market vendor</td>
<td>Physical disability, joint pain</td>
<td>Primary school diploma</td>
<td>Single</td>
<td>0</td>
</tr>
<tr>
<td>Helen</td>
<td>27</td>
<td>Embroidery</td>
<td>Physical disability, poliomyelitis</td>
<td>Part of secondary school completed</td>
<td>Single</td>
<td>1</td>
</tr>
<tr>
<td>Odelia</td>
<td>30</td>
<td>Shop owner</td>
<td>Physical disability, poliomyelitis</td>
<td>Primary school diploma</td>
<td>Boyfriend</td>
<td>1</td>
</tr>
<tr>
<td>Ambo</td>
<td>31</td>
<td>Seamstress</td>
<td>Physical disability, congenital talipes equinovarus (club foot)</td>
<td>Part of secondary school completed</td>
<td>Single</td>
<td>1</td>
</tr>
<tr>
<td>Florence</td>
<td>35</td>
<td>Embroidery and call box</td>
<td>Physical disability, poliomyelitis</td>
<td>Secondary school diploma</td>
<td>Single</td>
<td>0</td>
</tr>
<tr>
<td>Mum</td>
<td>38</td>
<td>Teacher</td>
<td>Physical disability, left-sided paralyisis following meningitis infection</td>
<td>Teaching diploma</td>
<td>Married</td>
<td>3</td>
</tr>
</tbody>
</table>

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and consultation fees often resulted in delays in seeking medical care. Participants knew prenatal monitoring was important and suffered fear and anxiety throughout their pregnancy and delivery, especially if they had no-one to answer their questions. Some of the women interviewed even considered abortion. “I feel so sad because I was thinking how am I going to deliver? How are people going to look at me? [my partner] was afraid, with this condition... [he said] let’s abort the child... I said that I had been hearing of many women aborting the child and dying, so I wanted to try this, so I refused” (Odelia). “I tell my mother when my pregnancy was already 6 months. I was afraid that they might beat me and send me out of the house” (Vero).

The community also feared for the women. The participants reported that people were shocked and concerned upon hearing that they were pregnant, fearing that the women would not be able to carry the pregnancy or die during pregnancy or childbirth. People would stare at them, causing some women to stay indoors during their pregnancy. For others, it made them question their role as a woman. “They don’t see you to suffer. They see that as a burden to you, not as something important in your personal life” (Ato). “I did not go out, I only go to church on Sunday or to the clinic. I wanted to have the child, but with my condition I did not want people staring at me” (Ceye). “I feel so bad. Am I not supposed to have a child? Am I not a woman?” (Odelia).

The participants who attended the prenatal clinic had positive experiences. They reported receiving special treatment by sympathetic healthcare workers who spent extra time and gave extra care. Counseling, education, and sometimes access to equipment or examining rooms were provided. “To make me feel comfortable, when I first went to the [prenatal] clinic they would make to satisfy me first, before any other person so that I should go home and rest” (Odelia). “The doctor provided a special room because there were steps to climb to get to the office. So when I had an appointment I did not have to climb” (Ceye). “For the delivery bed, they put me where it would be accessible for me, in a low bed” (Helen).

Lack of strength in their lower limbs caused difficulties bearing down during childbirth. Cesarean delivery, an expensive procedure, was often required. Many felt anxious about undergoing an operation. Anxiety was minimized when the women were counseled regarding the procedure early in the pregnancy, allowing them to prepare both mentally and financially.

WWD relied on their relationships with family, friends, and community for information as well as emotional, psychological, physical, and financial support. Some had a strong social support network and felt confident in their abilities to take control of their reproductive health. Others felt isolated owing to mobility impairment or stigma, or were not confident that they could identify who would provide them with support when they needed it. One participant responded: “with someone like me you can’t accept what someone says with their mouth because what the mouth says is not necessarily what is in the heart. They can say, yes I can do this, but when it happens everybody is turning his back” (Ato).

Romantic relationships and the prospect of marriage were hindered by the social and physical isolation. Most of the participants identified that they would like to be financially stable, married, or in a loving, mutually respectful relationship before having children. Participants reported that their communities did not encourage them to have boyfriends for fear that they would be poorly treated or become pregnant and the men would abandon them. On the other hand, community members encouraged them to marry and have children so that someone would care for them. It was often difficult for WWD to realize their potential as mothers or wives. One participant stated: “It is my condition that has hindered me from getting married. When most women are going to farm, if they married me now, how will they be living? They will have to be the one to do everything for you. That is the problem that causes them not to come” (Grace).

4. Discussion

The present study determined that the participants’ needs were education, information, and accessibility—both physical and financial. With the Republic of Cameroon’s commitment to decentralized health care, local providers should ensure that the healthcare rights of the disabled in their community are met. The government’s mandate to increase funding to health services needs to address physically accessible healthcare centers that provide accessible equipment and subsidized medical services, including transportation costs to service the disabled.

Analysis of the interviews indicates that WWD have a general lack of knowledge of reproductive health. Education needs to be provided directly through the community and schools, or information campaigns and health education sessions in local health centers. The key is to ensure that the educators and healthcare providers understand that WWD, as well as able-bodied women and girls, require reproductive health education. Early education and access to contraceptive methods are vital. Providing information and access to contraceptive methods reduces fear, anxiety, and unwanted pregnancies. Reproductive health information sessions, bringing together able-bodied and disabled women, would work to break down barriers, reducing stigmas against WWD and positively affect community perceptions.

Mobility impairment combined with a lack of education reduced the ability of WWD to earn an income, placing them, generally, in a lower income level. Encouragement to stay in school and funding to receive skills training, as well as financing opportunities to support income-generating activities would facilitate financial independence. The women could be valued, productive members in the community and be empowered to make choices. Access to membership of a disability group, possibly through a medical or community centre, would provide an important source of information and social and emotional support for WWD. This group might also be able to provide financial assistance if needed.

The study was limited to interviews with WWD. A further study with information gathered from able-bodied women as a comparison would be valuable. Future research could examine healthcare providers’ perceptions of the reproductive healthcare needs of WWD. In addition, evaluation of different interventions to determine those that are most successful at increasing knowledge and accessibility would be beneficial.

5. Conflict of interest

No conflict of interest exists for any of the authors.

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References


