Access to Care and the Use of Healthcare Services by Women in Rural Cameroon: A Participatory Action Research Study

Grace Tadzong-Awasum

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ACCESS TO CARE AND THE USE OF HEALTHCARE SERVICES BY WOMEN IN RURAL CAMEROON: A PARTICIPATORY ACTION RESEARCH STUDY

A Dissertation

submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for the degree of Doctor of Philosophy

By

Grace S. Tadzong

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By

Grace S. Tadzong

Approved November 6, 2018

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ABSTRACT

ACCESS TO CARE AND THE USE OF HEALTHCARE SERVICES BY WOMEN IN RURAL CAMEROON: A PARTICIPATORY ACTION RESEARCH STUDY

By
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December 2018

Dissertation supervised by Dr. Rick Zoucha PhD, PMHCNS-BC, CTN-A, FAAN

Women in rural Cameroon do not access health care as timeously and as often as they should. They fail to get screened for common diseases, with the consequence that such diseases are often diagnosed at a very advanced stage. This accounts for the high morbidity and mortality rates as well as low life expectancy recorded among women. The purpose of this study was to explore and understand the health access experiences of women in rural Cameroon. Methodology: Participatory action research was used guided by a Focused ethnography in phase one. Twenty-five women aged 21-77 years were recruited through local the administrative leaders to participate after giving their consent. Focus group discussions were organized to explore and understand the experiences of the women. Collected data was analyzed using Leininger’s four phases of qualitative data analysis assisted by NVivo 12 data analysis software. The study was conducted in the Eloumndem-
village, a suburb of Yaounde, Cameroon. **Findings:** Four major themes were identified, namely that women: (1) execute and promote folk practices because they cannot access healthcare services; (2) live in abject poverty which prevents them from accessing health care; (3) have no voice and/or power in their community which acts as a barrier to health care; and (4) desire to be better informed on how to care for themselves. **Discussion:** Findings revealed the need to educate women in order to improve their social status and give them a voice in their community. There is need for policy makers to increase health spending for communities in rural Cameroon in order to subsidize health care cost for women and possibly improve access.

**Key words:** Rural communities, Access to health care, Women, Cameroon.
RÉSUMÉ

L’ACCÈS AUX SOINS DE SANTÉ ET L’UTILISATION DES SERVICES DE SANTÉ PAR LES FEMMES EN MILIEU RURAL AU CAMEROUN : UNE ÉTUDE DE RECHERCHE-ACTION PARTICIPATIVE

par

Grace S. Tadzong

Décembre 2018

Sous la direction du Dr. Rick Zoucha PhD, PMHCNS-BC, CTN-A, FAAN

Les taux de morbidité et de mortalité chez les femmes ne cessent de croître au Cameroun. L’objectif de cette étude était d’explorer et de comprendre le vécu de la femme rurale camerounaise en matière d’accès aux soins de santé. Méthodologie : La recherche-action participative a été adoptée comme méthodologie et l'ethnographie ciblée n'a été utilisée que dans la première phase. Vingt-cinq femmes âgées de 21 à 77 ans ont été recrutées au Eloumdem une banlieue de Yaoundé, au Cameroun, pour participer à des discussions en groupe. Conclusions : Quatre grands thèmes ont été dégagés de l’étude, à savoir que : (1) les femmes adoptent et encouragent la pratique des thérapies traditionnelles parce qu'elles n’ont pas accès aux services de santé ; (2) les femmes sont privées d’accès aux soins de santé car vivant pour la plupart dans une pauvreté extrême ; (3) le fait de n’avoir ni voix ni pouvoir dans leurs communautés limite l’accès des femmes aux soins de
santé ; et (4) les femmes souhaitent être mieux informées sur les bonnes pratiques qu’elles doivent adopter pour rester en bonne santé. **Discussion** : Les conclusions de l’étude ont souligné la nécessité conscientiser les femmes afin d'améliorer leur statut social et de leur donner une voix dans leurs communautés.

**Mots-clés** : Communautés rurales, Accès aux soins de santé, Femmes, Cameroun.
DEDICATION

This dissertation is dedicated to my husband and five kids for their love and undying support which helped me complete this challenging journey. It is also dedicated to the remarkable women in the study whose unbridled expressions of joy in the face of adversity as well as their strength and determination to overcome their challenges brought me to the realization that it is difficult to kill a positive spirit, even in the darkest of circumstances.
ACKNOWLEDGEMENT

First, I thank my dissertation chair, Dr. Rick Zoucha for his time. I appreciate his encouraging spirit, his desire for excellence, his patience throughout my time as a student and his steady hand which never failed to put me back on track each time I seemed to have derailed. I thank Dr. Salman Khlood whose gentle spirit has always encouraged and guided me from the very first day I stepped foot on Duquesne soil. She has been a great inspiration in ways difficult to express. I equally thank Dr. Likeng Ekodi Julienne for all her support and encouragement. She always thought I was able to do better. I am grateful to the entire Duquesne faculty who sowed the seed of professionalism in me. They have been an invaluable team and are the model that I will like to have in my home university. I thank Pr. Alexander Nkoum for his timeless support from my novice days and for the battle he is waging to ensure excellence in the nursing profession in Cameroon. His love for the profession has molded me into a hard-working and tireless nurse educator in a context where nursing is hard, resources are limited, and nurses need not only work hard but also work smart.
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ABSTRACT

Introduction and purpose: Women in rural communities in Cameroon experience poor health and high mortality rates. The purpose of this review is to explore the literature in order to better understand access to health care for women in rural Cameroon.

Method: Qualitative and quantitative studies were found for this review that revealed most of the issues limiting access to health care for women in the rural areas of African countries other than Cameroon. Literature for Cameroon was limited at the time of the search, however, available literature from other countries located within the African sub-region was reviewed.

Results: A total of six studies was found, comprising two quantitative and four qualitative studies. The findings revealed that women have difficulties accessing health care on account of their disadvantaged position in traditional African society, lack of cultural understanding by health personnel, cultural and traditional practices, poverty, unemployment, and low levels of education.

Implication/Conclusion: The negative experiences recorded in the literature have contributed in limiting healthcare access for women, thus producing low quality of life and low life expectancy in most parts of Africa.

Key words: Access to health care, women, rural communities, Cameroon, culture
Background

Access to health care is about individuals being able to receive appropriate health care resources and services that ultimately can improve their overall health. The availability and relevance of health care services as well as the ability of the population to pay for such services actually determine the extent to which they can be accessed. It also includes the interplay of organizational, cultural and ethnic factors, the population’s satisfaction with health outcomes, and the availability of adequately trained and culturally congruent health care providers. Access to care relates to the timely use of individual health services to achieve optimum health outcomes, the accessibility of the health system, and the availability of healthcare providers (Gulliford et al., 2002; People, Health, & Services, 2010). Unfortunately, this is not the case for people in Cameroon where specialized centers for women’s health are totally absent (Weigner & Akuri, 2007). Health services are not readily accessible and most women in rural Cameroon are unemployed. Hence, they cannot afford health care services and do not have health insurance which can be obtained only through an employer (Amin & Dubois, 2000). The ethnic and cultural diversity of Cameroon makes it difficult for nurses and other health care providers to adequately provide culturally congruent care (McFarland & Wehbe-Alamah, 2014; Vubo, 2006). The fifth Millennium Development Goal (MDG 5) was intended to improve maternal health by reducing the maternal mortality ratio by three quarters between 1990 and 2015 in all countries (World Health Organization, 2014). This goal has unfortunately not been attained in most Sub-Saharan African countries in general and in Cameroon in particular (Easterly, 2009).
Purpose

The purpose of this integrative review is to explore existing literature on the significant problem of healthcare access faced by women aged 21-70 years who may or may not be pregnant in rural communities in Cameroon. It is primarily intended to evaluate the literature on access to care and the use of health care services by rural women in Cameroon and, more specifically, to identify the gaps in the literature for future research.

Methods and Design

The method utilized for this review allows the available literature, sourced from a variety of databases, to be summarized in order to get a fuller, richer and deeper understanding of the identified problem in accordance with the Whittemore and Knafl (2005) design: problem identification, literature search, data evaluation, data analysis, and presentation stages.

Problem Identification

Incidence and mortality rates are on the rise in Sub-Saharan Africa and Cameroon in particular especially as women in rural Cameroon do not access health care even where health services are available (Sando, Fouelifack, Fouogue, Fouedjio, & Essame-Oyono, 2015). Moreover, women tend to have additional and special health needs, especially during their reproductive years, compared to men within the same age group (Patchias, Waxman, & Fund, 2007; World Health Organisation, 2013a). Mortality rates keep rising for preventable diseases like cervical and breast cancers, malaria and other infectious diseases, which can be treated when diagnosed on time. It has been found that women fail to access care because they do not perceive health as a right and some lack the necessary knowledge to do so (Weigner & Akuri, 2007). This has led to very low life expectancy and high mortality rates for women in Cameroon. Indeed, the
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Life expectancy is 58.65 years for women (BURCREP, 2010; World Health Organisation, 2013a) and the maternal mortality ratio is 872 per 100,000. In Cameroon, about 1500 women were diagnosed with cervical cancer in 2010, and about 1000 die each year (De Sanjosé et al., 2012). Routine and timely access to health care can greatly improve the health of women and reduce maternal mortality. The problem identified for this review is that women do not access healthcare in a timely manner; consequently, an understanding of the issues that limit access to health care can yield lasting solutions for women in rural Cameroon.

Literature Search

A literature search was conducted using PubMed, CINAHL, MEDLINE and African Index Medicus databases. Only PubMed and MEDLINE produced articles within the African and Cameroonian contexts. Google scholar was also used but it yielded only some articles that had already been found through PubMed search. The assistance of a health science librarian was sought to improve the quality of the search. It should be noted that no nursing literature was found in this search, especially among the available studies in Cameroon. The keywords used for the search included: health care and women, rural women and access to health care, health care experiences of rural women, Cameroon, and Africa. Articles not directly related to women in rural communities and access to healthcare were excluded. Initially the literature was limited to Cameroon and yielded only two validated articles. Consequently, the search was broadened to include other African countries which have approximately the same level of economic development as Cameroon. An initial search yielded a total of 682 (PubMed =640, Medline =42) studies for Africa and Cameroon. Some 650 of these articles were discarded due to lack of consistency with the context (Figure 1). About 500 of the studies were specific to HIV and malaria for both males and females, which are not the focus of this review. To further refine and
focus on the topic of this integrative review, only six articles were finally retained. Other databases like the Cumulative Index and Allied Health Literature (CINAHL) only yielded results for other continents like Europe and America. Once Cameroon was added to the search, no articles could be found (figure 1). This search was conducted between April 20 and March 15, 2017 and studies outside the African continent were excluded from the search.

**Data Evaluation**

The quality of the studies was evaluated based on relevance to the topic, sample size, methodology, respect of ethical procedures and quality of the research studies. The Critical Appraisal Skills Program (CASP) qualitative checklist was used and the articles chosen for this review answered “yes” to at least 9 of the 10 questions that define a qualitative study. Scores ranged from 0-10 and each paper received a score of 9 out of 10. The quantitative studies were also evaluated using the CASP list for quantitative studies and the result was satisfactory for the chosen articles with the least score being a 9 on 10 (Critical Appraisal Skills Programme, 2017; Pearson, 2004). The articles retained for the study have been summarized in Table 1, while those that did not meet the qualitative and quantitative appraisal scale standards were discarded. No theoretical sources could be traced at the time this IR was written and so could not be considered.

**Data Analysis**

The data deemed relevant pertained to the purpose, design, sample, context, data collection tools and setting of studies on access to health care. Data from studies on access to health care for women (within and outside the context of pregnancy) was deemed useful and thus extracted. The data was then classified, summarized, organized into themes and categorized for a more refined synthesis of the results. Grouping and comparison of the data from different studies
yielded themes common to all the articles, especially those directly relevant to healthcare access in all its dimensions.

Results

The six studies used for the final analysis were published between 2007 and 2015 and were qualitative (n=4), mixed-method (n=1) and quantitative studies (n=1). Two of the studies were conducted in Cameroon and four in other African countries.

Description of Sample

The literature accessed focused on women in rural areas who may have common perceptions and/or experiences in terms of access to health care. For the qualitative studies, data was collected through focus groups and participant observation (Atuoye et al., 2015; Ganle, 2015b; McTavish & Moore, 2015; Weigner & Akuri, 2007). None of the studies specifically focused on rural women and their health care experiences and it cannot be claimed that these studies will speak to the questions that guided the review to the fullest. Nonetheless, they do provide insight for this review and future studies. Although most of the studies focus on maternal health care, this review goes beyond maternal health (defined by WHO as the health of women during and after pregnancy) to include other women’s health issues.
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Figure 1. Summary of literature search strategy

**Literature search**

*Search terms included:* health care and women, rural women and access to health care, health care experiences of rural women, Cameroon, Africa. Total (N=684)

- PubMed (n=640)
- Medline (n=42)

Records after duplicates were removed (n = 642)

- Validated articles that matched the topic (n = 32)
- Records excluded (n = 650)

Full-text articles assessed for eligibility (n = 6)

- Full-text articles excluded, with reasons (n = 26)

Studies included in qualitative synthesis (n = 4)

Studies included in quantitative synthesis (n = 1)

Studies included in both qualitative and quantitative synthesis (n = 1)
Specific Synthesis

Theme 1: The disadvantaged position of women in their communities blinds them to the perception of health care as a right.

Weigner and Akuri (2007) through a qualitative study discovered that the disadvantaged position of women in rural communities, and the burden of caring for their families without adequate support from their husbands led to a negative perception of health care. The result is that women do not perceive health care as a human right and so fail to take advantage of available resources.

Theme 2: Lack of cultural understanding by nurses and healthcare personnel can negatively affect access to health care.

Ganle (2015b), in qualitative study with 94 Muslim women in three rural communities in Ghana, found that these women experienced challenges on account of their religious obligations which led them to expect more privacy than could be provided by the hospitals. The insensitivity of health personnel and their ignorance of Muslim women’s cultural and religious practices became one of the major problems that prevented these women from seeking maternal health care services that they perceived to be inconsistent with their culture. Furthermore, the health care information was not tailored to their needs as Muslims. This experience underscored the need to introduce cultural competence training for health care providers who deal with both Muslim and non-Muslim women.

Theme 3: The cultural and traditional practices of women may negatively affect access to health care.

Traditional and cultural beliefs in some parts of Africa could make some women feel inferior to men or relegated to the background (McTavish & Moore, 2015; Tsawe & Susuman,
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2014a; Weigner & Akuri, 2007). Since they generally bear the burden of child bearing, child upbringing and education, these women tend to neglect their health to focus on the welfare of their husbands and children.

Theme 4: Poverty and unemployment (with consequent lack of health insurance) are major obstacles to health care access.

Tsawe and Susuman (2014a) explored some of the factors that affect access to maternal health care services in Mdantsane, a rural region in the Eastern Cape, South Africa, using a mixed-method approach. The quantitative part of the study, which focused on women who used maternal health services revealed that employment and eligibility to medical aid significantly affected access to health services. The qualitative phase carried out with health care providers confirmed that the inability to pay for services was a contributive factor to limited access.

Cameroon.

Theme 5: Lack of knowledge and of health information limits access to health care.

Available literature revealed that women who had at least completed secondary school were better informed of their health needs and tended to seek care more often than those who had no secondary education. According to Tsawe and Susuman (2014a), women with some academic background are better placed to access health information and understand the relevance of health care than those who are uneducated. Another study carried out with health care providers revealed that women’s limited education and poor understanding of the relevance of maternal health services also contributed to limited access. This is a concern in Cameroon where women have a low literacy rate and a significantly high primary school dropout rate. Net primary school attendance is 82.3 for females, compared to 87.3 for males; net secondary school attendance for females is 38.7 as opposed to 44.2 for males (World Health Organization, 2010).
Theme 6: Poor road infrastructure and long distances to health institutions are a hindrance to health care access.

Another study using a qualitative approach explored the transportation barriers that limit access to maternal and childcare in rural Ghana through focus group discussions. It revealed that, women in rural Ghana do not get to hospital on time or use risky transport means that put their lives and those of their unborn babies at risk. This has reduced the number of hospital births as women now tend to rely on the traditional birth attendants residing in their localities (Atuoye et al., 2015). In another study, Tsawe and Susuman (2014a) also revealed that women who lived less than 20km from a hospital were more likely to access maternal health services than those who had to cover longer distances. Cameroon is a developing country that lacks a developed road network linking its major towns and regions. Most of the women in rural areas must walk long distances or use motorcycle taxis, which are even more dangerous.

Theme 7: Social capital plays a major role in improving access to health care.

Another author in a quantitative study looked at access to maternal health care in rural communities and its link to social capital. This study revealed that lack of social capital could greatly reduce access to maternal health services. The education and empowerment of women is therefore pivotal in building social networks that could help them to understand the importance of seeking health care especially during pregnancy. Social networks improve the dissemination of health information and increase awareness among rural women (McTavish & Moore, 2015).

Discussion

The main purpose of this review was to explore available literature on access to care and the use of health care services by rural women in Cameroon and to identify the gaps that could
constitute areas for future research. However, given the paucity of literature in Cameroon, literature from some other African countries was included. All the literature studied revealed that access to care and the use of health care services by rural women is a topic that has not been fully explored, especially in Cameroon itself.

Available literature revealed issues that may affect women in rural communities. The predominant issue in all the reviewed literature was the low literacy and high unemployment rates among women and young girls. Unemployed women may not be able to afford health care as much as those who are employed. Education also increases awareness and can empower women to begin perceiving healthcare as a basic human right (Weigner & Akuri, 2007). Tsawe and Susuman (2014a) believe that educational programs for women will enhance their literacy skills and increase their sensitivity to health information. This review also revealed that poverty is another major obstacle to health care access. The literature revealed a connection between poverty and poor nutrition among women that weakened their resistance to disease. The reviewed literature also revealed that salaried employment was the only channel through which women could receive health insurance in order to access care.

As mentioned above, lack of social capital as well as cultural values and beliefs are some of the obstacles to health care access (McTavish & Moore, 2015). Social capital refers to the networks that women create amongst themselves and which have been shown to improve the circulation of health information. It was revealed that women with extensive social networks were able to access health care more than women whose networks were limited by cultural influences (McTavish & Moore, 2015).

Nurses and health care providers in some African countries have been blamed for adopting poor attitudes and for failing to provide culturally congruent care. Cultural and religious
considerations must be taken into account when providing care to women, like Muslims who have special cultural needs, in order to increase their access to health care. Ganle (2015a) argues that maternal health services must be designed to meet the needs of Muslim women and emphasizes the need for cultural competence training for health care providers.

The literature also revealed that the improvement of health care policies, transport infrastructure and communication networks between health services may translate into better quality of life and longer life expectancy for women, thus improving their perceptions and even experience of health care in general (Mahiti et al., 2015; Tsawe & Susuman, 2014a). Consequently, the need to intervene in rural communities with the appropriate health policies, transport infrastructure and communication networks cannot be overemphasized especially if the health of women must be improved to enhance their quality of life and prolong their life expectancy. Admittedly, the women themselves may not feel empowered enough to overcome their rural problems, which implies that the onus is on policymakers and health care providers to make things right. Policy makers have the obligation to help alleviate the situation through a restructuring of government policy, an improvement in the literacy rate through education, financial empowerment, health education and reorganization of the entire health care system in local communities. It is important to note that no nursing literature pertaining to these issues was found in Cameroon. While it is safe to assume that women in rural Cameroon face the same issues as women in other African countries, this assumption will have to be confirmed and validated through a research study.
Implications for Practice, Policy and Research

Nurses can play a key role in helping to reduce mortality rates for women in rural communities. However, very little research has been carried out to bring the healthcare access problems of rural women to the limelight. Research on the experiences, perceptions and factors that limit their access to health care could be the starting point that would prompt policy makers to take action. This review, which included articles from four Sub-Saharan African countries, revealed that the problems are similar in all the countries even when the context is slightly different. These problems include: poverty, lack of awareness, low literacy rates, long distances to health centers, bad roads, lack of health insurance, unemployment and inadequate circulation of health information. The governments of these countries therefore need to improve the general living conditions of rural women by investing more in education, reorganizing health systems, formulating targeted health policies and increasing the quality and number of health personnel (especially nurses) deployed to rural communities. Nurses need to work in collaboration with the women through research to better understand their needs and accordingly tailor all provided care to their needs and circumstances. The nursing hierarchy should reconsider the implications of cultural competency in the profession and ensure that nurses get training in this area. It is important for nurses to lead the way in providing culturally congruent care to diverse populations. Furthermore, an improvement in the education, working conditions and environment of nurses could motivate them to become better professionals and boost the recruitment and retention of nurses to serve rural women. Hence, a general improvement in policies, health infrastructure and geographical accessibility are necessary to improve the healthcare experience of women and guarantee their satisfaction.
Limitations

- Some of the reviewed studies did not mention any limitations or difficulties encountered that could constitute areas of study for future researchers. One study mentioned that it had relied on a convenient sample which may not be generalized and that some of the demographic data was self-reported and unverified (McTavish & Moore, 2015).
- The absence of nursing literature in Cameroon and the small sample of available papers constitute a serious limitation.
- Cultural inferences from other countries to women in rural Cameroon may be misleading caution must be taken when drawing conclusions.

Conclusion

The purpose of this review was to assess and evaluate existing literature on access to care and the use of health care services by rural women in Cameroon. The review revealed the need for further research to better understand the experiences of women as a step toward improving their health status. Nursing literature on this critical point is glaringly lacking in Cameroon. Poverty, low level of education, cultural practices, lack of health information, poor personnel attitudes and geographical inaccessibility are identified as some of the problems hindering rural women from accessing care. The recommendations that emerge from this review are the following: (i) the Government should embark on a major positive shift in its policies on girls’ education and nurse training in order to improve available healthcare services, expand access to care and ensure the training of culturally competent nurses; (ii) the Government should build, enhance and expand its transport and communication infrastructure in order to facilitate physical
access to healthcare facilities for rural communities; and (iii) women should be empowered and sensitized to the importance of access to health care early and routinely.
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<th>Design</th>
<th>Method</th>
<th>Results</th>
<th>Country</th>
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<tbody>
<tr>
<td>(Weigner &amp; Akuri, 2007). Cameroon</td>
<td>To explore Cameroonian women’s perceptions of their health care needs and the supportive resources available to them</td>
<td>Qualitative study</td>
<td>Structured interviews with women in a rural community of the South West Region of Cameroon where most women are farmers (n=26), (Age=20-70)</td>
<td>1. Women’s cultural and gender roles blind them to the fact that health is a right. 2. Women perceive poverty as a major hindrance to the attainment of good health. 3. Women lack educational opportunities. 4. Their subordinate status, relative to the men in their society is also perceived as a major barrier to good health.</td>
<td>Cameroon</td>
</tr>
<tr>
<td>(Tsawe &amp; Susuman, 2014a). South Africa</td>
<td>To determine whether women in Mdantsane (a rural community) access and use maternal health care services.</td>
<td>A mixed method study.</td>
<td>The quantitative option used a structured questionnaire to collect data from 267 female participants (aged 15 and above). The qualitative option was based on one-to-one interviews with health care professionals (nurses, doctors, and</td>
<td>Women aged 15-39 years, who are employed and have at least a secondary level of education accessed care more than women who were uneducated and unemployed.</td>
<td>South Africa</td>
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<tr>
<td>Study Reference</td>
<td>Study Objective</td>
<td>Methodology</td>
<td>Findings</td>
<td>Country</td>
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<td>(Ganle, 2015b)</td>
<td>To determine why Muslim women in Northern Ghana (a rural community) do not access health services.</td>
<td>A qualitative study.</td>
<td>Focus group discussions, key informants’ interviews and individual interviews. (n=94) (age=15-45) Muslim women experience difficulties linked to their religion which does not permit unlawful bodily exposure; healthcare providers are insensitive and lack the knowledge to provide care to Muslim women that is congruent with their culture.</td>
<td>Ghana.</td>
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<td>(Atuoye et al., 2015)</td>
<td>To examine perceptions of transportation challenges in accessing maternal health care services in a rural community.</td>
<td>Qualitative study</td>
<td>Eight focus group discussions were organized for both men and women (n=40), females (n=45) ages (18-70). Geographical and economic factors; the poor state and/or absence of transport facilities limit access to health care.</td>
<td>Ghana.</td>
<td></td>
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<tr>
<td>(McTavish &amp; Moore, 2015)</td>
<td>To determine the importance of social networks and social capital in the use of maternal health services in a rural community of Cameroon.</td>
<td>Mixed research method</td>
<td>A descriptive study was used for the quantitative option. Questionnaires were administered to a convenient sample of 110 women recruited on a door-to-door basis. The qualitative option was implemented using intensive semi-structured interviews with five women. The results revealed that women with limited or no social capital did not use maternal health services as much as they desired. Ethnic characteristics and culture did affect maternal health care access and, in this case, maternal health care use.</td>
<td>Cameroon.</td>
<td></td>
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</tbody>
</table>
(Mahiti et al., 2015) | To explore women’s views on maternal health services received at health facilities and identify gaps that may lead to low quality maternal care. | A qualitative study | Focus group discussions (15) were used to collect the data. Each lasted at least 50 minutes. (n=105), (age=14-45) | Women perceived that maternal health services are beneficial but they encounter certain problems that hinder them from accessing these services, such as: inaccessibility to health services due to distance and the presence and constant availability of traditional birth attendants in their culture and community. Women expressed some negative views about the quality of maternal health services that needed improvement. | Tanzania |
ACCESS TO CARE AND THE USE OF HEALTHCARE SERVICES BY WOMEN IN RURAL CAMEROON

DISSERTATION PROPOSAL

This dissertation proposal was presented on January 09, 2018

ACCESS TO CARE AND THE USE OF HEALTHCARE SERVICES BY WOMEN IN RURAL CAMEROON: A PARTICIPATORY ACTION RESEARCH STUDY

Proposal of thesis to be submitted in partial fulfillment of the requirements for the degree of a Doctor of Philosophy in Nursing
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ACCESS TO CARE AND THE USE OF HEALTHCARE SERVICES BY WOMEN IN RURAL CAMEROON

ABSTRACT

**Purpose:** To explore and understand the experiences of rural women related to healthcare access in Cameroon.

**Background:** While the morbidity and mortality rates for women of reproductive age are declining in developed countries, there is a rise in Sub-Saharan African countries and particularly in Cameroon (Alam, Hajizadeh, Dumont, & Fournier, 2015; World Health Organisation, 2010; World Health Organization, 2014). There is need to understand the healthcare access experiences of women in rural Cameroon in order to improve such access and curb maternal morbidity and mortality.

**Method:** The participatory action research (PAR) method, guided by focused ethnography in phase 1, will be adopted for this study. The sample will be composed of women aged 21-77 years.

**Setting:** The study site is located in the Eloumndem-village, a suburb of Yaounde, the capital city of Cameroon.

Key words: Health, Care, Access to health care, Cameroon, Women.
RESUME

L’accès aux soins de santé et l’utilisation des services santé par les femmes au Cameroun : l’expérience des femmes en milieu rural. Une étude de recherche-action participative.

Objectif : Explorer et comprendre les expériences des femmes rurales au Cameroun en matière d’accès aux soins de santé

Problématique : Alors que les taux de morbidité et de mortalité des femmes en âge de procréer diminuent dans les pays développés, on observe une augmentation dans les pays d’Afrique subsaharienne et en particulier au Cameroun (Alam et al., 2015; World Health Organisation, 2010; World Health Organization., 2014). En dehors des structures qui accueillent les femmes enceintes et les mères avec des bébés de moins de trois ans, il n’y a pratiquement pas de structures médicales spécialisés pour la santé de la femme au Cameroun (Weigner & Akuri, 2007). Les études qui ont exploré les défis relatifs à l’accès ou à l’utilisation des services de santé sont extrêmement rares ou inexistantes au Cameroun.

Méthodologie : La méthode de la recherche-action participative (RAP) a été adopté pour cette étude, qui va porter sur un échantillon de femmes âgées de 21 à 77 ans.

Site : L’étude sera menée dans le village Eloumndem situé dans une banlieue de Yaoundé, la capitale du Cameroun.

Mots clés : Santé, soins de santé, l’accès aux soins de santé, Cameroun, femme
Access to health care is about individuals being able to receive appropriate health care services and resources that can ultimately improve their health. The availability and relevance of health care services as well as the ability of the population to afford them are crucial determinants of accessibility. Healthcare access also involves the interplay of organizational, cultural and ethnic factors; the population’s satisfaction with health outcomes; and the availability of adequately trained and culturally congruent health care providers. Ultimately, it depends on timely use of individual health services to achieve optimum health outcomes; affordability of the health system; and the availability of health care providers (Gulliford et al., 2002; People et al., 2010). Unfortunately this is not the case in Cameroon, a developing country in which women fail to gain timely access to health services, even where such services are available (Weigner & Akuri, 2007).

Moreover, most women in rural areas are unemployed and may not be able to pay for health care services. Furthermore, they lack medical insurance, which can currently be obtained only through an employer. There is no State-funded social security system in Cameroon to help reduce the heavy healthcare burden for the unemployed. Cameroon has approximately 350 ethnic groups. This ethnic and cultural diversity tends to affect the quality of care provided in most circumstances (Sylvestre, 2006). Target 5A of the United Nation’s Millennium Development Goals (MDGs) was to improve maternal health by reducing the maternal mortality ratio (MMR) by three quarters between 1990 and 2015 in all countries. Unfortunately, this goal was not attained by most countries of this region, including Cameroon (Easterly, 2009).
1. Problem Identification

Maternal morbidity and mortality rates for pregnancy-related complications and for cervical and breast cancers are soaring in Sub-Saharan Africa, and especially in Cameroon. Globally, women are reported to have higher morbidity rates and special health needs, especially during their reproductive years, relative to men within the same age group (Macintyre, Hunt, & Sweeting, 1996; Patchias et al., 2007; World Health Organisation, 2013a). They therefore have a greater need to access care in order to screen and prevent certain diseases like cervical and breast cancers, pregnancy-related complications and related health issues before they become chronic. Unfortunately, most of these women fail or delay to access care and this gives rise to high morbidity and mortality rates and a low female life expectancy of 58.65 years (BURCREP, 2010; World Health Organisation, 2013a).

The problem identified for this study is that most women in rural communities do not access health care at all or fail to do so on time, even where healthcare services are available. This has led to high morbidity and mortality rates for women as reflected in the maternal mortality ratio (MMR) of 596 per 100,000 (World Health Organization & UNICEF, 2015), mainly from pregnancy-related complications and preventable diseases like cervical and breast cancers. Furthermore, according to WHO (World Health Organisation, 2017), maternal mortality is usually higher among women who live in rural and poor communities, mainly due to limited access to health care and screening services.
The World Health Organisation (2017) contends that 99% of all maternal deaths occur in such communities, especially in developing countries. Unfortunately, most of these deaths are preventable. Maternal mortality dropped globally by 44% between 1990 and 2015. That notwithstanding, Sub-Saharan African countries made no noticeable improvement in this area as they still account for approximately 50% of the global estimate of maternal deaths (Alam et al., 2015; World Health Organisation, 2017; World Health Organization, 2010, 2014). Cervical and breast cancers in rural women is always diagnosed at an advanced stage with over 80% of women presenting with advanced invasive stages of the disease despite the availability of effective preventive methods (Patchias et al., 2007; Rengaswamy Sankaranarayanan et al., 2007; W. H. O. Unicef, 2014; World Health Organisation, 2013b, 2014). Although cervical cancer had been the leading cause of death among women in developed countries, this trend has been reversed considerably over the last 40 years because women regularly visit healthcare services for routine screening to diagnose and treat the disease in its early stages (United States Cancer Statistics Working Group, 2014).

Incidence and mortality rates remain high in Sub-Saharan Africa, including rural Cameroon, due to limited access to health care services that facilitate early detection and treatment of pre-cancerous cells (Goldie et al., 2005; Sando et al., 2015). In Cameroon, about 1500 women were diagnosed with cervical cancer in 2010 and approximately 1000 die each year, with an estimated 1,993 new cases diagnosed annually (De Sanjosé et al., 2012; Enow Orock, Ndom, & Doh, 2012). Access to health care, especially in the early stages of the disease, can greatly improve the health of women and reduce mortality. An understanding of the obstacles to healthcare access could yield lasting solutions for
women in rural Cameroon. Hence, the purpose of this study is to explore and understand rural women’s experiences in the area of healthcare access in Cameroon, and to promote actions that could improve their health status and expand their access to care.

2. **Long-Term Objectives**

The objectives of this study are, inter alia, to:

- Explore, identify and understand the experiences of rural women (21-77 years of age) in Cameroon and to involve them in identifying ways of improving access to health care.
- Identify the issues that affect access to health care and, in collaboration with the women, pave the way toward increasing health care access and improving their health status.
- Intervene to empower women, giving priority to their most pressing needs.

3. **Specific Aims of the Study**

This study seeks to:

- Identify the experiences of rural women in accessing health care and, together with them, seek ways to improve access to health care;
- Involve the women of the community in defining the problems and proposing lasting solutions;
- Prioritize identified problems and solutions together with the women;
- Engage in actions with the women to solve at least one identified priority problem; and
- Evaluate at least one priority intervention identified by the women.
4. Research Questions

- What are the experiences of women regarding access to health care in rural Cameroon?
- What are the health care needs of women in rural Cameroon?
- What is the culturally congruent process of developing strategies within the community to address the health care and health care needs of rural women in Cameroon?

Significance

1. Critical Evaluation and Synthesis of Literature

Literature relating to access to health care for women was not available for Cameroon at the time of the literature review. However, literature from countries within the African sub-region was exploited. A qualitative study discovered that the disadvantaged position of women in rural communities and the burden of caring for their families without adequate support from their husbands gave them a negative perception of health care. The resulting effect is that women tend to care for others and do not perceive health care as a human right and so fail to take advantage of available resources. Furthermore, women in most rural communities in Africa place the health needs of other family members above their own and this is detrimental to their wellbeing (Patchias et al., 2007). Cameroon and most Sub-Saharan African countries do not have national health insurance schemes. Consequently, such facilities can only be acquired through an employer. Considering that the unemployment rate in these countries is quite high, it can
be assumed that a large proportion of women may not have health insurance since they are not formally employed. However, this may be confirmed through this study.

In another qualitative study with 94 Muslim women in three rural communities in Ghana, it was revealed that women were sensitive to their religious obligations and expected more privacy than could be provided by the health personnel in their hospitals and health centers. Insensitivity and lack of knowledge about Muslim women’s cultural and religious practices by health personnel was one of the major problems that prevented women from seeking maternal health care services. Furthermore, health care information was not tailored to meet their needs as Muslims. This reveals the need for cultural competence training for health care providers that will equip them to meet the needs of both non-Muslim and Muslim women (Ganle, 2015a).

Sando et al. (2015) explored some of the factors that affect access to maternal health care services in Mdantsane, a rural region in Eastern Cape, South Africa, using a mixed-methods approach. The quantitative option focused on women who used maternal health services and it was revealed that occupation and access to medical aid significantly affected access to health services. The qualitative phase carried out with health care providers confirmed that the inability to pay for services was a contributive factor to limited access. This study also revealed that women who at least had secondary education were more informed about their health care needs and tended to seek care more often than those who did not. Women with an academic background can access health information and understand the relevance of health care more than those who are uneducated. This study also revealed that limited education among women and their inability to understand the relevance of care provided by maternal health services were
contributive factors to limited access. In Cameroon, the literacy rate is quite low and may affect access to health care. The primary school dropout rate is higher for women than for men. According to Weigner and Akuri (2007), the net attendance ratio is 82.3 for girls compared to 87.3 for boys in primary education; and 38.7 for girls as opposed to 44.2 for boys in secondary education.

Ganle (2015b) used a qualitative approach through focus group discussions to explore the transport barriers that limit access to maternal and child care in rural Ghana. This study revealed that women in rural Ghana often failed to get to hospital on time or use risky means of transport that put their lives and those of their unborn babies at risk. This has reduced the number of hospital births as women now tend to rely more on the traditional birth attendants found in their communities. In another study, women who lived less than 20km from a hospital were reportedly more likely to access maternal health services than those who had to cover longer distances (Tsawe & Susuman, 2014a).

Tsawe and Susuman (2014a) in a quantitative study explored access to maternal health care in rural communities and its link to social capital. This study revealed that lack of social capital could greatly reduce access to maternal health services. The education and empowerment of women are therefore pivotal in building social networks that could help them to understand the importance of seeking health care especially during pregnancy. Social networks improve the dissemination of health information and increase awareness among rural women.

The literature has revealed that women in rural communities in Africa find it difficult to access health care due to lack of financial resources, ignorance, inaccessibility, poor communication networks, distance and lack of culturally competent health care providers.
ACCESS TO CARE AND THE USE OF HEALTHCARE SERVICES BY WOMEN IN RURAL CAMEROON

However, the experiences of women in rural Cameroon have not been explored and understood. It is therefore important to reach out to these women in order to better understand them and fill the gap in the literature on healthcare access for rural women in Cameroon.

2. Gaps in the Literature

A comprehensive review of the literature has revealed the absence of nursing literature that addresses issues and experiences pertaining to healthcare access for women in rural Cameroon. This study will pave the way for nursing literature in Cameroon as far as access to health care is concerned. Nurses need to understand the healthcare access issues faced by women in rural Cameroon and be better prepared to address them. The research methodology proposed for this study has not yet been used to explore women’s healthcare experiences. Publication of this research would improve on the existing nursing literature in Africa and Cameroon. It will be made available to policymakers and the nursing professionals who may be ignorant about some of the healthcare access problems faced by women in rural areas.

3. Significance of the Research to Health and Nursing

This research may enhance understanding of the experiences of women in rural Cameroon. It may eventually lead to the empowerment of women in the Eloumndem-village by raising their awareness of health concerns and the relevance of accessing health care. Furthermore, this research is expected to lead to an improvement in health care access and the long-term benefit of a reduction in mortality from diseases that affect women. Nurses would be better informed on rural women’s issues and be better prepared
to assist them in protecting their health. This research may be published and made available to policy makers who could become enlightened on the relevant problems faced by rural women and consequently work toward improving the health system.

4. Methodology and Guiding Framework (Participatory Action Research)

A qualitative research method will be used to explore the experiences of these women and an intervention will be carried out as an innovation to nursing research in Cameroon. The framework to be used is the participatory action research (PAR) method which has been described as a collective, self-reflective method that leads to the collaborative creation of knowledge while improving the situation of the participants concerned (Koch, Selim, & Kralik, 2002; Maguire, 1987). It is composed of five main steps/phases as presented in the diagram below.
Participatory Action Research

Adapted from (Montero, 2000).

Many authors have used a variety of terms to refer to the different stages and some have even combined two stages into one. However, they end up with the same process for results and interventions. For the sake of clarity and to facilitate understanding of the process for the researcher, the stages have been simplified but not re-created. Through this process, the researcher and members of the target community will work together to plan, collect data, and identify problems. The data is collected simultaneously by encouraging the co-researchers to engage in discussions with each other with the goal of exchanging ideas, broaching relevant questions, and sharing experiences (Kitzinger, 1995). After the problems have been identified, the women will
be brought together once more to propose possible solutions. They are best able to identify the solutions because they have a better understanding of the problems and how they should be solved. After the solutions have been proposed and prioritized, a plan of action will be prepared and validated together with the women. This process will actively incorporate the women in the community to ensure a better understanding of their experiences through the collaborative structures created. After the problem identification phase, the action-planning phase will bring together some women representatives from each of the focus groups to propose and prioritize interventions that may improve their experience and access to health care. The action phase of the study and the interventions will be based on the suggestions and priorities that result from the action-planning phase. One of the interventions will be implemented and evaluated for this dissertation.

The PAR method is well known for its emphasis on collaboration between the researcher and the researched while taking into account the culture and history of the participants (Barnett, 2016). PAR also generates a dialogical relation in the sense that the researcher is neither the sole owner of the research schedule and plans, nor the sole producer of knowledge (Atuoye et al., 2015). It differs from other types of health sector action research in that it may lead to the empowerment of individuals and communities for the purposes of improving health (J. M. Chevalier & D. Buckles, 2013), and could usher in a social change (Tsawe and Susuman (2014a). PAR a suitable research method that may eventually lead to the empowerment of both researchers and co-researchers (participants), and the community benefits from the interventions. The engaging nature of PAR only finds full meaning when those affected and concerned get involved and actively engage in the production of new knowledge from different sources (McTavish
and Moore (2015). Some authors also think that the experience of those affected is a great resource for the researcher, a rich source of information that can be transformed into new scientific, nursing, and health care knowledge (Baum, MacDougall, & Smith, 2006; Grbich, 1998; Minkler & Wallerstein, 2011).

Innovation

1. Innovative Character of the Study

   Most of the studies found in published literature used other research methodologies other than the participatory action research method. This study will involve community members in the research process and eventually empower them, especially as PAR is a novel method in nursing research in Cameroon. This study involves an intervention (action) that will be jointly proposed and developed by both the women and the researcher based on chosen priorities. This may bring change to the community in question and constitute an innovation because this research methodology has not been used in this community before. Most of the studies conducted so far in Cameroon have been epidemiological surveys that do not lead to action.

2. Challenges to Current Research Paradigms

   Traditional research in the social sciences does not include participants as co-researchers. Participatory action research challenges this paradigm by including action, which involves the full participation of the subjects who become co-researchers in all phases of the research process. Participants are at the core of the research process, identifying problems but also proposing and prioritizing solutions. Traditional research methods are conventional whereas PAR is a cyclic process of reflection and action that
enables further inquiry and action for change, while seeking to decentralize traditional research methods (Marshall & Rossman, 2014; Minkler, 2000; Stringer, 1999). Indeed, PAR has been described as a collective, self-reflective method that leads to the collaborative creation of knowledge while improving the situation of the participants concerned (Koch et al., 2002; Maguire, 1987).

**Approach**

**1. Preliminary Studies**

A mini-study was conducted with five women aged 22-44 in a rural community near Yaounde-Cameroon. The purpose of the mini-study was to explore and understand the healthcare experiences of women in rural Cameroon and to further refine the research questions for the dissertation proper. The first four stages of PAR were exploited in this mini-study.

The planning stage brought the women together to inform them of the study. The women were contacted through the leader of the local women’s group after obtaining permission from the local traditional administrator. A series of meetings were held with some of the women, and those who accepted to participate in the study signed the consent form. However, all those who collected the consent forms did not turn up and only five of the eight who had signed the form participated in the study. In the problem identification phase, the women through focus group discussions, identified the issues that affect access to health care. The discussions were recorded and later transcribed, coded, organized, and synthesized into common themes using NVivo11 data analysis software. The field notes helped to facilitate understanding of the chosen community and the local administration.
The following themes were evident after data analysis.

- Lack of financial resources and health insurance prevent women from seeking care.
- Inaccessibility to health facilities prevents women from accessing care.
- Lack of health education and expressed understanding of the relevance of care prevents women from accessing care.
- Poorly organized health systems are significantly limit access to health care.
- The poor attitude and insensitivity of health personnel limit access to health care by discouraging women from visiting health facilities.

The results of the mini-study reflect those obtained in other African countries and reveal the need for intervention studies to empower the women by focusing on their most pressing problems. The women cited poverty, inaccessibility to health centers, language differences, long waiting times and poor personnel attitude (“rudeness”) as some of the reasons preventing them from accessing health care. They preferred to use folk healers who are cheaper and more accessible. The current study will still focus on the same community but the number of focus groups will be increased from one to five.

2. Specific Details for the Conduct of the Dissertation Research

Participatory action research is a method that includes participants as co-researchers and eventually leads to their empowerment. It comprises five phases as follows:
Phase 1: Problem Identification

Women will be brought together and divided into different groups within which they will discuss their experiences, and health care needs. They are expected to identify the issues affecting access to health care in their community.

Phase 2: Action Planning

The women will propose and prioritize the implementable interventions that can lead to an improvement of health care in their community. This planning phase will involve only a few women acting as representatives of their respective focus groups.

Phase 3: Action Taking

The interventions to improve health care access in the community will be based on the results of the data generated and the list of priorities drawn up by the women. However, for the dissertation, only one of the priorities and resulting actions will be chosen and implemented.

Phase 4: Observation/Evaluation

The implemented intervention will be observed, evaluated and its results publicized.

Phase 5: Dissemination of Knowledge

Knowledge generated through the five phases of this process will be made available for the dissertation and to the women of the community through the core group.

Details will be clarified in the research design section.
3. Methodology

Research Design

Action research and particularly participatory action research (PAR) has been chosen for this study. A complete cycle of PAR will be advantageous for the community as it may enable them to benefit from the interventions carried out during the study many years later. This method enables the researcher and community members to jointly plan activities, collect data, and identify problems. The data is collected simultaneously by encouraging the co-researchers to discuss with each other in order to exchange ideas, debate and share experiences (Kitzinger, 1995).

After the problems have been identified, the women will be brought together once again to propose possible solutions to their problems. They are best able to identify the solutions because they have a better understanding of the problems and know how they should be solved. After the solutions have been proposed and prioritized, a plan of action will be prepared and validated together with the women. PAR is a unique process because it requires collaboration between the researcher and the researched while taking into account the culture and history of the participants (Barnett, 2016). It also promotes communication and dialog such that the researcher is neither the sole owner of the research schedule and plans, nor the sole producer of knowledge (Atuoye et al., 2015). It differs from other types of health sector research in that it may lead to the empowerment of the individuals and the community concerned for the purposes of improving health (J. M. Chevalier & D. Buckles, 2013), and could also usher in a social change (Tsawe & Susuman, 2014a). The engaging nature of PAR only finds full meaning when those affected and concerned get involved and actively engage in the production of new
knowledge from different sources (McTavish & Moore, 2015). The experience of those affected is a great resource for the researcher, and a rich source of information that can be transformed into new scientific, nursing and health care knowledge (Baum et al., 2006; Grbich, 1998; Minkler & Wallerstein, 2011).

**The Participatory action research (PAR) Process**

The PAR process is cyclical in nature and starts with the researcher gaining insight into the community to be studied, living with them and understanding their conditions. It comprises five main steps. Many authors have used a variety of terms to refer to the different stages and some have even combined two stages into one. However, they end up with the same process for results and interventions. For the sake of clarity and to facilitate understanding of this process for the researcher, the stages have been simplified but not re-created.

**Phase 1: Problem Identification**

During this stage, the researcher and the individuals who accepted to take part in the research process and who signed the consent forms will reflect on the issues in their community that relate to the study topic. These individuals share their experiences and potential problems, and any discernable patterns and causes are identified and tabled for discussion in focus groups. Focused ethnography will be used to understand the group or cultural phenomena from a personal perspective by actively listening and recording the voices of the women (Creswell, 2013). Through focused ethnography, the researcher is able to understand all or part of a community’s culture by describing a practice or practices within that community. This method focuses on a specific “situation within a larger social scene” (Munhall, 2012, p. 311). Focused ethnography will enable the
researcher to understand contextual and cultural meanings as well as the experiences of rural women in Cameroon.

**Phase 2: Action Planning**

After the problem identification process in phase 1, the researcher and community members continue to work together as they propose possible solutions to the problems faced by the community. This is a very important stage because it determines the action stage of the research. The members of the community propose solutions that they consider to be the best, considering that they are better placed to know what can work for them. A list of priority actions is established although alternative courses of action could be discussed depending on available resources. This planning stage will involve the main researcher and representatives of the different focus groups who will identify priority interventions.

**Phase 3: Action Taking**

Action is vital in the PAR process and is dependent on the solutions proposed by the community members. The list of priorities proposed by them is used to direct this stage and one priority intervention will be chosen and implemented for dissertation.

**Phase 4: Evaluation**

An evaluation is conducted after completion of the intervention, depending on the type of activities implemented (short-term or long-term results). The evaluation can take place at each stage and not necessarily at the end since the PAR process is more cyclical than it appears. Each evaluation may lead to a modification of some of the activities during the action phase. This is very important and takes place in the long term. For the
current study, an intervention that is measurable in the short term may be carried out depending on the priorities of the women.

**Phase 5: Dissemination of Knowledge**

After evaluation, there is need to share the experience and knowledge that resulted from the process. This will be done first for dissertation purposes and published both nationally and internationally to fill the nursing knowledge gap in Cameroon as far as healthcare access for women is concerned. Considering that nursing literature is almost non-existent in Cameroon, there is need to share the knowledge through publication so that it would be available to policymakers for subsequent review and action where appropriate. The results and recommendations of the study will be made available to nurses in Cameroon through the national nursing and regulatory council to build their knowledge on some of the issues that they may be ignorant of. The women of the community who participated in the study will also be informed of the findings.

a. **The Setting**

This study is intended for women in rural communities. The literature has revealed that women in rural communities do not perceive health care as a human right and so fail to access it. Rural communities tend to preserve some cultural aspects that influence care negatively and would be considered in this study. The study will be carried out within a rural community of Cameroon, situated in the Eloumndem-village on the outskirts of Yaounde, the capital city. Cameroon is a Sub-Saharan African country located on the Gulf of Guinea that has a varied terrain and a rich wildlife. It has a population of over 23.44 million inhabitants, composed of 250
culturally-diverse ethnic groups, a situation that makes it extremely challenging to provide culturally-congruent care (McFarland & Wehbe-Alamah, 2014; Sylvestre, 2006; UNICEF, 2015). The Eloumndem-village in which the mini-study was carried out is situated on the outskirts of Yaounde, about 15km from the capital city. It has a population of over 800 inhabitants, composed essentially of subsistence farmers who have no formal employer.

b. Population
The study population is composed of women in rural Cameroon.

c. Sample and Sampling Procedures
The sample will be composed of approximately 30 women within the 21-77 years age group.

d. Variables and Measuring Instruments
The data collection instruments will include: interview guides, focus groups and field notes.

e. The Intervention
Interventions are a key component of the participatory action research process. They will be implemented following a list of priorities agreed upon during the action-planning phase. One intervention will be selected for dissertation purposes after the problem identification and action-planning stages.

f. Data Collection Procedures
The data will be collected through focus group discussions and participant observation. The use of multiple methods to collect the data may overshadow the limits
of each method and lead to more robust results and action plans (Montero, 2000; Speziale, Streubert, & Carpenter, 2011).

- **Focus Groups**

  This involves communication between the principal investigator and participants (co-researchers). After the women have agreed to participate in the study, they will be divided into multiple groups. The timetable for the focus group discussions will be agreed upon for the convenience of all participants. Five groups will be created, each composed of at least six members. The focus group discussions are intended to serve as forums that enable the women to discuss with each other and identify the problems that affect their health care. They will be allowed to ask questions, exchange ideas and share their experiences on healthcare access. While the women debate on the questions asked by the main researcher, their discussions will be recorded and the participants may be photographed.

- **Participant Observation**

  The observation of research participants makes it possible to collect the subjective and objective aspects of human behavior that may not be revealed through focus group discussions (Gillis & Jackson, 2002; Mulhall, 2003). Observation may take place throughout the research process and field notes will be taken and later analyzed.

### g. Plans for Data Analysis

Leininger’s four phases of qualitative data analysis will be used for phase 1 of the PAR as well as data from focused ethnography (Leininger & McFarland, 2006). The phases include: (1) Collection and documentation of raw data; (2) Identification of
descriptors and categories according to the domains of inquiry and research questions; Emic and etic data is coded for similarities and differences; (3) Identification of patterns and contextual analysis – discover saturation of ideas and recurrent patterns; and, (4) Identification of themes and theoretical formulations and recommendations from the data. NVivo11 software will be used to manage, code and analyze the data. This software imports transcribed data from a word document and makes it possible to organize the data into themes and to code it for better analysis and understanding. The results will be analyzed using the four phases of Leininger’s qualitative data analysis framework.

h. Potential Problems and Strategies to Address Them

A potential problem will be the involvement of community members in the data analysis procedure. Demographic data collected during the mini-study revealed that most women in rural communities do not have any educational background. Most of them are primary school dropouts and none of them had attained secondary education. It may be difficult to involve them in this stage of the process. However, all the groups may come together to confirm that the main themes reflect the points agreed upon during the discussions.

i. Ethical Clearance

Ethical clearance will be sought from the Duquesne University School of Nursing Institutional Review Board and the Cameroon National Ethical Committee. Authorization to collect data will be obtained from the Centre Regional Delegation of Health. The consent of participants will also be obtained in order to give this study the credibility it deserves.
References


ACCESS TO CARE AND THE USE OF HEALTHCARE SERVICES BY WOMEN IN RURAL CAMEROON


World Health Organisation. (2014). Maternal mortality: To improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system: Fact Sheet No. 348. Available at: http://www.who.int/mediacentre/ factsheets.


World Health Organization. (2014). Maternal mortality: to improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system: fact sheet. Available at http://www.who.int/mediacentre/.


Appendix 1: Timeline and Budget

**Timeline**

<table>
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<th>Item</th>
<th>December</th>
<th>January</th>
<th>February - April</th>
<th>May</th>
<th>June</th>
<th>July - October</th>
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<td>Proposal defense</td>
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**Budget**

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<td>Data collection tools (Interview and observation guides)</td>
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<td>5000</td>
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<td>Office material (pens, pencils, camera, audiotape, paper)</td>
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<tr>
<td>Lunch and water for participants</td>
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<tr>
<td>Transport</td>
<td>As needed</td>
<td>10,000</td>
</tr>
<tr>
<td>Printing, photocopy and documentation of data collection material</td>
<td>As needed</td>
<td>10,000</td>
</tr>
<tr>
<td>Planning and preparation of meetings (lunch, water, transport)</td>
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</tr>
<tr>
<td>Data analysis software</td>
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<td>Transcription material</td>
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<tr>
<td>Final printing and binding of protocols and thesis</td>
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<td>200,000</td>
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<tr>
<td>Intervention depended on priority needs of the participants</td>
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<tr>
<td>Miscellaneous and unexpected</td>
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<tr>
<td>Total</td>
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</table>
Appendix 2: Participant Demographic Form

Instructions: Please answer each of the following questions:

What is your age? ______

What is your main language □ English □ French and/or others __________________________

What is your marital status?
Single □ Married □ Separated □ Divorced □ Widowed □

Are you gainfully employed Yes □ No □

What is your profession /Occupation __________________________?

If you do not mind, can you state how much you earn per year? _____________

Do you have any other source of income? Yes □ No □

Do you have children? Yes □ No □

If yes how many? __________________

What is your level of education?
Primary □ Secondary □ School dropout □ Higher □ None □

What is your profession/occupation? __________________________

What is your religion? __________________

Are you practicing? _____________

What is your ethnic group? _____________________________________

Do you earn a monthly salary? (Please explain) _________________________

Do you have any other sources of income? Please specify __________________

Do you have some form of health insurance? (Please explain) _______
Appendix 3: Profil démographique des participants

Instructions : Veuillez répondre à chacune des questions suivantes :

Quel âge avez-vous ? __________

Quelle est votre langue principale □ Anglais □ Français et/ou d'autres
________________________

Quelle est votre situation familiale ?

Célibataire □ Marié □ Séparé □ Divorcé □ Veuf □

Avez-vous un emploi rémunéré ? Oui □ Non □

Quelle est votre profession/métier ________________

Si cela ne vous dérange pas, pouvez-vous nous dire combien vous gagnez par an ? _____

Avez-vous d’autres sources de revenus ? Oui □ Non □

Avez-vous des enfants ? Oui □ Non □

Si oui, combien ? ____________________

Quel est votre niveau d’études ?

Primaire □ Secondaire □ Abandon □ Universitaire □ Aucun □

Quelle est votre profession/métier ? ________________

Quelle religion pratiquez-vous ? ________________

Quel est votre groupe ethnique ? ________________________________

Gagnez-vous un salaire mensuel ? (Veuillez préciser votre réponse)

Avez-vous d’autres sources de revenus ? Veuillez préciser votre réponse __________

Avez-vous une assurance maladie quelconque ? (Veuillez préciser votre réponse) _
Appendix 4: Interview Guide

I am very interested in learning from you about your health care experience and health care access in this community:

1. Can you tell me about your community?
2. Could you explain what you understand by health?
3. What does health care mean to you as a woman?
4. How do you maintain your health?
5. What types of health care are available in your community? Any folk healers?
6. Can you share your experiences focusing on the use of health care services in your community?
7. Where do you go for health care? Can you tell me about the last time you used health care services? What was it like?
8. Have you ever used a hospital? When was the last time you used a hospital? What was it like for you?
9. What do you do when you are sick and at what point in your illness do seek health care?
10. What other remedies have you used to maintain your health and why do you use them?
11. If you do not access care, can you tell us about why you do not?
12. How do you then take care of the health problem?
13. What can you tell me about health in your culture and in the community in which you live?
14. Name some of the problems you face with health care in your community?
15. We have talked about health, health care, health care access and some of your local realities. Based on our discussion, let’s discuss all the problems or concerns that you have considered.

16. Do you have any thoughts about how the concerns you raised can be solved for you and your community?

17. What are some of the possible solutions?

18. On the list we have discussed, what aspect do you think is the most important?

19. Do you have any questions for me?
Appendix 5 : Guide d'entretien semi-directif

J’aimerais connaître votre expérience en matière de soins de santé et d'accès aux soins de santé dans cette communauté :

1. Parlez-nous un peu de votre communauté.
2. Que comprenez-vous par « la santé » ?
3. Que représente les soins de santé pour vous en tant que femme ?
4. Comment maintenez-vous votre santé ?
5. Quels sont les différents types de soins de santé disponibles dans votre communauté ? Y a-t-il des guérisseurs traditionnels ?
6. Parlez-nous de votre expérience en matière de l'utilisation des services de soins de santé dans votre communauté ?
7. Dans quelle structure allez-vous quand vous avez besoin des soins de santé ? Parlez-nous de la dernière fois où vous avez visité les services de soins de santé ? Quel a été votre expérience ?
8. Êtes-vous déjà allé à l’hôpital ? Quelle était la dernière fois où vous y êtes allé ? Comment avez-vous trouvé cette expérience ?
9. Que faites-vous quand vous êtes malade et à quelle étape de votre maladie décidez-vous de solliciter les soins de santé ?
10. Pouvez-vous citer d'autres remèdes que vous utilisez pour maintenir votre santé et pourquoi vous les utiliser ?
11. Et si vous n'accédez pas aux soins de santé, pouvez-vous nous dire pourquoi vous ne le faites pas ?
12. Que faites-vous donc pour résoudre vos problèmes de santé ?
13. Parlez-nous un peu de la santé dans votre culture et dans la communauté où vous vivez.

14. Veuillez citer certains des problèmes de soins de santé que vous rencontrez dans votre communauté.

15. Nous avons parlé de la santé, des soins, de l'accès aux soins de santé et des réalités de votre milieu. Essayons maintenant d’aborder tous les problèmes ou préoccupations que vous avez lors de notre discussion.

16. Pouvez-vous suggérer des solutions aux préoccupations que vous avez exprimées, pour vous-même et pour votre communauté ?

17. Quelles sont les solutions possibles ?

18. Lors de notre entretien, vous avez exprimé certains besoins ; parmi ces besoins, quel est celui que vous estimez être le plus important ?

19. Avez-vous autre chose à nous dire ?
Appendix 6: Consent Form

DUQUESNE UNIVERSITY
600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

Consent to Participate in a Research Study

Title: Access to care and the use of health care services by women in Cameroon; the experience of women in rural communities: A Participatory Action Research Study

Investigator:
Grace S. Tadzong, BCH, RN, BSN, MSN, Faculty member, Catholic University of Central Africa. Yaounde- Cameroon, Student, Duquesne University School of Nursing. 
+237(699008977/699925253
Email: tadzongg@duq.edu/gstawasum@yahoo.com

Advisor:
Rick Zoucha, PhD, PMHCNS-BC, CTN-A, FAAN 527 Fisher Hall. Tel:412-396-6545
Email: zoucha@duq.edu

Source of Support:
This study is conducted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the School of Nursing at Duquesne University. This study does not have any source of support as of now.

Purpose:
You are being asked to participate in a research project that seeks to investigate and understand your experience regarding access to health care and also to identify potential
problems and solutions. Some pictures may also be taken to facilitate understanding and analysis of the research. In order to qualify for participation, you must be female, within the age range of 21-77 years and currently living in the Elounndem-village.

**Participant Procedures**

To participate in this study, you will be asked to permit me to interview you in a group one or two times. Subsequently, you will discuss with other women about your health care and issues undermining your access to health care. You will then be invited to propose possible solutions to any problems that may be raised. You will be asked short questions within the group and given time to discuss them. Your discussions will be recorded with audio tape and transcribed. Each focus group will be scheduled at your convenience as you will choose the date, time and place with other women. Each discussion group may take between one to two hours or more of your time. If need be, you may be asked to participate in additional focus groups for the purposes of clarification and solutions. Any additional focus groups will be scheduled at your convenience. I urge you to respect the confidentiality of other group members and to refrain from disclosing focus group discussions to other people.

These are the only requests that will be made of you.

**Risks and Benefits:**

There are no risks greater than those encountered in everyday life.

**Compensation:**

No monetary compensation will be provided. However, lunch and water will be provided during and after the focus group discussions. Participation in this project will require no monetary cost to you.
Confidentiality

Your participation in this study and any personal information that you provide will be kept confidential at all times and to every extent possible. Since you will be part of a group interview you will be requested to keep the discussion in the group confidential as well. Your name will never appear on any survey or research instruments. All written and electronic forms and study materials will be kept secure. Your response(s) will only appear as de-identified quotes and cannot be linked to you personally. Any study materials will be maintained for three years after the completion of the research and then destroyed. The audio tapes will not reveal the names of any individuals and the pictures that may be taken will be use purposely for this research and will be destroyed three years after the completion of the study.

Right to Withdraw

You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time by informing the researcher or by calling any of the numbers below to give notification of your decision to withdraw. In that case, any data and pictures concerning you will also be deleted from the study.

Summary of Results

A summary of the research results will be provided to you, at no cost, upon request.

Voluntary Consent

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to
participate in this research project. I understand that should I have any further questions about my participation in this study, I may call Ms. Grace Tadzong at 6999252253, or the Advisor, Dr. Rick Zoucha at +001 412-396-6545. Should I have any questions regarding protection of human subject issues, I may contact Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board, at +001 412.396.1886.

__________________________________________ _____________________
Participant’s Signature Date

__________________________________________ _____________________
Researcher’s Signature Date
Titre : L'accès aux soins et l'utilisation des services de santé par les femmes en milieu rural : Expériences des femmes au Cameroun : Une étude participative.

Chercheur : Grace S. Tadzong, BCH, RN, BSN, MSN, Enseignante, Université Catholique d’Afrique central. Yaoundé- Cameroun, +237(699008977/699925253.
Email : tadzongg@duq.edu

Superviseur : (Le Cas Echéant:)
Rick Zoucha, PhD, PMHCNS-BC, CTN-A, FAAN 527 Fisher Hall. Tel:412-396-6545
Email: zoucha@duq.edu

Source de soutien : Cette étude est réalisée dans le cadre des travaux exigés pour satisfaire aux conditions d’obtention du doctorat en sciences infirmières à l'Université Duquesne aux Etats-Unis d’Amérique. Elle ne bénéficie d’AUCUN SOUTIEN pour le moment

Objectif : Vous êtes invitées à participer à un projet de recherche qui vise à étudier et à comprendre votre expérience en matière d'accès aux soins de santé et à cerner les problèmes et les solutions possibles. Des photos peuvent également être prises pour
faciliter la compréhension et l'analyse de la recherche. Quant à l’éligibilité à participer à ce projet, vous devez être une femme âgée de 21 à 77 ans et vivant actuellement dans le village d’Eloumndem.

**Procédures de participation**

Pour participer à cette étude, vous allez nous permettre de vous interviewer en groupe une ou deux fois. Par la suite, vous discuterez avec d'autres femmes de vos soins de santé et des problèmes qui nuisent à votre accès aux soins de santé. Vous serez ensuite invité à proposer des solutions possibles aux problèmes qui pourraient être soulevés. On vous posera de brèves questions au sein du groupe et on vous donnera le temps d'en discuter. Vos discussions seront enregistrées sur bande sonore et transcrites. Chaque groupe de discussion sera organisé à votre convenance, car vous choisirez vous-mêmes et avec d'autres participantes la date, l'heure et le lieu de rencontre. Il vous faudra une ou deux heures de temps, voire plus, pour chaque groupe de discussion. Au besoin, on pourrait vous demander de participer à d'autres groupes de discussion afin d'obtenir des éclaircissements et proposer des solutions. Tout autre groupe de discussion supplémentaire sera organisé à votre convenance. Je vous exhorte à respecter la confidentialité des autres membres du groupe et à ne pas divulguer les discussions de groupe à d'autres personnes.

Voilà les seules exigences auxquelles vous devez vous conformer.

**Risques et Avantages**

Il n'y a pas de risques plus importants que ceux que l’on rencontre dans la vie de tous les jours.
Rémunération

Aucune compensation monétaire ne sera versée. Toutefois, le déjeuner et l'eau seront fournis pendant et après les séances des groupes de discussion. La participation à ce projet ne vous coûtera rien.

Confidentialité

Votre participation à cette étude et tout renseignement personnel que vous nous fournirez demeureront confidentiels en tout temps et dans la mesure du possible. Comme vous ferez partie d'un entretien de groupe, il vous sera également demandé de garder la discussion confidentielle dans le groupe. Votre nom n'apparaîtra jamais sur aucun sondage ou instrument de recherche. Tous les formulaires écrits et électroniques et le matériel d'étude seront gardés en lieu sûr. Vos réponses n'apparaîtront que sous forme de citations dépersonnalisées et ne peuvent pas être liées à vous personnellement. Tout matériel d'étude sera conservé pendant trois ans après la fin de la recherche, puis détruit. Les enregistrements sonores ne révéleront pas le nom des personnes et les photos qui pourront être prises seront utilisées à des fins de recherche et seront détruites trois ans après la fin de l'étude.

Droit de retraction

Vous n'êtes pas obligé de participer à cette étude. Vous êtes libre de retirer votre consentement à participer en tout temps en informant le chercheur ou en composant l'un des numéros ci-dessous pour l'avis de votre décision de vous retirer. Dans ce cas, les données et images vous concernant seront également supprimées de l'étude.

Résumé des résultats
Un résumé des résultats de cette étude vous sera fourni, sans frais et sur demande.

**Consentement volontaire**

J'ai lu les déclarations ci-dessus et je comprends ce qu'on attend de moi. Je comprends également que ma participation est volontaire et que je suis libre de retirer mon consentement en tout temps, pour quelque raison que ce soit. Sur ce, je certifie que je suis disposé à participer à ce projet de recherche. Je comprends que si j'ai d'autres questions au sujet de ma participation à cette étude, je peux l'appeler Mme Grace Tadzong au +237 699925253, le Superviseur, Dr Rick Zoucha au +001 412-396-6545. Si j’ai des questions concernant la protection des sujets humains, je peux aussi contacter le Dr. David Delmonico, President du Duquesne University Institutional Review Board au +001 412-396-1886.

______________________  __________________
Signature du participant  Date

______________________  __________________
Signature du chercheur  Date
ACCESS TO CARE AND THE USE OF HEALTHCARE SERVICES BY WOMEN IN RURAL CAMEROON

FINDINGS MANUSCRIPT

This manuscript was approved on November 6, 2018 after the final dissertation defense.

Access to care and the use of health care services by women in rural Cameroon: A participatory action research study

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Access to care and the use of health care services by women in rural Cameroon: A participatory action research study

ABSTRACT

Morbidity and mortality rates for women are soaring in Cameroon. The purpose of this study was to explore the experiences of rural women in accessing health care. Methodology: Participatory action research was used. Focused ethnography was only used in phase one. Twenty-five women aged 21-77 years were recruited to participate through the use of focus groups in Eloumndem-village, a suburb of Yaounde, Cameroon. Findings: Four major themes were identified, namely that women: (1) execute and promote folk practices because they cannot access healthcare services; (2) live in abject poverty which prevents them from accessing health care; (3) have no voice and/or power in their community which acts as a barrier to health care; and (4) desire to be better informed on how to care for themselves. Discussion: Findings revealed the need to educate women in order to improve their social status and give them a voice in their community.

Key words: Rural communities, Access to health care, Women, Cameroon.
Timely access to healthcare is known to save lives and lead to better health outcomes (United States Cancer Statistics Working Group, 2014). Women in rural Cameroon do not access health care on time and as often as they should. They fail to get screened for common diseases, with the consequence that such diseases are often diagnosed at a very advanced stage. This accounts for the high morbidity and mortality rates especially with respect to gynecological and pregnancy-related health issues (Tebeu, Halle-Ekane, et al., 2015; Tebeu, Ngassa, Kouam, Major, & Fomulu, 2007; World Health Organization & UNICEF, 2015).

This study therefore, seeks to explore and understand the experiences of women accessing care in their community.

**Background and Significance**

Target 5 of the Millennium Development Goals (MDGs) was to improve maternal health by reducing the maternal mortality ratio (MMR) by three quarters between 1990 and 2015 in all countries (World Health Organization, 2014). This goal was unfortunately not met in most countries of this region and particularly Cameroon (Easterly, 2009). In addition, the World Health Organisation (2017) states that 99% of maternal deaths are recorded among women who live in rural and poor communities. Although maternal mortality declined by 44% between 1990 and 2015 worldwide, Sub-Saharan African countries still account for approximately 50% of global maternal deaths (Alam et al., 2015; World Health Organisation, 2017; World Health Organization, 2010, 2014). Women in developing countries and especially rural women are often diagnosed at advanced stages of most diseases which then become difficult to treat (Tebeu, Halle-Ekane, et al., 2015) This is the case with malaria, diabetes, hypertension, tuberculosis, HIV/AIDS, pregnancy-related complications as well as cervical and breast cancers (World Health Organization, 2013a, 2015). Considering breast and cervical cancers an example, over 80% of affected women are diagnosed when the disease is already at the chronic stage despite the availability of effective preventive methods (Patchias et al., 2007; Rengaswamy Sankaranarayanan et al., 2007; R. Sankaranarayanan & Ferlay, 2006; Tebeu, 2008; Tebeu, G., et
According to the World Health Organisation (2017), social determinants of health play an important role in determining disease and health outcomes. Most of these women are born, live and operate in rural areas, which have some constraints that curb their access to care and can influence their health outcomes. Other social and economic constraints include unemployment, poverty and ignorance which limit access to health in most settings (Skolnik, 2015; Watch Women, 2012). Cameroon is a culturally diverse country with more than 250 ethnic groups. Such diversity has further weakened the health system as far as the harmonization and provision of care is concerned (Sylvestre, 2006). Furthermore, there is a noticeable shortage of health personnel in almost all settings and especially in the rural communities of the country (Tandi et al., 2015). The Abuja Declaration (2001) calls on Sub-Saharan African countries to raise their health spending to at least 15% of their GDP (World Health Organization, 2016). Cameroon has not yet been able to meet this threshold, with the result that there are still numerous gaps in health care.

Although morbidity and mortality rates for women of reproductive age are declining in developed countries, there is an unfortunate rise in Sub-Saharan Africa and particularly in Cameroon (Alam et al., 2015; World Health Organisation, 2010; World Health Organization, 2014). The problem identified for this participatory action research study was that most women in rural communities do not access health care early enough even in localities where such services are available, leading to high morbidity and mortality rates. Considering that very little is known about the experiences of women in rural Cameroon, this participatory action research (PAR) study resides in its intent on addressing this gap in the literature. This PAR may eventually lead...
to the empowerment of women by improving their knowledge of health and the relevance of accessing health care. Its long-term benefits may be a reduction in mortality linked to diseases that affect women. Nurses would be better informed on the issues and experiences of rural women and thus be better prepared to assist them in disease prevention and health promotion.

Purpose

The purpose of this study was to identify the experiences of rural women in accessing health care and, in collaboration with them, seek ways to improve such access by involving them in the process of identifying common problems as well as proposing and prioritizing lasting solutions. To that end, the following research questions were used.

Research Questions

- What are the experiences of women in accessing health care in rural Cameroon?
- What are the health care needs of women in rural Cameroon?
- What is the culturally congruent process of developing strategies within the community to address health care and the healthcare needs of rural women in Cameroon?

METHOD

Participatory action research (PAR) was chosen as the guiding framework for this study. Ethical approval and informed consent were obtained from the University of Duquesne Institutional Review Board and the participants respectively. A complete cycle of PAR was deemed appropriate for this community, as it would enable both parties to contribute to the research process while taking into account the culture and history of the participants with collaboration being a vital resource for change (Barnett, 2016; Henderson, Martin, & Charlesworth, 2010; Kitzinger, 1995; O’Brien, 1998; Susman, 1983). PAR also promotes communication, participation and dialog that lead to the generation of new knowledge (Atuoye et
ACCESS TO CARE AND THE USE OF HEALTHCARE SERVICES BY WOMEN IN RURAL CAMEROON

al., 2015; Meyer, 2000; O’Brien, 1998). It differs from other types of health research in that it may lead to the empowerment of individuals and the community for the purposes of improving health and bringing social change (J. M. Chevalier & D. J. Buckles, 2013; Levy, 1971; McNiff & Whitehead, 2011; Meyer, 2000; O’Brien, 1998; Reason & Bradbury, 2001, 2008; Tsawe & Susuman, 2014b) The engaging nature of PAR only finds full meaning when those affected get involved and actively participate in the production of new knowledge from different sources (Lewin, 1946; McTavish & Moore, 2015; Winter & Munn-Giddings, 2002). The experience of those affected is a great resource for the researcher, and a rich source of knowledge that can be transformed into new scientific, nursing and health care knowledge (Baum et al., 2006; Grbich, 1998; Minkler & Wallerstein, 2011). Inspired by Montero (2000), this PAR was successfully carried out through a series of five phases as described in figure 1 of appendix 3.

Phase 1 – Problem identification: Focused ethnography was conducted using focus groups to identify problems within the cultural context of women in rural Cameroon. This method was helpful in assisting the women to explore their experiences and identify possible problems. Data was analyzed concurrently with data collection using NVivo 12 data analysis software and the resulting themes were also considered and discussed in subsequent groups.

Phase 2 – Action planning: Action planning was conducted using a core group composed of one participant from each of the five focus groups to determine priority actions to be implemented in Phase 3.

Phase 3 – The intervention: Education and awareness-raising activities were conducted in response to the wishes expressed by the women during the action-planning phase. A sponsored screening program for common diseases was organized for the women to sensitise them to the importance of accessing health care even when they are apparently in good health.
Phase 4 – Evaluation: A question-and-answer session was organized to evaluate the success of the intervention, and it revealed the women’s desire to achieve and maintain better health.

Phase 5: Dissemination of knowledge by communicating the findings of this study in presentations and submitting them for peer reviewed publication.

Leininger’s four phases of focused ethnography were used to collect and analyze the data in phase 1 of the PAR. The first phase consisted of collecting, describing and documenting raw data using an audio recorder and field notes; the recordings were later transcribed verbatim. The second phase focused on the identification of categories. Emphasis was placed on the identification of patterns in phase three while the major themes were identified in phase four (Madeleine Leininger, 2002; M Leininger & McFarland, 2006).

Setting

This study was conducted in Eloumndem-village, a rural community in Yaounde, Cameroon. It has an estimated population of 800 inhabitants and about 15km from Yaounde central town. Cameroon is a developing country in Sub-Saharan desert with an estimated population of 23.44 million inhabitants (National Institute of Statistics, 2018).

Participant Description and Inclusion Criteria

Women were accessed through the local administrative leaders who provided consent for the study. An invitation was sent to the women through the different cultural and church groups in the community, inviting them to a planning meeting. The objectives of this study were explained to them and those who agreed to participate were invited to a subsequent planning meeting. During the planning meeting, consent forms were distributed to the women and those who accepted to participate gave their consent and were recruited. Twenty-five women joined the research team. To be eligible for the study, they had to have lived in the community for at
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least two years; be aged 21-77 years; be capable of expressing themselves in either English or French; and must have given their consent to participate (Demographic data found in table 1 of Appendix).

FINDINGS

Problem Identification (Phase 1)

Focused ethnography was used to identify and describe the experiences of women in rural Cameroon. Five focus group discussions were conducted to collect raw data which was analyzed using Leininger’s. four phases of qualitative data analysis (Creswell, 2013; Munhall, 2012). NVivo 12 data analysis software was used to assist in analyzing the data. This process led to the identification of 17 categories, nine patterns and four themes (Madeleine Leininger, 2002; M Leininger & McFarland, 2006). Data analysis was done concurrently during the data collection process with a view to refining already collected data for subsequent data collection. This process yielded four major themes: Theme 1: women provide and promote folk practices because they cannot access healthcare services; Theme 2: women live in abject poverty which prevents them from accessing health care; Theme 3: women complain that their lack of voice and power in the community acts as a barrier to health care for them and their families; Theme 4: women desire to be better informed on how to care for themselves and their families. These findings guided the action phase of the intervention as directed by the women.
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Women provide and promote folk practices because they cannot access healthcare services

The women in this community are not able to access healthcare services but make efforts to stay healthy. They tend to rely on traditional medicine because it is more affordable and locally available. One of them stated: “We harvest and boil leaves to treat all types of diseases. Sometimes we go to see other herbalists who understand us well and who take time to put together some herbs for us”. They believe that herbal treatment has helped to maintain their health. They also believe that many diseases cannot be treated in the hospital. So strong is their belief in traditional medicine that one of them said their grandparents never went to hospital but lived healthier and longer lives than most people today.

Women live in abject poverty, which prevents them from accessing health care

This was a major challenge raised time and again by all 25 women in the different groups. All but two women are small-scale subsistence farmers who sell some of their farm produce to cater for their other needs. They have large families and live with family members whom they support in all dimensions. Considering that healthcare services are paid out-of-pocket and prior to care in Cameroon and that these women are not employed and have neither stable incomes nor health insurance, it is difficult for them to access health care. They stated that they had other pressing like food, clothing and education for their children. Some declared that they do everything for their families with little support from their husbands. One woman stated, “When it is not possible to feed and clothe the children, how can one even think of going to the hospital? The hospital requires money: you have to take a taxi to go to the hospital especially when you cannot walk; then you have to pay first before the doctor sees you; and after that they give you a long list of lab tests which you must take before you are given medication”
Women complain that their lack of voice and power in the community acts as a barrier to health care for them and their families.

The findings revealed that women have no voice in their community especially when it comes to the prevention of sexually transmitted diseases. Some of them stated that their health is at stake because their husbands go with other women and they cannot say anything about it. In addition, some women fail to access care because they dread being diagnosed with HIV/AIDS, which is still a taboo in their community. One of them said, “Any man goes with any woman, especially our men”. Another said “Our husbands even have children with other women and we cannot do anything. If you talk they will send you away and marry them.”

Women in this community also have the burden of family upkeep. They mentioned that their husbands do not assist them but desire to have their meals ready when they come home. These women take almost full charge of their entire families, including their husbands and are unable to do anything to address the situation. One of them declared, “My husband goes out and comes back and requests food even though he had left no money. I struggle with the children and I cannot even pay their school fees. It is very difficult, yet he is not doing anything to assist me”. When asked why they had many children, one of them said: “In our community if you do not have many children, you are not a woman. Women marry to have children and if you are unable to have children at all, you will be sent away or abandoned for another woman”.

Women desire to be better informed on how to care for themselves and their families.

The findings revealed that most of the women are ignorant of the need for medical care, screening tests and prevention of certain diseases. They believe that health is “not being sick” and have thus refrained from accessing care except when they are “very sick”. Some are aware of the need to access care but are negligent. One of them said “we are really negligent with our
health. The government has helped us with a few hospitals but we do not use them. Sometimes, I find it hard to go to hospital and so my experience is that women are negligent and have other priorities other than health added to the lack money”. Another woman agreed: “We are really ignorant. You see, in the past when my child would give me money to go to hospital, I would tell myself I am not sick, so why go to hospital. I am learning every day that hospital is not only for the sick and that not all diseases have symptoms so ignorance is another problem”. The findings also revealed women’s desire to be sensitized through health education on diseases and how they can be transmitted. One of them stated, “We need assistance with environmental care, infectious diseases affect many people and I think that people need sensitization to care for themselves”. Another woman mentioned the need for “more health education on all these diseases” Most of the women in this community admitted to knowing the benefits of healthcare but also acknowledged their negligence and ignorance of their personal health issues. The majority of them mentioned that they only went to hospital regularly when they were either pregnant or had to give birth, thus placing the focus of healthcare on pregnancy and childbirth. They saw no reason to go to hospital if they were “not sick” or to spend all that time in hospital when they could easily handle the situation in their own way.

**Action Planning (Phase 2)**

After the identification of problems articulated as themes, these themes were brought to the women through a core group (composed of one member from each of the focus groups). The core group determined the priority action that best suited their present context and was feasible in the short term. Based on these findings and the priorities set by the women, an education and awareness-raising activity, followed by a sponsored screening program, were organized in response to their wish to be better informed about health and healthcare access. It should be
noted that, in Phase 1, the women had expressed the desire to be better informed about healthcare in order to improve care for themselves and their families.

**The Intervention (Phase 3)**

The intervention activities were consistent with the priorities set by the women. Phase 1 of this PAR focused on problem identification using focused ethnography. Through focus group discussions, the women shared their experiences in accessing health care services. A core group in Phase 2 helped to prioritize the problems raised in Phase 1. The women expressed the wish to be better informed about health and health care so that they could contribute to the enhancement of their general wellbeing. In the action phase, the women benefited from an educational intervention and a hospital visit meant to raise their awareness on healthcare and the need for timely access to ensure better health.

The educational intervention focused on the importance of hospital visits for health screening and timely care. While reassuring them that traditional treatment was not a bad idea, it was emphasized that some diseases can be properly diagnosed and treated only in hospital. They were empowered with knowledge on HIV/AIDS and how it should no longer be perceived as a taboo. It was important for the women to perceive HIV/AIDS as a disease like any other. Another intervention was free screening sessions targeting common diseases. Prior to the screening, the women were counseled and educated on the importance of accepting their results. The intervention included screening for diabetes, hypertension as well as breast and cervical cancers. It led to the confirmation of five previously diagnosed diabetic and hypertensive patients, six newly diagnosed diabetic and hypertension, and two cases of pre-cervical cancer lesions to be confirmed by biopsy. The principal investigator paid the screening and treatment fees.
Evaluation (Phase 4)

The evaluation session was organized one week after the intervention and consisted of a question-and-answer session with all 25 women that lasted for about four hours. The session was organized at the convenience of the women and they participated actively by show of hand and in an orderly manner. The major results of the evaluation were documented as field notes and later analyzed. The questions were based on the lessons learned during the education and awareness-raising program and many of them responded enthusiastically. It can be concluded that theoretically, the women are more enlightened on their health issues than they were before. The women in the study are evidently enthusiastic about change. However, given the context of poverty in which they live and operate, such change will unfortunately take some time. (See table 2 of appendix for evaluation summary).

Dissemination of Knowledge (Phase 5)

Knowledge generated through this process will be made available for dissertation and to the women of the community through the core group. The integrative review and findings manuscripts are ready for publication and presentation at conferences.
The purpose of this study was to explore the experiences of women in a rural community in Cameroon when accessing health care. The findings reveal that the women in this study use and promote folk healing practices to address their health needs. They rely on traditional and herbal concoctions to treat themselves and their families and to maintain good health. Folk practices have been used and passed down from generation to generation within this community for such a long time that they have become an integral part of community life. However, it is worth noting that many diseases today cannot be diagnosed through folk practices, because reliance on such practices cannot guarantee that all chronic illnesses would be diagnosed on time.

The women live in abject poverty, which hinders them from accessing health care. This is evident in their socioeconomic status as many are not officially employed and lack a steady source of income. Most of them are subsistence farmers who grow just enough food to feed their families. They also make an effort to provide clothing and education for their children. From their stories, it is clear that healthcare has never been their priority since they cannot afford hospital expenses. This finding reflects that of Tsawe and Susuman (2014a) who found that women were unable to access maternal healthcare services due to financial poverty related to lack of employment, health insurance or a decent income. Weigner and Akuri (2007) found that women perceived poverty as a major hindrance to the attainment of good health. Women need financial and educational empowerment in order to perceive and access health as a right and a priority.

Another important finding was women’s lack of voice and power in the community. Most of them feel oppressed by their husbands and bear the burden of bearing, raising and educating
the children. They understand that they are exposed to sexually transmitted diseases through the rampant infidelity of their husbands. Consequently, they dread accessing healthcare for fear of being diagnosed with sexually transmitted diseases, especially HIV/AIDS which remains a taboo in their community. Tolerance of male adultery and polygamy has fueled the spread of HIV/AIDS, with women bearing the greatest burden of the disease. Consequently, they prefer to stay ignorant of their status because they claim that a positive diagnosis could be unbearable for them and their families. McTavish and Moore (2015) found that women in some cultures were limited from accessing maternal healthcare services by ethnic challenges that relegated them to the background. Weigner and Akuri (2007) also found that women in some rural communities experience subordination in societal status relative to the men. Women therefore need some form of empowerment to help them better understand how to deal with a hard-to-kill societal ailment like male adultery. These women need awareness in order to perceive HIV/AIDS as a normal disease and to seek help when they get infected.

The findings of this study also revealed that women desire to be better informed on how to care for themselves and their families. The women in the study community acknowledged that they were also very ignorant of many health issues. For instance, they do not see the need for screening when they are seemingly healthy. In their opinion, being healthy actually means, “not being sick”. However, they expressed the desire to be informed on how they can improve their health and that of their families. Weigner and Akuri (2007) found that women are ignorant about their right to health due to their gender roles and their status in the communities in which they live. Skolnik (2015) has emphasized the link between education and health, specifically health education that will enable women to better understand and manage their diseases.
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Implications for culturally congruent nursing and health care

The results of this study reveal the challenges of rural women who lack the voice to bring change. Women in rural Cameroon need both educational and financial empowerment to be able to care for themselves and their families. Such empowerment is impossible in the short term unless the government improves the education and employability of women, such that they understand what is right for them and go for it. Tsawe and Susuman (2014a) found that women who are employed and are educated at least up to secondary school are able to understand the need for healthcare more than those who are not. Moreover, such women are noticeably more able to access. There is need to lay emphasis on women’s empowerment through basic education in rural Cameroon which will increase their employability, boost their income and maybe expand access to healthcare. Nurses in rural Cameroon need be reminded of the special needs of these women so that they can lay emphasis of health education which this study has revealed to be a priority need for these women.

CONCLUSION

The purpose of this study was to explore and understand the experiences of women in rural Cameroon. Focused ethnography used within a participatory action research framework yielded the following findings: women execute and promote folk practices because they cannot access healthcare services; women live in abject poverty which prevents them from accessing health care; women in the community complain that their lack of voice and/or power in the community acts as a barrier to health care for them and their families; and women desire to be better informed on how to care for themselves and their families.

The above findings clearly account for the statistics linked to morbidity, mortality and
low life expectancy for women in Cameroon. This is cause for concern, not only for nurses and other healthcare personnel, but also for the government and policymakers who have to step in and improve access to healthcare for these women. Such access can be improved by laying emphasis on the education of women in rural Cameroon and developing the health system in general (improve the quality of education for health personnel; lay emphasis on health education, awareness-raising and healthcare subsidies for rural women; and improve the employability of such women so that they will be able to afford their basic needs and also seek care). Improving the educational and social status of rural women can also help to lend them a voice and some leverage within their community.

It is recommended that special emphasis be placed on nurse education with regards to community health. Nurses in Cameroon should increase their scope of influence by meeting the women and the general population in their community rather than waiting for them to come to hospital. Emphasis must be placed on disease prevention and health promotion through mandatory and adequately monitored health education sessions. Such initiatives, coupled with an improved social status, will enable the women to perceive health as a right and to understand the need for timely access. This study will therefore be made available to the government of Cameroon through the Ministry of Health and the nursing council to ensure proper exploitation of its findings and promote awareness-raising. An increase in health spending may lead to an improvement in the general health system and thus enhance health care for all in Cameroon.
LIMITATIONS

This study was limited to a single local community. Results cannot be generalized to the entire Cameroonian population.

FUTURE RESEARCH

As far as future research is concerned, it will be necessary to understand women’s beliefs and values regarding specific diseases with high mortality that affect them, such as cervical and breast cancer. This study may need to be carried out within other communities including the urban areas. Another interesting research area would be the long-term impact of educational interventions on access to care for women in rural Cameroon.
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References


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World Health Organisation. (2014). Maternal mortality: To improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system: Fact Sheet No. 348. Available at: http://www.who.int/mediacentre/ factsheets.
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World Health Organization. (2014). Maternal mortality: to improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system: fact sheet. Available at http://www.who.int/mediacentre/.


### Appendix 1: Demographic Data

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<tr>
<th>Characteristic</th>
<th>Definition</th>
<th>N = 25</th>
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</tr>
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<td>21-30</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>31-40</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>41-50</td>
<td>8</td>
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<tr>
<td></td>
<td>51-60</td>
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<tr>
<td></td>
<td>61-70</td>
<td>3</td>
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<tr>
<td></td>
<td>70-77</td>
<td>2</td>
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<tr>
<td>Subsistent farmers</td>
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<tr>
<td><strong>Occupation</strong></td>
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## Appendix 2: Summary of Evaluation

<table>
<thead>
<tr>
<th>Questions</th>
<th>Summarized responses</th>
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<tbody>
<tr>
<td>Lesson on importance of timely hospital visits</td>
<td>The women admitted that they had learned the importance of timely hospital visits considering that many diseases do not have symptoms and can only be diagnosed at the hospital. While reliance on folk medicine is not a bad idea, folk medicine can neither diagnose nor treat some of the diseases on time. They acknowledged the importance of staying healthy to care for their families.</td>
</tr>
<tr>
<td>Lesson on folk medicine</td>
<td>The women understood that though folk medicine is affordable and has contributed to save lives, it is sometimes dangerous as the concoctions may not be hygienic and the doses may not be accurately calibrated for specific diseases.</td>
</tr>
<tr>
<td>Fear of being screened (Demystification of HIV/AIDS)</td>
<td>The women acknowledged their fear of screening but agreed that they had to learn to accept a positive diagnosis as it may lead to timely treatment. They had learned that HIV/AIDS was no longer a taboo and should be viewed as any other disease. They admitted that this was not easy within their context but that it was a learning process.</td>
</tr>
<tr>
<td>Making health a priority</td>
<td>The women admitted that it is difficult to start perceiving health as a priority given that it is costly. However, they are now aware that health is wealth and that unless they are healthy, they cannot care for their children. They admitted that they have to learn to save money because it is less expensive to be diagnosed and treated early than later.</td>
</tr>
<tr>
<td>General knowledge gained</td>
<td>The women admitted they were happy to have learned much about their health and how to preserve it. They would make an effort to take up the challenge within the context of their limited resources.</td>
</tr>
</tbody>
</table>
Appendix 3: The Four Phases of Participatory Action Research

Participatory Action Research

Disseminate knowledge created through the research process. Continue evaluation and identify new problems for eventual action

Diagnosing (Identifying or defining a problem)

The Community

Action Planning (Considering the alternative courses of action for problem solving)

Observe, evaluate the actions taken in the previous phase

Action taking (Select priority courses of action together with those affected)

Adapted from (Montero, 2000).