

Cameroonian Women's Perceptions of their Health Care Needs

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ABSTRACT

Twenty-six Cameroonian women responded to a structured interview which explored their perceptions about (1) whether health care is a human right (2) measures that impact their health positively and negatively and (3) what supportive resources are available to them. Findings of this qualitative study show that respondents didn't consider health care as their human right. Generally they worried about their health and recognized many factors that threatened their health, yet placed the burden for maintaining their health almost exclusively upon themselves. Some could not rely on family and community members and did not see government health care services as an available or comprehensive option. The authors hope that this article alerts both society and the women themselves to the importance of women's health concerns and their right to health care.

Keywords: *Women, Cameroon, Health Care, Human Rights, Cameroonian Women*

INTRODUCTION

Close observation of Cameroonian society shows that women, particularly poor women who are in the substantial majority, have too much work to do each day. Cameroonian women cook for their families, provide primary health care for them, accompany their sick children to the doctor (when the family can afford it), do laundry, work on the land, keep the house clean, and generally do whatever else their husbands want them to so that they can maintain their marriages. To accomplish all these tasks that are critical for family survival, a woman must be in good health virtually all the time. However, apart from the public Mother and Infant Centers in Cameroon that generally serve pregnant women and women with children up to age 3, there are no specialized medical settings in the country that focus on women's health.

The authors of this paper have some knowledge of the enormous workload carried by most Cameroonian women, the importance of women's health for family survival, and the dearth of health services available to meet their needs. These issues raised our interest in investigating Cameroonian women's understanding of their health and special health-care needs. We thought that

findings of such a study might open the way for training programs to empower women in Cameroon to manage and advocate for their own health. The results might also be useful to stakeholders charged with the design and implementation of health policy in Cameroon.

Although Cameroon has signed the universal Declaration of Human Rights there is insufficient research to determine whether Cameroonian women perceive health care to be a basic human right. This exploratory research will investigate several issues: 1) whether Cameroonian women perceive health to be a human rights issue; 2) what factors these women perceive to be harmful to their health; 3) what preventative measures they currently take to protect their health; and 4) what they know about existing familial, communal, and governmental supports and measures to protect their health. The authors will highlight respondents' viewpoints in these four areas, pointing out themes and selecting quotes that illuminate the women's opinions. Our study will also explore the interconnections among these four investigative areas for insights into women's health as a human rights issue.

1. BACKGROUND

1.1 INTRODUCTORY INFORMATION ABOUT CAMEROON

Cameroon has a population of roughly 16 million people and is situated along the Atlantic Ocean, surrounded by Equatorial Guinea, Nigeria, Chad, Central African Republic, Republic of the Congo, and Gabon. It has over two hundred ethnic groups, each with its own local language, though English and French are the country's official languages. Indigenous spirituality, Christianity and Islam are the major religions. Cameroon is largely an agricultural country, with a diversity of climatic conditions enabling it to produce diverse products such as coffee, cocoa, palm oil, wood, rubber, and cotton.

There are various providers of health care within the country. Government run health units include two general government hospitals (one in Douala and the other in Yaoude), ten provincial hospitals, and a good number of district hospitals. In some provincial and district hospitals there are specialists in some disciplines of medicine. Also integrated health centers exist to serve a few surrounding villages in which nurses, their aides and a midwife provide the care. Yet many Cameroonians cannot afford hospital or specialized care. They often live far from the providers and do not have transportation to health services.

Besides government run facilities there are private clinics and hospitals whose costs are much higher than government facilities. Missionaries operate clinics and hospitals with relatively low cost to patients. However, these facilities often lack highly trained personnel and modern equipment. Cameroonians often turn to traditional healers who live within their communities and whose fees are often less expensive than formal medical care.

1.2 HEALTH FACTOR: LOW SOCIAL STATUS

In Cameroon, as in many other countries, women's lower status in society endangers their health (Ahmad, 2000; Defo, 1997; Torkington, 2000; Wallace and Giri, 1990). Even though poverty and disease imperil the health of both men and women in developing nations, the effects of these detrimental conditions are not gender neutral. Women's higher illiteracy rates, poverty and unemployment levels, disproportionately impact their health. In addition, economic instability and the HIV/AIDS pandemic provide an additional blow upon women's physical and mental well-being (Global Health Council, 2005).

The patriarchal structures in Cameroon at home and in society place hardships on women that negatively affect their health. It is not unusual for poor women in the developing world to perform exhausting tasks, many of which are physically strenuous, from the time they get up at daybreak until they go to sleep late at night (Mebratu, 2000; Torkington, 2000). Women in developing countries work longer hours than men, and they do so throughout their lives (Anunobi, 2003; Weekes-Vagliani, 1985). Women in rural sub-Saharan Africa are estimated to work between 15 and 18 hours per day (Anunobi, 2003). Moreover, studies show that women are more likely to be sick, less likely than men to get medical treatment for the same illness, and more likely to finally get medical care when their illness is already advanced (Manderson, 1998). Patriarchal practices based on favoritism of male children often includes providing girls and women with less food or food of lower quality than that given to boys and men, and depriving them of an education (Leslie, Essama, and Ciemins, 2004; Trueblood, 1970). Having inadequate information as well as less power in decision making can jeopardize women's health. No example of this corollary is more striking than the rising rate of AIDS among women, who often lack the authority in their relationships to insist on practicing safe sex (Karim and Frohlich, 2000; Rankin and Wilson, 2000; Torkington, 2000). Furthermore, this subservient position of women contributes to their rampant physical and sexual abuse (Mebratu, 2000; Torkington, 2000; Turshen, 2000).

Some traditional practices based on patriarchal beliefs also degrade and imperil women's psychological and physical health (Ajao, 1986; El Hadi, 2000; Pearce, 2000; Turshen, 2000). These include female genital mutilation, child marriages (the marriage of very young girls to adult men), the demand that women bear children almost immediately after marriage, widowhood rites, forced feeding of the bride (to make her gain weight for the wedding), food restriction during pregnancy, and patrilocal residence restrictions. It is no wonder, given all these factors stemming from their subordinate status, that women in much of Africa lose most of their innate biological advantage of greater life expectancy. In most industrialized nations on the average women live 79 years and men live 72 years. In developing nations the longevity ratio is reduced with women's average life expectancy from birth being 66 years compared with men's at 63 years. (CIA-World Factbook, 2005) According to

The World Factbook (2005) men's and women's life expectancy in Cameroon , 49 and 47 years respectively, is below the average for developing nations and the differential between them is 2 years.

1.3 HEALTH FACTOR: POVERTY

The power imbalance between genders traps a greater proportion of women than men in poverty, which notably influences their health (Defo, 1997). Phrases like 'feminization of poverty' and 'poverty with a woman's face' reflect the fact that seventy percent of the world's poor are women (Erb-Leoncavallo, 1997). The United Nations Department of Public Information (1996) states that sixteen percent of the world's poor live in Africa, leaving half of all Africans poverty-stricken. Not only has rural poverty increased in Cameroon in recent years, but so has urban poverty. In the mid 1980s less than one percent of the households in Cameroon's two largest cities, Douala and Yaounde, fell below the poverty line (World Bank Group, 1995). By 1993, 20 percent of households in Yaounde and 30 percent in Douala lived in poverty. Today, per capita consumption is roughly 10% lower in Yaounde than it was in 1964.

Living in poverty often deprives a woman of an adequate, nutritious diet which in turn reduces her resistance to illnesses and makes recovery from sickness more difficult (Manderson, 1998; Torkington, 2000). A lack of electricity, frequent and prolonged power outages, sanitation problems, and inadequate supplies of potable water may particularly burden women, who are the primary caretakers of their families (Khosia, 2003). Women may have to carry water over long distances or search for firewood far and wide and then chop and lug it home. Living in poverty generates still other obstacles to good health. For example, inadequate obstetric facilities, lack of transportation, and unpaved roads with potholes may prevent Cameroonian women from getting timely medical care when they have pregnancy complications (Mebrahtu, 2000).

Poverty also breeds desperation. In Goosen and Klugman, Isaac Mwendapole, vice-president of the Africa region of the World Federation of Mental Health, is quoted as saying, "Poverty is the most important obstacle to mental health in families" (as cited in Turshen, 2000, p. 88). Mwendapole explains that poverty results in more frequent homelessness and higher rates of infant mortality and mental retardation, and also contributes to substance abuse, greater likelihood of sexual and physical abuse of women and children, and higher rates of depression, severe mental illness, and suicide. Mebrahtu (2000) agrees that stresses from poverty boost the likelihood of sexual and physical abuse as well as mental illness. Consequently, poor women may take any job available even if the working conditions present health dangers. Many poor women and girls are forced into prostitution in an attempt to survive, and they thereby increase their risk of contracting STIs and HIV/AIDS (Karim and Frolich, 2000; Manjate, Chapman, and Cliff, 2000). Generally, women's

economic dependence and subordinate social position permit them little control over their bodies and make them more vulnerable to contracting HIV and other sexually transmitted diseases (Karim and Frolich, 2000; Mebrahtu, 2000).

1.4 HEALTH FACTOR: REPRODUCTION

In developing nations, women's biological and social roles, which center around reproduction, predispose them to health problems. Africa is the continent that ranks highest in maternal deaths accruing from complications during pregnancy and childbirth (Pearce, 2000; Turshen, 2000). The World Health Organization states, "Africa has 20% of the world's births but 40% of the world's maternal deaths" (as cited in Leslie, Essama, and Ciemins, 2004). Although maternal mortality rates are falling in other developing parts of the world, in Africa they are rising (Pearce, 2000). Enduring malnutrition and illnesses during pregnancy without access to prenatal care puts mothers at risk and increases perinatal and infant mortality (Leslie, Essama, and Ciemins, 2004). Each year, eight million infants die before they are one year old (The Population Institute, 2005). In sub-Saharan Africa 3.6 million low birth-weight babies are born every year (UNICEF, 1996).

Many issues can complicate and endanger women's reproductive health, including limited access to family planning; early, frequent, or unwanted pregnancies; pressure to have large families; the taboo of childlessness; unsafe abortions; delivering without the assistance of a trained person; female genital mutilation (which creates scarring that can interfere with delivery); and sexually transmitted diseases (Mebrahtu, 2000; Turshen, 2000). Although dangers from pregnancy and delivery are better known, even menstruation can present health risks for women who subsist on inadequate diets. Without sufficient iron intake and proper nutrition, a woman can become anemic and suffer energy loss during menstruation.

Women's socially disadvantaged position, their greater poverty, and the health risks that stem from their role in bearing and raising children are interconnected factors that compound health risks for women. Poor women run into double jeopardy as they are more likely to be sick, and their illnesses are more likely to be detrimental to their earnings and their personal and family welfare (Leslie, Essama, and Ciemins, 2004).

2. METHODOLOGY

The convenience sample in our study consisted of 26 women from the South West Province of Cameroon who were between the ages of 20 and 70. The respondents' ages were spread fairly evenly across this 50-year age spread, with the exception that only three women were in their fifties. Nineteen out of the 26

respondents were currently married, one woman had never married, one had been divorced and five others were widowed. The average number of children was 4.4 per family. The majority of respondents worked as subsistence farmers and small scale saleswomen. Invariably their economic situations primarily focused them on meeting basic survival needs of their families.

The respondents were approached outside of their own homes and asked if they would participate in this research. If they agreed, then the interview took place on the spot or within their own homes and lasted approximately 45 minutes. The structured interview schedule consisted primarily of open-ended questions about whether women's health is a human rights issue, common health problems and hazards that women face, sickness prevention strategies, and awareness of services and supports available to protect women's health. Three students conducted eight interviews each, and the researchers conducted two interviews. Before data collection, the researchers led two training sessions to acquaint the students with the interview schedule, provide instruction in interview techniques, and allow them to role-play in simulated research interviews.

Students were instructed to take some notes during the interviews as prompts to themselves for the purpose of remembering the respondents' comments. Immediately after each interview, a student would refer to these notes and record the interview in as complete a manner as possible. The researchers typed up these notes so that careful reading, coding, and tabulating could be carried out effectively. Grounded theory was used as an inductive method to analyze the qualitative data. The theory's coding procedures were used to select major themes in the respondents' perspectives about women's health issues.

3. THEMES

3.1 HEALTH AS A HUMAN RIGHT

Even though all but one woman asserted "yes" when asked whether women's health was a human right, the respondents' explanations did not strongly justify the protection of women's health as inalienable. The majority explained that women's health care is a human right because women provide critical service for others, stating, for example, that "women must be in good health in order to work," and "women are responsible for child bearing; if not healthy, they cannot maintain their children." Women have to be in good health, the respondents said, to fulfill their reproductive roles and perform dual labor, working inside and outside the home.

In this way, the respondents' explanations of their responses actually reversed their initial affirmative reply. They did not view women as having a human right to good health care based on their own intrinsic worth as human beings, but only because of what they produce: babies, farm labor, housework,

and “important things for progress.” Women’s health is of primary value solely because of their service to others. Only when given leads or examples of human rights by the interviewer (for example, that it is a human right to eat well) did the women say such things as “If I have the right to feed well, sleep well, then I also have the right to be in good health as would any other human being.” However, even with such leading comments, not one woman spontaneously asserted that she had any worth apart from performing tasks to satisfy the needs of others. Just two women substantiated their affirmative response, claiming that women had many health problems and, because of the multiplicity of these problems, care was due them.

3.2 HEALTH PROBLEMS

The health problems that the respondents mentioned most frequently were menstrual problems, particularly menstrual pains and variation of blood flow. After the interviews, the researchers wondered why menstruation was such a major issue among the women. Were the respondents worried that variations or pain was related to fertility? Do they have enough information about menstruation? Are they having excessive pain? Is their nutrition so compromised by poverty that menstruation is leaving them anemic and weakened? Is this a common health problem because menstruation is common to all women, or was this due to the unusual prevalence of problems these particular Cameroonian women were having related to their menses?

Respondents also stressed pregnancy and delivery problems – long labor, labor pains, possible death of the baby and the mother – as critical problems for women. The frequency with which this concern was mentioned reflected the high maternal and infant mortality rates in Cameroon and the culture’s ironclad pronatalism. Here childbirth and pregnancy are considered “illnesses” because they pose such high risks to the mother, her fetus and newborn. In industrialized nations, because of sensitization by the women’s movement and other cultural changes, pregnancy and childbirth have been destigmatized in recent decades and are now regarded as natural phases of life. Women’s natural life cycle should not be considered as going through periods of illness; it is not an inherent sickness to be female. However, in the developing nation of Cameroon, childbirth and pregnancy are regarded as illnesses by these women respondents because they painfully know the high rates of danger that confront women in carrying and delivering their babies. Because of the looming hazards surrounding pregnancy and childbirth, the respondents did not have the luxury of taking reproductive health for granted.

Along with the physical threats presented by pregnancy and childbirth are the respondents’ psychological and emotional concerns about infertility. The severe social mandate that true womanhood requires motherhood comes through in some of the women’s responses. They recognize that, without bearing

children, they will not be considered viable spouses, because marriage in Cameroonian culture is primarily for the purpose of bearing and rearing children rather than establishing intimate partnerships: “Not being able to get pregnant, [a woman] will face problems with her husband. When her children are dying her husband will get another wife and she might be abandoned.” The social imperative to be mothers leaves women in the double bind of either becoming pregnant and going through the perilous pregnancy and birthing process, or facing social condemnation.

A few women cited issues with their husbands as health problems because of all the “psychological problems” or physical endangerment that stemmed from these relational issues. As one respondent explained, “When having problems with [a] husband, the man might not even bother about it while the woman thinks over it for what might have been the cause of the problem, and this affects your health.” Women’s greater vulnerability to AIDS and STDs was also mentioned. According to the respondents, men tend to transmit AIDS to women, who contract the disease far more easily than men. Occasionally, the researchers suspected that a respondent was hinting at the psychological stress of being beaten by her husband, but this was rarely mentioned directly. Neither did the researchers push for explicit comments in deference to cultural sensibilities shunning such open discussion of taboo topics.

3.3 CAUSES

3.3.1 Traditional Practices

Serious and prevalent health problems for Cameroonian women are not only reflective of poverty, inadequate medical care for reproductive functions, and rigidly maintained and unequal gender roles, but traditional practices also contribute to women’s health risks. Women respondents believe that if they do not rigorously comply with gender roles and tasks prescribed by tribal norms, they will be bewitched into illness or even death. They must always stay in the straightjacket of their gender roles or terrible calamity will befall them. For example, illness or death may overcome a woman if she “goes out or sleeps with another man before the mourning period for her husband ends.” In such a case, the woman might be bewitched by her in-laws or by the spirit of her dead husband. If she has the audacity and curiosity to peep at an all-male juju practice that is off limits to females, an outbreak of scabies will cover her body. Madness awaits her if at menopause she does not submit herself to a communal washing carried out by tribal women in a particular river and then offer sacrifices to the mermaids.

Even when a Cameroonian woman and/or her family comply with proscribed traditional practices, there might be a glitch somewhere that deprives her of children or even her life. For example, if her father takes bride price from two

men, the young woman who marries one man may be cursed into “barrenness” by the other. Danger can be perpetrated from within one’s own family as well. If the bride price is not distributed to all the expectant relatives, the offended relative may “cause you to be sick, even lead to death, or even kill your children.”

Traditional medical practices, many of which center around women’s reproductive capacities, were also regarded by some respondents as jeopardizing women’s health. These practices include female genital mutilation, “delivering children at home, and using crude equipment [that] might harm both baby and mother,” and ritualistically cutting a pregnant woman’s stomach, which “causes serious bleeding [after which] the woman may die.” “In villages where traditional medicine is preferred, such traditional medicine, like herbs to protect pregnancy, can cause danger to women’s health.” Not all women, however, denounced traditional medicine; indeed, many saw traditional medicine as protective of their health. However, some voiced concern over some practices, such as herbalists using a single blade when cutting and rubbing herbs into the body without sterilizing the blade from using it on one person to the next. “Enemas made of several concoctions that are not good for the women” can also be endangering. Abortion performed outside of hospitals, away from conventionally trained personnel, “[if] done traditionally harms the woman or could kill her due to excessive bleeding.” Only a few women stated that they did not know of any traditional practices that might impair women’s health.

3.3.2 Harmful Life-styles

Overarching poverty is regarded as the primary threat to women’s health, although the respondents did not express it in those terms. Half of the women brought up prostitution as a way that Cameroonian women are harming their health. This high response rate suggests the depths of poverty that force many women to take the most desperate of measures to attempt to survive and provide for their children. “Poorer women try to get money by prostituting, which can cost them their lives.” Respondents also stressed the excessive labor that women have to perform to survive; sometimes they even work without having food to eat: “[Women] go to the farm without eating and when they come back [they] might still have nothing to eat.” “Hard work with no money endangers their health. When women work so hard and fall sick for a long period . . . and there’s no one [to help them], they might eventually die.” Additionally, a few women indicated that some Cameroonian women harm their health by excessively drinking alcohol.

3.3.3 Obstacles to Protecting their Health

If the respondents did not directly state that financial problems were intrinsic to an unhealthy life-style, the overwhelming majority did say so when asked what

difficulties women face in protecting their health. They saw lack of money as the primary obstacle barring women from maintaining good health. They blamed living in poverty for their inability to buy drugs and afford medical care, and for the excessive labor, lack of rest, and lack of quality food they must tolerate. The respondents noted the cumulative impacts of poverty and its ravaging repercussion on women's health. As one respondent explained, "When women fall sick and go to the hospital and the doctor prescribes drugs, she does not have money to afford the drugs. [This] means that she neglects the body and the sickness will increase, maybe leading to other health problems." Another woman also illustrated these effects: "Women need to rest and relax in order to get away from stress, but because they are hard up financially, this limits their time to obtain this rest." The respondents not only vividly portrayed the health risks inflicted by poverty but emphasized its cyclical grip. One respondent stated: "Poverty makes them unable to have money to start a small business or even money to buy seeds for plants. This difficulty makes things impossible for them to protect their health."

In addition to poverty, a few research participants mentioned women's dual roles and men themselves as impediments to maintaining good health. Some respondents indicated that they had to take their small children or babies to the farm or to their businesses and simultaneously care for them while working. This hampers their productivity. Not only do the women carry their infants on their back, but some also believe that their husbands add additional weight to their burdens. Interviewees explained that men may be unfaithful, endangering women's health all the while the women are careful to remain a steady partner; or that men may not allow their wives to engage in certain businesses that would ease their financial hardships. "The majority of [women] have men who are not supportive and considerate. They expect them to perform all the labor and at the end even prepare food from the little they have."

3.4 PREVENTION

3.4.1 Self

The most common measures that these women take to prevent illness is to keep their houses clean, observe personal hygiene, eat well, seek medical advice, and take appropriate drugs when sick. Other precautionary measures subscribed to by some of the respondents include earning money to pay medical bills and purchase needed drugs, avoiding sex with multiple partners, trying not to overwork, and getting enough rest. A couple of women linked abortion and birth control measures to their health: "I will not want to suffer with the baby since there will be no money to care for my health and the baby's health too." Two respondents claimed to try to avoid all stress, but subsequently one mentioned having constant stress headaches, and the other said she was a "gastric patient."

A couple of women emphasized that they were vigilant about any emerging health problems. These two women said that they take drugs immediately when “threatened” by illness. Impending illness may be particularly intimidating when the well-being or very survival of their family relies on their labor.

3.4.2 Other Women

Respondents perceived that other Cameroonian women would protect their health in similar ways by keeping their environment clean, remaining monogamous, “feeding well,” and practicing personal hygiene. Individual respondents suggested that women take therapeutic laxatives or enemas, and supplement pharmaceutical drugs with less expensive traditional medicine. A couple of women made a distinction between the measures wealthy women are able to take to preserve their health compared with what poor women can afford to do: “Only rich women protect themselves by doing constant check-ups in hospitals and live well by eating good food.” In contrast, another respondent believed that “poor women only have to beg from their husbands to get what they need.”

3.5 WHAT ELSE IS NEEDED?

When asked what else Cameroonian women should do to protect their health, respondents advocated more of the same things that they themselves and other Cameroonian women were doing already. However, a theme emerged about the need for more health information for rural and less educated women. Some suggested that educated women give lectures on health maintenance to less privileged women. A few suggested the need for small sensitizing awareness groups, where women could discuss health problems and solutions.

A few respondents thought the Cameroonian government should do more to help less privileged women become better off so that they could care for their health. One respondent suggested that women come together in groups to fight for more government measures to protect women's health. However, several women put the responsibility on women themselves to work harder and to seek out small business opportunities to earn extra money to protect their health. Women “should work hard like doing business or even on the farm so that [they] can have money to better [their] living condition and improve [their] health.” Even as the respondents pointed out that many women did not have the funds to get proper and early medical treatment and pay for drugs, they admonished those same women for being dependent on men and not earning enough of their own money: “[Women should] do small business or farming so that they can have their own money to go to the hospital any time they don't feel their health fine [sic] and not only to be dependent on the man.”

Yet another statement shows that women are unaware of how this double-bind places an unhealthy burden on them and then robs them of recognizing that they have been carrying nearly the full weight of family responsibility: “Every woman should try to have something that can earn her some money because most women that are stressed up lack finance and suffer dependency on husbands.” On one hand, the respondents have reported that poor women are getting sick because they overwork, while on the other hand, some advise that women need to work still harder so that they have some “extra” money to obtain medical care for themselves. It seems that few women look to the government or to men in general to contribute substantially to their medical care but instead revert to placing more burdens on themselves. Once again, though they claimed health to be a basic human right; respondents did not place themselves under that human rights umbrella.

3.6 OUTSIDE SUPPORT

The large majority of respondents related that they receive financial assistance from their families when they are sick. In response to the question of whether they received support from their families, respondents generally interpreted “family” to mean their families of origin. This interpretation shows a continued sense of connectedness with their original families. However, though to a lesser extent, other family members – husbands, in-laws, and older children – were also cited as providing help. Families generally provide the respondents with concrete support in the form of money, and in some cases food. Only two respondents mentioned that family members offer emotional support by “coming to discuss with [them] to at least relieve [them] a bit from the illness.” This might be either because the respondents do not recognize emotional support as being as important as financial assistance, or that they do not receive emotional support from their family members. Even though strong families are the principal societal unit in Cameroon, five respondents reported not receiving any help from their families. Modernization (with its own financial constraints and demands) may put extra burdens on those who might otherwise have been able to provide these women with assistance. Perhaps the family members who might have given the expected financial support do not have the means to do so. Another explanation could be that, because of other societal issues, the extended family is gradually being narrowed down to the nuclear family.

The nature of community and peer support mirrored the concrete financial and food support these women receive from their families when they are sick. Ten women said that they receive money for drugs or treatment from their friends or community groups; eight stated that their friends and community members bring them food and/or cook for their children. Concrete support rather than emotional support was mentioned, perhaps because material needs are appropriately recognized as first and foremost by those who are sick and

financially deprived. Both family and friends may know that this is the first order of response. One woman referred to emotional support, saying, "People around me only comfort me when I'm sick by saying 'Ashia' [I'm sorry]," which gives her some heartfelt warmth. A couple of women said that they get advice from neighbors about where to get traditional medical treatment. Though not emphasized by respondents, perhaps emotional support is also conveyed when material goods are provided, because the message of care, concern, and solidarity may accompany it.

Significantly, 11 of 26 respondents, a significant minority, reported receiving no community support at all. Apparently, a strong extended family network does not necessarily translate into community unity. Furthermore, some women do not receive help from their families. Indeed, our sample revealed that some women do not receive any outside help and have to totally fend for themselves. If the viable family unit is shrinking from an extended to a nuclear family and community support does not reach everyone, then there is an increasing social need for formal help to target women who become ill.

Existing government support around issues of women's health was regarded as centering on the building of clinics and hospitals. But hospital care was seen as prohibitively expensive for many. One respondent stated that the government builds "hospitals but rural women can't afford to go to the hospital, and they are the ones who need more attention – so basically there are no [government] measures." A few respondents could not name any governmental activities in this sphere, but a few mentioned governmental provision of free vaccines, education on health issues, and free mosquito nets. Minimal perceived government support, combined with waning help from families and gaps in community aid, highlight how some ill women in Cameroon are truly alone when they need others the most.

4. CONCLUSION

Results of this study indicate that the concept of human rights is not clearly understood by many Cameroonian women, or at least as it relates to their health. The cultural background of gender roles ascribed to women serves to blind them from appreciating their right to maintain good health. To these respondents, it is "others" who primarily matter. Taking care of their children and serving their husbands pre-empts efforts and expenditures to sustain their health for their own sake. Women regard the right to good health as contingent on fulfilling their purpose of taking care of and meeting the needs of others.

It is my role to do what I'm supposed to do like cooking and childrearing. So no matter the problems or how my health is affected I will always take it as normal. If you are working on the farm to feed the family whether you overwork yourself or not it is your obligation because the family is supposed to feed well [sic].

Women recognize that women's health is a human rights issue not because their existence in and of itself is important but solely because of their caretaking role.

Though respondents perceive women as having many health problems that are influenced and imposed by external forces such as poverty, lack of educational opportunities, and the necessity for backbreaking labor, they still put the onus of health care largely on themselves. Although they thought some women took preventive measures to look after their health, most respondents recommend that women heighten these efforts. The respondents chiefly identified the protection of women's health as their own responsibility and do not expect others to bother about it. They largely let government off the hook, further demonstrating that they did not really see women's health as a matter of human rights. Their understanding that good health care is not truly a human right for women was corroborated by the scarcity of specialized public services in Cameroon that focus on women's health.

The respondents, for the most part, regarded having sufficient funds as being a prerequisite for maintaining good health. They thought that wealthy women could implement more measures to protect their own health, such as getting drugs, going to the hospital as needed, having regular check-ups, and eating sufficient and nutritious food. In contrast, they perceived their own poverty as a great limitation to their attainment of good health.

Respondents regarded women's subordinate position to men as inextricably tied to a woman's poverty, health problems, and stress. The women's responses pointed out the disadvantaged position of women in general, who are usually homemakers, which means taking care of their husbands and children, working the land, and conducting small trade for petty cash. A woman's status exposes her to the strangulating effects of poverty. Her subsistence living leaves her to be dependent on a man, whether that man is her husband or another male. However, a woman's survival needs are not usually met by men. For example, many respondents indicated that when they are ill, they fall back on their family of origin for financial support.

The heavy burden of taking care of her family and herself without adequate support from her husband or the community causes a Cameroonian woman respondent great worries. Her mind is perpetually at work to figure out measures to maintain the survival of her family, which is her primary responsibility, before she even thinks of herself. The respondents sometimes said that women should "not think too much" as a way to protect their health. They seemed to imply that the stress of worrying backfires and jeopardizes their own health, worsening their precarious survival.

Using this study's findings in a positive way might lead to more public attention and concern for women's health in Cameroon and in other developing nations. Knowledge about the women's awareness of the sacrifices they make for their families might sensitize their communities and increase the esteem, respect, and consideration afforded women. One way to rally this public support would be to organize training programs to sensitize and educate community members on the importance of women's health for human survival. Such

understanding may help raise the status of women in society. External validation and support for women's health may encourage women to value their own health as a human right. If community education can improve awareness of the importance of women's health, thereby increasing the societal recognition of women, this heightened status would be expected to lower women's susceptibility toward diseases and premature death.

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