

STUDENT PERSPECTIVES

Women with disabilities in the North West province of Cameroon: resilient and deserving of greater attention

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Cameroonian women living with disabilities face three-fold discrimination as a result of their sex, perceived inability and low socio-economic status. A needs assessment using focus groups (two focus groups, $n = 24$) and key participant interviews ($n = 12$) was conducted to explore the experiences of women with disabilities in the North West province in both urban and rural areas. The findings show that women faced both physical and attitudinal barriers, lived in poverty and felt that they lacked opportunities for gaining an education, finding employment and forming meaningful social ties. There was significant complexity of relationships, marriage and children in their lives. Participants generated ideas on changes that needed to be made for the betterment of their lives. Aspirations included increasing empowerment and education, gaining support from family and friends, increasing public awareness, adapting the physical environment and finding allies.

Keywords: women; disabilities; developing countries; Cameroon; qualitative research

Introduction

According to the World Health Organization (WHO) 600,000,000 people globally have some form of disability, with 80% living in low income countries (WHO 2005). Of the disabled population, as many as 75% are women in low and middle income countries (Human Rights Watch 2006). In Africa women with disabilities face stigma, isolation, invisibility, punishment and generally are on the receiving end of negative attitudes on the part of the community (Ghana Federation of the Disabled 2001). In many developing countries disability is barely addressed by public health and other social policies, leaving disabled women and their caregivers with hardly any structural support (WHO 2005). This situation raises issues of interest and calls for more study.

Cameroon, situated in sub-Saharan Africa, is considered a lower middle income country (World Bank 2007). Cameroonian women compose two-thirds of the work force, while receiving only one-tenth of the total income and owning one-hundredth of national property (Fonjong 2001). Despite their contribution, women have a limited voice in social discourse, including in the media, as described by Ndangam (2003). One would conclude that the voice of a woman with a disability is even more limited in Cameroon, although there is little research to confirm this. The combination of a lack of structural support, gender bias towards women and the stigma experienced by

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persons with disabilities makes disabled women a significantly marginalized group (Limen 2006).

The experiences of women in Cameroon have been studied to some extent, however, literature specifically on disabled women is lacking. This paper reports a qualitative study that was conducted to shed light on the issues of women with disabilities in the North West province. This needs assessment was conducted to increase our knowledge as this is a gap that had been identified in recent work with several organizations. It is part of ongoing collaborative research on disability and rehabilitation issues in the province, in partnership with the Cameroon Working Group of the International Centre for Disability and Rehabilitation at the University of Toronto.

Background and literature review

Global situation of women with disabilities

Women are more likely than men to become disabled during their lifetime due to gender bias in the allocation of resources and their lack of access to health services (Emmett and Alant 2006). Women and girls are less likely to receive preventative medical care, such as immunizations and medical attention when needed (Human Rights Watch 2006). In developed countries the percentage of women with disabilities is higher than that of men with disabilities, due to a larger aging female population (WHO 2003). However, in certain low income countries the recorded number of women is lower than men, possibly due to under reporting and women receiving less care and support leading to earlier death (Emmett and Alant 2006).

Localized studies present a picture of the marginalization many women with disabilities experience in low income countries. A study done in the Philippines discovered that 80% of women with disabilities had no jobs and were totally dependent on others for the meeting of their basic needs (UNESCAP 1995). Women who did work typically occupied labour-intensive and poorly paid jobs, such as weaving, sewing, basket making, assembling toys or producing handicraft items. In Nepal, where marriage is the norm for women, 80% of disabled women were reported to be unmarried (UNESCAP 1995). In Zambia women with disabilities are often excluded from reproductive health education programs as there is an assumption that they are not sexually active and do not require reproductive health services (Smith et al. 2004).

Promising initiatives globally

There is much room for improvement in the lives of women with disabilities and in some parts of the world change is starting to take place. Microcredit initiatives have received international attention for alleviating poverty in marginalized groups, however, they have traditionally not included disabled women in their programs (Lewis 2004). In 1998 'The International Symposium on Microcredit for Women with Disabilities' brought together 13 women from developing countries (not including Cameroon) to receive intensive education on microcredit programs, to find ways to increase the inclusion of women with disabilities and to create an action plan for implementing selected strategies (Mobility International USA 1998). In 1995, a report entitled 'Leadership development strategies for women with disabilities: A cross-cultural survey' (Hershey and Stephens 1995) identified barriers which prevent women with disabilities' leadership from being realized. This report suggested nine

recommendations for international leadership training programs and led to a series of projects aimed at building leadership capacity in women leaders with disabilities. These initiatives are instilling hope for groups of disabled women in developing countries, however, they have not yet extended their benefits to women in the North West province of Cameroon.

Methods

This needs assessment was framed as a gap analysis examining the current and desired life situations of women with disabilities in both urban and rural areas. There has been an outcry from disabled people's organizations about research that is done about persons with disabilities without their involvement (Dutch Coalition on Disability and Development 2005). With this in mind, the investigator felt that the most authentic way to determine the needs of women with disabilities was to have them participate in this assessment as advisors. This study incorporated collaboration (e.g. piloting interview questions and sampling) with women yet was carried out by the investigator. The advantage of this approach was that an outsider can observe norms and intricacies in ways that participants may not detect. Ethical approval was received from the National Ethical Review Committee of Cameroon, the University of Toronto and Simon Fraser University.

To gather diverse information the investigator conducted two focus groups ($n = 24$), 12 interviews and used participant observation. Both the focus groups and the interviews provided an opportunity to elicit a range of opinions. Interviews provided rich and specific details about individual experiences. During the focus groups participants had the opportunity to consider other women's responses and were not required to answer every question or respond to every comment, which may have led to more genuine and substantial responses. Lastly, participant observation was beneficial in examining persons and events in natural, everyday settings, which provided insights that were unavailable in structured milieus.

The study, including participant observation, occurred from June to August 2007. During this time the investigator developed an appreciation of the socio-cultural and physical environment, communication conditions and the general infrastructure of the North West province. Visits were made to major hospitals and rehabilitation centers and the investigator collaborated with relevant stakeholders in the planning of the 2007 'Bamenda Conference on Disability and Rehabilitation'. Informal discussions took place with women, family members and other stakeholders.

All participants were asked for informed consent prior to commencement of interviews or focus groups. These meetings were conducted in English or in Pidgin English with the help of an interpreter and were audiotaped and transcribed by the investigator.

Thematic coding was used, including both a priori categories and codes and emergent codes (Fereday and Muir-Cochrane 2006). A priori codes were generated by reviewing the academic literature that addressed issues pertaining to women with disabilities globally. The a priori categories were: (1) challenges existing in a woman's life situation; (2) solutions to overcoming these challenges; (3) stakeholders that need to be involved. After coding all transcripts, the investigator took the most frequent codes to create sub-categories (e.g. challenges [category 1] contained the following recurrent codes: physical barriers; attitudinal barriers; lack of opportunities). Sub-categories were revised to generate the themes which are presented in the results section.

Semi-structured interviews

Characteristics of the sample of 12 key participants are outlined in Table 1. The investigator contacted the leaders of 'disability groups' in the North West province and asked to speak at their next meeting regarding the intention to conduct a needs assessment and the need for participants. Meetings for three different disability groups were attended and the majority of participants were recruited in this manner. A few participants were identified through snowball sampling. For example, one participant introduced the investigator to an individual who worked in providing evangelical support to women in villages. The investigator accompanied this individual on two outreach visits and recruited four participants from villages. Targeted sampling was used to obtain a range of disabilities, marital status and other characteristics.

Women were interviewed in the community, either in their own homes or at a quiet spot in town. Interview length varied from 30 to 90 minutes and consisted of open-ended questions regarding knowledge, attitudes and personal experiences of:

- growing up with a disability;
- gaining an education and finding employment;
- getting married and starting a family;
- living in their respective community;
- accessing health care services;
- any other topics which the woman wanted to discuss.

Focus groups

Two focus groups were conducted, one in a rural area and one in a city. The first group was with 15 women in rural Njinteh. A key participant in Bamenda informed the investigator about meetings held by the Njinteh disability group and the investigator attended their monthly meeting and recruited participants for a focus group. Due to logistical constraints, specific characteristics of women interviewed on that occasion are not available. The second focus group was with nine participants in urban Bamenda and the characteristics of these women are outlined in Table 2. Participants were recruited when the investigator attended a monthly meeting of a Bamenda disability group. Focus group participants were asked about their knowledge, attitudes

Table 1. Characteristics of 12 key participants.

Residence	Age	Marital status	Disability type	Age of onset of disability	No. of children
Urban	20-29 (2)	Single (7)	Lower extremity paralysis, quinimax injection (3)	Congenital (1)	0 (3)
Bamenda (6)	30-39 (6)	Widow (2)	Undiagnosed (3)	0-10 (6)	1 (3)
Rural	40-49 (1)	Married (2)	Meningitis (2)	11-20 (2)	2 (2)
Bamessi (2)	50-59 (3)	Common law (1)	Polio (1)	21-30 (0)	3 (3)
Santa (2)			Amputation (1)	31-40 (3)	4 (1)
Bambui (1)			Osteomyelitis (1)	41-50 (0)	5 (1)
Akum (1)			Stroke (1)	51-60 (1)	

(x), × = number of participants with characteristic.

Table 2. Characteristics of nine participants in the focus group in Bamenda.

Residence	Age	Marital status	Disability type	Age of onset of disability	No. of children
Urban	20–29 (3)	Single (6)	Lower extremity paralysis, quinimax injection (4)	Congenital (1)	0 (2)
Bamenda (9)	30–39 (1)	Widow (2)	Blindness (2)	0–10 (5)	1 (4)
	40–49 (4)	Married (1)	Club foot (1)	11–20 (1)	2 (0)
	50–59 (1)		Spinal cord infection (1)	21–30 (2)	3 (1)
			Polio (1)	31–40 (0)	4 (0)
				41–50 (1)	5 (1)
					6 (1)

(x), with x = number of participants with characteristic.

and experiences in the same areas as the key participants, with an emphasis on general experiences rather than personal ones.

Results

Characteristics of participants

On average participants in the interviews and the second focus group were 35 years of age (range 20–58) and single. Many women acquired their disabilities at an early age, often from lower extremity, intramuscular Quinimax injections which, as Babalola et al. (2004) have discussed, are used to treat malaria. The injections led to paralysis in three of the key participants and approximately half of the focus group participants. Only two women had congenital disabilities, while the rest acquired disabilities after birth, with the majority acquiring their disability prior to 10 years of age. In the first focus group approximately half of the participants had mobility issues and half were blind, half were single and half were widowed and the average age was 40 years old.

In general, women in Cameroon have on average five children (UNICEF 2004), however, participants in this study had on average fewer than two children. In Bamenda two women were unemployed. The occupations of working participants included teaching, shopkeeping, craft selling, selling crops, phone operators and secretarial. Among the women interviewed from villages approximately half were farmers and/or crop sellers and the rest were unemployed.

Challenges

Women were asked to identify their current struggles and challenges. From their responses the following categories emerged: physical barriers leading to segregation; attitudinal barriers that oppose women; the cycle of poverty and disability; interpersonal challenges in a woman's life; lack of opportunities at multiple levels.

Physical barriers in the community leading to segregation

The most frequently mentioned challenge to women was physically moving around their communities and accessing areas that were important for daily living. In many

instances these physical barriers kept women homebound. Areas identified as difficult to reach were schools, markets, workplaces, churches and hospitals.

Schools. Participants reported that most children in Cameroon walked to school. When a child was unable to walk, their chances of getting an education were greatly reduced. Approximately half of the participants reported that their education halted at some point in their lives due to their inability to walk to school. Several participants reported that their parents did not have the funds for school transportation (e.g. motorcycle, taxi or tricycle).

Market. Many participants were unmarried, single mothers or widowed and were responsible for completing household tasks while receiving little assistance from others. These women needed to go out into the community to purchase food and household items. The food market in Bamenda was situated in a muddy area with narrow paths that were unable to accommodate a tricycle. Women reported finding it strenuous both to travel to and shop at the market and so most avoided it, thus forcing them to buy food items near their homes at higher prices.

General difficulties with moving around. In Bamenda there is no public or accessible transportation system and most citizens walk or use taxis to get to their destination. Taxis primarily service main roads unless the passenger is able to pay extra fares to be dropped closer to their destination. Many women lived slightly outside the city or on side roads where they could not readily flag down a taxi. Consequently, women reported walking up to 2 kilometres along unpaved roads to where a taxi could be taken. This could be a laborious and painful process. Once participants reached a place where they could take a taxi they had longer wait times for a taxi than the average person, as taxi drivers would often refuse to carry them, not wanting the additional inconvenience.

Attitudinal barriers that oppose women

Attitudes within a woman's family. Several women noted that discrimination that impeded their growth started in their own homes. Participants reported that parents of young girls with disabilities often did not feel that it was beneficial for their daughters to be sent to school and that the financial investment in their education was a poor one. Instead, parents sponsored non-disabled siblings. One participant stated:

This issue of discrimination it is right from home, if we can fight it better at home, it will not extend out. But if we cannot fight it at home it spreads out. That is why I always emphasize this idea of the parents of persons with disabilities, because they are lukewarm about their disabled children. They always prefer that their able children go to school, and that we stay back home. When they look at you from head to toe they are not seeing where they can benefit. So them spending their money on you is a waste of time. They will never regain it. So they tell you, 'you stay back at home, your brother and sister will care for you'. They forget you can also go and come back and care for your brothers and sisters. (Interviewee 1)

Other barriers within the home environment were that women were excluded in decision-making and the lack of consideration for the opinions of women with disabilities.

Attitudes in the community. Attitudinal barriers were also experienced by many women. For example, participants reported that most taxi drivers drove away once they could see that a woman had a disability. Many drivers did not have the patience to wait for persons with disabilities to enter their taxis and women reported being chastised for the additional time they were taking. In addition, many women who could only sit in the front passenger seat had difficulty with other passengers being asked to give up their seats and move to the rear of the taxi.

Several participants pointed out that some members of the public felt that persons with disabilities should stay at home and not be in the community as they were 'disturbing' others. For example, women who used tricycles stated that they were often chastised by drivers who did not want to share the roads with them. A less apparent barrier was the exclusion of participants in valued social activities.

The cycle of poverty and disability

Many women reported difficulties with obtaining enough income to support themselves and their families. It appeared to be very difficult for participants to move out of poverty. In order to earn money and try to meet their daily expenses participants often had multiple sources of income, for example supplementing their incomes by selling nuts and sweets in front of their homes.

Women reported having additional health care costs compared with other individuals. The financial costs started from childhood and continued throughout the rest of the woman's life. Approximately half of participants described their families spending a great deal of money to cover the expenses of their medical treatments when they were younger.

Having children is an important part of the Cameroonian culture and represents the livelihood and pride of many individuals. Parents in Cameroon, with an average of five children (UNICEF 2004), face tough financial choices. As a result, parents may choose not to send their daughters with disabilities to school. Girls were then unable to receive an education and develop skills, making it difficult to find employment in adulthood and to gain an adequate income. Many participants reported simply not being able to afford to pay for their healthcare needs (e.g. surgery and rehabilitation services) and going without, bearing the pain, illness and difficulties associated with poverty. Participants talked of how their financial worries increased when they chose to have children or accidentally fell pregnant through sexual abuse. Many women with disabilities required a caesarean delivery and the costs of the operation, approximately 85,000 CFA francs (~Can\$170) at the time of the study, was beyond the means of most women. Lastly, mothers with disabilities reported the added guilt of not having the finances to send their children to university.

Challenges in a woman's personal life

Difficulties in forming and maintaining friendships. Forming social ties and having meaningful relationships are important for all women. Participants reported finding it challenging to develop friendships and relationships that were genuine and lasting. Many people were ashamed of being seen with a person with a disability, including members of one's own family. Several participants stated that few profound friendships existed with women outside the disability community. Participants who acquired

disabilities later in life noticed a marked difference in the way their friends interacted with them after the onset of their disabilities.

Challenges in getting married and starting a family. One of the main challenges that all participants shared was finding a suitable marital relationship. One woman stated that many men were afraid of disabled women due to the false belief that disability was contagious. Other women felt that African cultural norms expect women to perform household chores while bringing in an income. This creates a difficult expectation for women with disabilities and they are seen by men as 'unfit'. One participant suffered psychological stress from a man who only pointed out her inadequacies:

A boy look at you, tell you he loves you. We are together, our relationship is going well. I ask him: 'Please would you like to get married to me?' He says: 'I can't get married to you; your responsibility is too much. I cannot carry your responsibility. First, you will not know how to cook. If I am sick, you cannot take care of me'. They will complain, so many complaints that he will start to make you go mad. (Interviewee 1)

The other recurrent fear that participants had was abandonment by men who seemed committed. Five women reported that they were impregnated by men who subsequently left them. One of these women was raped, while the other four had been in consensual relationships and been told by their partners that they would be supported in raising the child. However, none of these men remained to provide any support.

Two participants were happy being single and stated they were fearful of being 'used' by men. One woman was married with three children and reported that her husband was very helpful. Prior to meeting her husband she had been approached by two other men with marriage proposals, one who was 30 years her senior and the second man who wanted her to be his second wife. The majority of participants reported wanting to have one or two children, however, most did not insist on getting married as they felt that relationships with men were generally tainted with exploitation and little commitment.

Lack of opportunities at multiple levels

Due to various factors, participants stated they felt blocked from realizing their full potential. They believed they had the capacity to contribute richly to their communities, yet obstacles of various types exist. Several of these obstacles were articulated by the participants.

Difficulties in gaining education. As explained earlier, many girls with disabilities were not sent to school by their parents due to physical barriers, attitudinal barriers or lack of family finances. Participants stated that another reason why some parents discontinued the schooling of their daughters was that many months and sometimes years of schooling were lost while girls were in treatment, making it difficult for them to return to school. Participants stated that girls who did not get an education grew up to believe that they could not contribute to society and they lacked confidence and self-esteem as adults.

Discrimination in getting employment. A major concern of participants was their difficulty in obtaining employment due to discrimination by employers. One participant noted:

You may drop off your application when the boss is not around. You fill the application and they see the English is very presentable, very qualified for the job. When you come for the interview and they discover you are physically disabled, they conclude that you cannot do the job. That is why persons with disabilities like to be self-employed. (Bamenda focus group participant)

Two participants informed the investigator that there was a law stating that 10% of jobs should be allocated to persons with disabilities. Participants could not provide examples of instances where this law was actually followed, suggesting that it did not translate to reality. Two skilled urban participants reported that in their experiences jobs were unattainable due to discrimination, while other participants reported lacking the education necessary to apply for certain jobs.

Learned helplessness. Women discussed how their experiences with treatment systems and with their families had left them feeling disempowered and helpless. One rehabilitation facility in Cameroon had been visited by many of the participants, where they received rehabilitation and mobility aids. However, one participant reported that the prolonged amount of time spent there as a child (7 years in her case) and the high degree of assistance given to patients led disabled persons to become functionally dependent on others. Likewise, women became helpless through excessive assistance from their families. Three rural participants who lacked mobility aids had families take care of all of their daily needs; with appropriate aids they believed they would have been able to be much more independent. These women were not encouraged to participate in their own lives and reported spending their days completely unengaged and bored.

Strengths and resources of women with disabilities

Despite the many challenges and barriers, participants were finding ways to better their lives. Sometimes the efforts made were individual and other times group initiatives were used to overcome adversity.

Individual strengths

Throughout the interviews the investigator discovered that it was often the women's perseverance that led to positive changes in their lives. One woman, now a teacher, was not permitted to finish her schooling by the institution she was attending due to her perceived 'inability'. She appealed against this discrimination by writing a letter to the Ministry of Social Affairs (MINAS) requesting support to acquire her teaching diploma. Her appeal was granted by MINAS, overriding the barriers set by the institution and allowing her to finish her degree.

Participants were leading the way in building partnerships with the community to raise public awareness and change misconceptions of persons with disabilities. One woman organized a day at church where disabled persons were thoroughly involved in all levels of the services that they were typically excluded from. Another participant approached the principal of a school to encourage him to make benches more accessible for children with disabilities. Others were writing books and speaking on radio talk shows to highlight the issues of persons with disabilities to the public.

Group initiatives

One example of a group initiative was the 'Special needs women entrepreneurs' in Bamenda. This group was dedicated to uniting women and promoting independence and empowerment. The women designed and created crafts and sewed clothing to sell to the public. Participants who had developed skills in these areas trained other women. Collectively they were able to run a shop in town and to make themselves a visible part of society.

Solutions coming from women with disabilities: what needs to happen

In addition to identifying gaps, the investigator took a solution-focused approach and asked participants to generate ideas and visions for how their needs could best be met.

Empowerment

Participants stated that key characteristics of women who thrive in the community are a sense of independence or self-reliance, self-esteem and assertiveness. Participants stated that they needed to prove themselves and to attempt to do things that others perceived as undoable by women with disabilities in order to change the stereotypes they had been saddled with. One participant felt that even if a woman could participate in a small part of a task, she should try to do so instead of sitting idle.

One woman described how it was important that women with disabilities be aware of the ways in which they perceived themselves and that they should disregard negative comments that are made by others. Similarly, participants stressed the importance of focusing their attention on what they were able to do instead of what they could not do to create a healthy self-image and positively influence the perceptions of the public.

Education

Another component to empowering women was providing them with the knowledge and skills that will better their life situation. Participants who had limited opportunities for education as young girls felt that a shift needed to be made for the next generation. Women felt that parents of girls with disabilities needed to understand the positive effects that sending their daughters to school could have in terms of ensuring financial independence, reducing the risk of poverty and bettering their marriage prospects.

Participants felt that it was important for women to be provided with an education on understanding their bodies, especially with regard to reproductive and sexual health. Participants were most enthusiastic about learning skills that would generate an income, such as computer use, knitting, embroidery and craft-making. Many participants in the Bamenda focus group agreed that they would have liked to learn entrepreneurship in order either to start a business successfully or to excel at the ones they currently operated. It is important to note that participants felt that, in addition to learning skills, they needed the capital to run and maintain their businesses.

Support from family and friends

Women reported that parents are gatekeepers in determining whether their daughters have certain opportunities. They felt parents needed to be educated in the importance of supporting the endeavours of their daughters with disabilities.

Educating the public and changing attitudes towards women with disabilities

Participants felt that their communities need to undergo a paradigm shift. Education and desensitization of the public was vital to the successful empowerment of women. Two methods repeatedly mentioned to educate the public were radio talk shows and discussions during church services. One participant stated that women with disabilities needed to take every opportunity they had to educate others, whether it was speaking to people in taxis, at the market, in church or in the bank. Several participants recognized that the government needed to be pressured to include persons with disabilities in decision-making. One woman identified that to really advance as a group, women with disabilities needed to work to make partnerships both locally and globally.

Adapting the physical environment

The most frequently mentioned challenge to participants was difficulty moving within their neighborhoods and towns. These structural barriers led women to stay at home, becoming segregated from society. To overcome these barriers, participants hoped to approach architects interested in accessibility issues and discuss with them how accessible buildings could be designed and built. Women would also like to see the building of sporting facilities and Internet cafés that were accessible. Participants stated that the community at large needed to endorse the vision of accessibility.

Experiences of village women compared with women in Bamenda

Discussions comparing the experiences of women living in villages and women living in Bamenda revealed differences in the quality of life. It appears that women in rural areas have less access to healthcare and rehabilitation-related services. Three rural participants reported that they were unaware of the cause of their disability and when seen by local healthcare professionals they were told there was 'nothing wrong'. The majority of women in villages did not seek medical treatment due to the high cost and the long distances needed to be travelled.

Participants from rural areas rarely left the boundaries of their home due to a lack of mobility aids (e.g. tricycles, crutches and walkers) due to financial limitations and a lack of awareness that such aids existed. Two rural women moved by dragging themselves on the ground. In rural areas homes were observed to be more widely spaced apart and participants' were often left at home alone; this often put girls and women at risk of sexual abuse. One participant reported that she had been raped as a result of being home alone while her sister and mother had gone to the farm to gather crops. Another disadvantage noted was the lack of networking and information sharing between women with disabilities in rural areas.

Experiences of women with disabilities compared with men with disabilities

Participants reported that many of their challenges were shared with men with disabilities. However, certain concerns were unique to women.

The most prevalent difference noted was that men with impairments had much less difficulty getting married than women with similar impairments. It appeared that men with disabilities also had an easier time starting their own families, as their wives, typically able bodied, could take care of the family needs. Participants in this study did not have the same level of assistance from their male partners in caring for their children. This was primarily attributed to gender roles prevalent in African culture, as noted previously. The marriage prevalence was reportedly higher for disabled men compared with disabled women in the North West province; exact numbers were not available, but participants estimated that at least 50% of disabled men were married, compared with an estimated 5% of disabled women.

Another prominent difference described by participants was the stress they experienced during childbearing. Participants reported anxiety over the pregnancy and birthing process, stress over whether they would have their babies safely and worries about affording the cost of a caesarean delivery, which many required.

Stakeholders: who needs to be involved

Participants did not possess significant power to affect the social contexts of their lives or create broader social change and, therefore, felt that it was important to identify stakeholders who could be engaged in working with them to improve their lives

The majority of participants felt that the government, through ministries like Social Affairs, is a key stakeholder in providing financial support and advocacy. Women were especially concerned about the cost of sending their children to school. Only half of participants were aware of law no. 83-013 (Gladnet 1983) permitting parents with disabilities to have their children's school fees waived; participants reported that the process involved was complicated and time consuming. Participants also felt that partnerships with the Ministry of Women's Affairs needed to be made to have the specific issues of disabled women made visible to all women. It is interesting to note that the Ministries of Public Health, Education and Labour were not mentioned as key stakeholders. Spiritual and religious leaders, as well as Fons (i.e. chiefs) of villages were also seen as important figures to engage as they are highly respected and have the power to change public perceptions. There was also acknowledgment that men had a role in supporting their mothers, daughters, sisters and wives with disabilities.

Discussion

Where to go from here

This study is an initial attempt to identify the needs and strengths of women living with disabilities in the North West province of Cameroon. The identification of the needs and strengths of these women in this context led to several recommendations.

Training community-based rehabilitation workers, health workers and community leaders to identify girls with disabilities

As previously discussed, discrimination and lack of opportunities for participants often started in their home environment at an early age. It appears that a root cause is the families' lack of awareness of the potential of their daughters. Local community-

based rehabilitation and public health workers have a key role to play in reaching out to families and working to increase the opportunities available to disabled girls. These girls need to be identified and visited by healthcare workers who can get an idea of their needs. The screening process could assess a girl's need for adaptive equipment, her parents' attitude towards sending her to school, daily activities she could take part in, ways she could contribute to the livelihood of her family and recommendations to reduce the risk of sexual abuse. Health workers can develop support groups for parents of children with disabilities and can help start mentorship programs between women and girls with disabilities.

Maintaining the education of girls with disabilities during prolonged treatment

A barrier to the education of girls with disabilities is the prolonged amounts of time spent in treatment while their schooling is postponed or at times halted altogether. These institutions need to incorporate education into their activities. One way to provide education while they are in treatment is to support relatives who regularly visit, such as older siblings or cousins, to act as tutors. Alternatively, a facility could hire teachers to provide children with a basic education. The facilities and parents of children with disabilities can lobby MINAS and the Ministry of Education for this kind of program.

Capitalizing on microfinance options available in Cameroon

Microfinancing has been successful in helping women gain financial independence in many developing countries, including Cameroon (Mayoux 2001). However, women with disabilities are often marginalized and overlooked by microfinance initiatives (Lewis 2004). It is important for leaders of the disability community, especially women, to approach microfinance non-governmental organizations in Cameroon and start advocating that they be more inclusive of disabled persons in their loan programs.

Approaching the drivers' union on having disability-friendly taxis

Participants reported knowing taxi drivers who were patient and accommodating of persons with disabilities and that they often called these drivers for services. It would be useful to have a more formal service in place. For instance, with the help of the MINAS disability groups could approach the local drivers' union and ask for five taxis to be designated 'disability friendly taxis'. Persons with disabilities could call these taxis to be picked up; in addition, taxis would display a logo that participants would recognize and know that front seat priority was given to disabled persons.

Future considerations for research

Throughout this assessment additional questions arose. There was a lack of clarity on the dynamics between women and men within the disability community. Specifically, questions emerged about how women with disabilities were being marginalized by men with disabilities or whether there was an inherent shyness of women as a result of their oppression at a young age. Employment of and work by participants indicated that most were self-employed in labour-intensive, poorly paid jobs. Research looking at the types of income-generating activities that are most fruitful for women is needed.

Lastly, this needs assessment speaks solely from the perspective of women with mobility and visual impairments. It would be valuable for future research to examine the experiences of women with mental illnesses, cognitive impairments, intellectual disabilities and invisible disabilities. Studies could also examine comparisons between sub-groups of women, such as the differences between women who had had a disability from childhood and those who acquired them later in life, or the differences between women who have a strong social support system and those who lack this.

Conclusion

This study has revealed that, contrary to popular belief, women are not primarily 'disabled' by their physical limitations; the larger disabling factor is negative attitudes on the part of the public and physical barriers in their communities. The findings from this study of women with disabilities in Cameroon have relevance for understanding the situation of women in other developing countries. Many of the needs outlined by participants in this study, such as an education, accessible communities, support from their family and equal opportunities, are shared with their counterparts globally (Dhungana 2006). It is expected that as these needs are met women will experience self-efficacy, see improvements in their health and well-being and increasingly participate in and contribute to the livelihood of their communities.

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