



Availability, accessibility, acceptability and quality framework on access to health care for persons with disabilities: Addressing Compliance under Cameroonian Law

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Abstract

Cameroon has enacted local instruments in line with international commitments so as to realize the Availability, Accessibility, Acceptability and Quality (AAAQ) framework on the rights to access healthcare for Persons with Disability (PWD). But the lived reality by many PWDs is one of persistent barriers and profound disparities in accessing essential health services. Adopting a qualitative research methodology, this paper investigates the compliance with the AAAQ framework by Cameroonian law and concludes that there is a disconnect between statutory provisions and practical access to healthcare for PWDs. It recommends inter alia a substantial increase in financial investment in disability-inclusive healthcare and other targeted policy interventions to achieve compliance with the AAAQ framework.

Keywords: Availability, accessibility, acceptability, quality, access, healthcare, compliance

Introduction

The promise of equitable healthcare, a cornerstone of human dignity and a fundamental human right, often remains an elusive ideal for one of the world's most vulnerable populations: persons with disabilities (PWDs). Access to health care as a right considers health care as a means to serve the health and well-being of human beings, which is indispensable to the exercise and enjoyment of other human rights. By virtue of being a human being, all individuals are equally entitled to their corresponding inalienable human rights, including the right to health care. The right to access to health care consists of a right to equal treatment in accessing health care and responds to the special needs of vulnerable and disadvantaged people.^[1] Access to health care transcends mere absence of disease to encompass a state of complete physical, mental, and social well-being. In Cameroon, the promise of equitable access to healthcare has been welcomed and is indicative in the preamble of the Constitution,^[2] in line with provisions of Article 25 of the Universal Declaration of Human Rights 1948 and Article 12^[1] of the International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966 among others. Cameroon has enacted Law N° 2010/002 on the Protection and Promotion of Persons with Disabilities, with its 2018 Decree of implementation^[3], in a bid to align with international commitments under the UN Convention on the Rights of Persons with Disabilities (CRPD)^[4]. These instruments lay a robust legal foundation, mandating non-discrimination and the provision of inclusive health services for all.

While commending current efforts, the lived reality for many PWDs in Cameroon is one of persistent barriers and profound disparities in accessing essential health services. Reports indicate that PWDs in Cameroon are disproportionately affected by health issues, facing societal stigma, economic hardship, and systemic neglect that often translate into life-threatening delays and substandard care.^[5]

^[5] The gap between the aspirational language of the law and the practical experience on the ground raises a critical

questions on the effectiveness of Cameroon's legal and institutional mechanisms in ensuring genuine access to healthcare for its citizens with disabilities.

To appraise Cameroon's adherence to its obligations and the effectiveness of its efforts, this paper employs the widely recognized AAAQ framework, examining the Availability, Accessibility, Acceptability, and Quality of healthcare services for PWDs. This analysis does not only highlight areas of progress but, more importantly, expose the systemic gaps that continue to deny PWDs their right to access healthcare, offering insights crucial for fostering a truly inclusive health ecosystem.

The Foundational Framework: Understanding AAAQ in Disability Rights

The right to health is an empty promise if there is no practical access to healthcare. Certain criteria have to be met before there is actual access to healthcare. A number of guiding principles can be discerned which describe how this right to healthcare is to be fulfilled. In General Comment (GC) No. 14 on Article 12 ICESCR, the Committee on ICESCR adopted a four-fold classification of guidelines,^[6] which requires that health care must be Available, Accessible, Acceptable and of Good quality (AAAQ). This is equally reflected in Article 15 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa 2018.^[7] The four-fold classification set out in GC No. 14 ICESCR covers major aspects of access and are discussed based on the AAAQ framework according to General Comment No 14 of the International Covenant on Economic, Social, and Cultural Rights committee, with the intention of bringing out what is required as far as healthcare access is concerned.

1. Availability of Health Services

At the very bedrock of the right to access healthcare, lies the concept of availability which entails the assurance that a sufficient quantity of functioning public health, health care

facilities, goods, services, and programs exist within a state's purview to ensure access for PWDs. Without adequate availability, all other dimensions of access, such as affordability or physical reach, become moot, rendering the right to health care an empty promise. Therefore, the availability of health services stands as a foundational pillar, reflecting a state's commitment and capacity to provide the necessary infrastructure, personnel, and resources for its population's health and well-being.

The legal foundation for ensuring availability of health services for persons with disabilities is firmly rooted in international human rights law. Article 25 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) explicitly recognizes the right of persons with disabilities to the enjoyment of the highest attainable standard of health, without discrimination on the basis of disability^[8]. This includes the right to access the same range, quality, and standard of free or affordable healthcare and programmes provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes. Article 9 further obligates states to ensure that persons with disabilities have access, on an equal basis with others, to the physical environment, transportation, information and communications, including information and communication technologies and systems, and other facilities and services open or provided to the public^[9].

The availability of health services extends beyond the mere existence of buildings. It encompasses a comprehensive array of provisions critical for a functioning health system. Firstly, it demands a sufficient number of functioning public health and health care facilities. This includes primary health centers, community clinics, district hospitals, and specialized tertiary health care institutions, strategically distributed to meet geographical needs. These facilities must not only exist on paper but be operational, equipped with essential utilities, and maintained to provide a safe environment for healthcare. A dilapidated structure or an abandoned clinic, though physically present, fails to contribute to true availability.^[10] Secondly, availability necessitates an adequate supply of trained medical and professional personnel. Doctors, nurses, midwives, pharmacists, therapists, and public health workers are the human engine of any health system^[11]. Thirdly, the availability component underscores the constant supply of essential medicines, equipment, and technologies. This includes a consistent stock of life-saving drugs, vaccines, medical devices, diagnostic tools, and assistive technologies.^[12] Finally, availability also encompasses the existence of functioning public health programs and services. This moves beyond individual treatment to collective well-being. Immunization campaigns, sanitation initiatives, health education programs, disease surveillance systems, and maternal and child health services are all integral to availability.^[13]

The legal and ethical implications of ensuring availability are profound. International human rights instruments, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), explicitly obligate states to take steps to achieve the full realization of the right to health, which inherently includes ensuring the availability of health care services.^[14] This is not an immediate obligation to provide all services instantly, but a commitment to progressive realization, utilizing the maximum available resources to improve availability over time. Failure to ensure basic availability, particularly where resources could have been allocated, can constitute a violation of human

rights.^[15] With regard to the required quantity in terms of availability, no concrete criteria are prescribed in GC No. 14 of the ICSECR. Nevertheless, from the conclusions of the Committee in which the provisions of the ICESCR are interpreted, at least three criteria for the assessment of the availability of healthcare can be detected. These are i) the number of hospital beds and health care providers per inhabitant, ii) the amount of resources allocated to healthcare, and iii) the length of waiting time for admission to health care services. The availability of health services is therefore, not merely a precondition for the right to access health care for persons with disabilities, but an obligation that demands proactive measures to ensure inclusivity and equitable access.

2. Accessibility to Health Services

Accessibility is a decisive element of the right of persons with disabilities to access health care. It determines whether available services can actually be reached, understood and used by persons with diverse impairments. Analysing accessibility therefore requires examining legal obligations (international and domestic), the different dimensions of accessibility (physical, economic, informational, communicational, attitudinal, administrative), typical barriers (with attention to the Cameroonian context), state duties (what governments must do), measurable indicators, and practical measures to implement accessibility in health systems. The UN Convention on the Rights of Persons with Disabilities (CRPD) defines accessibility broadly and requires states to take measures to ensure access, on an equal basis with others, to the physical environment, transportation, information and communications, and other facilities and services open to the public and specifically to health.^[16] The CRPD Committee's General Comment on accessibility clarifies that accessibility is a cross-cutting, enabling right that removes barriers to participation and independence.^[17] The International Covenant on Economic, Social and Cultural Rights (ICESCR General Comment No. 14 on the right to health further require availability, accessibility, acceptability and quality (AAAQ), with accessibility subdivided into non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility.^[18] Human rights grant individuals a right to access to health care. According to GC No. 14, different dimensions of the accessibility of health care can be distinguished; non-discrimination in physical accessibility, financial accessibility, informational accessibility and economic accessibility.

On physical accessibility, Article 9 of the CRPD is to the effect that "To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia: Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces..."^[19] No wonder, Article 18 of the 2018 Decree read alongside section 33 of the 2010 Law is to the effect that; The State; Decentralized Territorial Communities, public and private bodies take all necessary measures to facilitate the accessibility of people with

disabilities to public and private buildings and institutions open to the public. Article 9 establishes accessibility as a cross-cutting, enforceable human-rights obligation that goes beyond preventing new barriers to requiring the active identification and removal of existing obstacles

As regards informational access, the legal and ethical imperative for accessible health information formats is deeply rooted in international human rights law. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) serves as a cornerstone, obligating States Parties to ensure that persons with disabilities have access to information and communications, including information and communications technologies and systems, on an equal basis with others (Article 9). Article 25 on the right to health necessitates that health care services are provided in a manner that is "disability-sensitive" and non-discriminatory, which inherently includes accessible communication to facilitate informed consent and effective treatment. The UN Committee on Economic, Social and Cultural Rights (ICESCR) also underscores information accessibility as a key dimension within its General Comment No. 14 on the right to health^[20]. Cameroon has concretized these formats by clearly providing in Article 22 of the 2018 Decree implementing the 2010 Law on the protection of the rights of PWDs, stating that "The State, the Decentralized Territorial Collectivities and their dismemberments shall facilitate access of disabled people to communication and information means, particularly through audiovisual equipment, telecommunications and various media."^[21]

There is no gainsaying the fact that the journey to health care begins with a simple act of information: reading a pamphlet, listening to a radio announcement, or browsing a clinic's website. Information conveyed through qualified sign language interpreters, visual diagrams, and video presentations is paramount during consultations for persons with hearing impairments^[22]. We equally have Augmentative and Alternative Communication (AAC) like picture boards or speech-generating devices which enable individuals with severe speech impairments to communicate their needs and understand information.^[23] The absence of accessible formats for health information leads to severe and pervasive consequences, undermining not only individual health but also the integrity of health care systems.

The ethical principle of informed consent is predicated on the patient's full understanding of their condition and treatment options^[24]. Without effective communication, true informed consent is unattainable, rendering medical procedures potentially unethical and legally questionable. The duty to provide reasonable accommodation also directly applies, requiring necessary and appropriate modifications to ensure effective communication in health care settings.^[25] Effective communication during consultations is not merely a courtesy but a fundamental right and a critical determinant of health outcomes for persons with disabilities. It is the living bridge that connects medical knowledge with patient understanding, transforming abstract health care services into tangible, person-centered health care.

Finally, economic accessibility requires that health care, including drugs, should be affordable for everyone.^[26] This affordability is an important element of the accessibility to health care and forms part of the information that should be provided in the State reports that have to be submitted to the Committee.^[27] The cost of health care should not place an excessive financial burden on individuals as access to health care should be based on need and not on ability to

pay.^[28] Steps must therefore be taken to reduce the financial burden on patients if necessary. These could include ensuring the effectiveness of the subsidies provided by the Law as far as health care for PWDs is concerned, based on the presentation of the disability card.

3. Acceptability

Acceptability refers to the extent to which health services are provided in a way that respects the culture, beliefs, dignity, and autonomy of individuals and communities, and are appropriate to specific groups (e.g., gender, age, disability status). It encompasses ethical soundness which requires respect for informed consent, confidentiality, privacy, and non-discrimination.^[29] It also involves Cultural Appropriateness, requiring Sensitivity to patients' socio-cultural backgrounds, religious practices, and traditional beliefs, ensuring services are delivered in a way that aligns with, rather than conflicts with, their values.^[30] It further requires Gender and Age Sensitivity which addresses the unique health needs and preferences of different genders and age groups, and ensuring services are delivered in a respectful and non-judgmental manner.^[31] Most importantly, Disability Sensitivity demands understanding the specific communication, physical, and sensory needs of persons with disabilities, and ensuring services are delivered with respect for their autonomy and dignity^[32], as well as Trust and Empathy by building rapport between patients and providers, fostering an environment where patients feel heard, respected, and confident in the health care they receive.^[33]

According to General Comment No. 14 acceptable health care signifies that it must be 'culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements'.^[34] This means that the tradition of persons should be respected. Examples are the refusal of blood transfusions by Jehovah witnesses, the use of traditional preventive health care, healing practices and medicines by various indigenous groups and the use of alternative medicines and medical treatments.^[35] Therefore, without dignity, respect, cultural sensitivity, and a high standard of medical practice, the availability and physical accessibility of health services become hollow offerings, failing to alleviate suffering and often causing further harm. States have a profound legal and ethical obligation to ensure that health care systems are designed and delivered in a manner that is both acceptable and of good quality for all people, particularly for vulnerable groups like persons with disabilities.

4. Good Quality

Good Quality on the other hand, refers to health care that is effective, safe, people-centred, timely, efficient, and equitable. It encompasses: Safety which requires minimizing risks, preventing errors, and ensuring that health care does not cause harm to patients.^[36] Good quality also encompasses effectiveness which requires the delivery of evidence-based interventions that achieve desired health outcomes and meet established standards of health care. It equally involves Patient-Centeredness where health care is organized around the needs, preferences, and values of individual patients, involving them in shared decision-making.^[37] Providing health care promptly, without undue delays that could worsen health conditions or cause distress, and availability of necessary medicines, equipment, technology, and a well-maintained infrastructure to support effective as well as safe healthcare equally constitute good

quality.^[38] In the conclusions of the ICESCR Committee, no concrete interpretation of the term quality is given. This is probable due to the fact that the quality of health care in a member state is very difficult to assess within the context of international reporting procedures.

However, the international human rights framework firmly establishes quality as core components of the right to access health care. The International Covenant on Economic, Social and Cultural Rights (ICESCR), in Article 12, guarantees the right to the highest attainable standard of physical and mental health. The UN Committee on Economic, Social and Cultural Rights (CESCR), in its seminal General Comment No. 14, explicitly lists good quality as one of the four essential and interrelated elements (AAAQ framework) of the right to health. For persons with disabilities, the UN Convention on the Rights of Persons with Disabilities (CRPD) further solidifies these obligations. Article 25 mandates states parties to “recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability,” and to take all appropriate measures to ensure access to the same range, quality and standard of free or affordable healthcare and programmes as provided to other persons.

The AAAQ framework summarizes what would constitute the guarantee of healthcare access for PWDs signifying that it must be affordable, accessible from all dimensions, acceptable and of good quality. Of importance is that Cameroon has tried to concretize this effort through the adoption of a 2010 on the promotion and protection of PWDs and its Decree of implementation. It has also tried to give effect to the aforementioned instruments through various efforts.

Efforts Made by Cameroon to Implement the AAAQ Framework

The issuance of the Prime Ministerial Decree No. 2018/6233/PM of 26 July 2018 was hailed as a landmark moment for the protection of Persons with Disabilities (PWDs) in Cameroon. Designed to operationalize the Law of 2010, the Decree provides the operating manual for how rights the right to access health care are to be exercised. However, a specific provision within this Decree has become a focal point of legal debate: the requirement that beneficiaries must hold a National Disability Card and justify a Permanent Potential Incapacity Rate (IPP) of at least fifty percent (50%).^[39] This section addresses Cameroon's efforts in implementing the AAAQ Framework in view of assessing the effectiveness of the law on the guarantee of access to healthcare for PWDs. This includes; the Requirement and Establishment of the National Disability Card, Integration of PWDs into Universal Health Coverage, Medical Management and Disability Allocation for Persons with Disabilities and Community-Based Rehabilitation (CBR) among others.

1. The Requirement and Establishment of the National Disability Card

The need to enhance economic accessibility to healthcare in Cameroon has moved from the realm of abstract constitutional promises to concrete administrative action. At the heart of this transition is the National Disability Card. The National Disability Card finds its legal basis in Law No. 2010/002 of 13 April 2010 on the Protection and Promotion of Persons with Disabilities. Under this law, the card is the official instrument issued by the Ministry of Social Affairs (MINAS) to certify that an individual has a disability that

warrants state protection. By formalizing a patient's disability status, the card acts as the primary mechanism for triggering the State's obligations and the health care provider's liability, theoretically ensuring that the medical contract is both accessible and affordable. Article 2 of the 2018 Decree is to the effect that a PWD will only benefit from the provisions of the Law upon presentation of the Disability Card. In the eyes of the law, the card creates a legal status for the PWD, moving them from a general user of the health system to a protected beneficiary with specific, enforceable claims.

One of the most significant efforts to guarantee access is the mandated 50% reduction in the cost of consultations and medical acts in public. For a PWD, the presentation of the card at the billing desk is a contractual right that modifies the price of the medical service. The card entitles the holder to Priority Access in hospitals. This mechanism acknowledges the physical and sensory challenges many PWDs face when waiting in long queues. It imposes a duty on hospital staff to fast-track cardholders, a duty that, if ignored, can be viewed as a breach of the reception and safety clause of the medical contract.^[40]

From a legal standpoint, the National Disability Card is the trigger for contractual liability. When a patient presents their card upon registration, they are effectively notifying the provider of their specific needs and their right to subsidized health care. If a hospital accepts a patient's registration but refuses to apply the 50% discount or refuses to provide reasonable accommodation, the patient can point to their Disability Card as the proof that the hospital was aware of its statutory and contractual obligations. The card also serves as evidence in tort actions. If a PWD is injured due to a lack of priority health care or inaccessible infrastructure, the fact that they possessed a valid card proves that their vulnerability was legally declared, making the provider's negligence even more difficult to defend. As per Article 2 of the 2018 Decree, the card is technically reserved for those with a Permanent Potential Incapacity Rate (IPP) of at least 50%. This leaves those with moderate disabilities (e.g., 30% or 40%) in a legal vacuum where they face barriers but lack the card to demand accommodations. We are of the opinion that this increases lack of access to health care for PWDs. Therefore, a disability/impairment of such person(s) should be able to benefit from every service just like other PWDs. The fact that there are PWDs with IPP rate of 30% or 40% does not make them less disabled. We think that the Law is therefore harsh in this perspective.

2. Integrating PWDs into the Universal Health Coverage (UHC)

UHC is a program that aims to dismantle the financial barriers in accessing medical services, transforming health care access from a luxury into a guaranteed statutory right. The period between 2023 and 2026 marks a historical pivot in the Cameroonian health care landscape with the official launch and phased implementation of Universal Health Coverage (UHC).^[41] For decades, Persons with Disabilities (PWDs) in Cameroon faced the double burden of high medical costs and systemic inaccessibility. The introduction of UHC represents a shift from a fragmented system of discretionary discounts to a structured, solidarity-based mechanism by integrating PWDs as a priority vulnerable group.

Launched in April 2023, the first phase of Cameroon's UHC explicitly identifies PWDs among the target populations for subsidized healthcare. This integration is not merely a policy choice but a legal fulfillment of Law No. 2010/002,

which mandates state support for the health of disabled citizens. Under the current UHC framework, the mechanism for PWDs involves a “Basic Package of Services” which includes consultations, essential medicines, and specialized treatments such as dialysis. For the PWD, the UHC acts as a third-party payment system. By removing the requirement for out-of-pocket payments at the point of service, UHC ensures that the formation of the medical contract is no longer contingent upon the patient's immediate financial liquidity, which has historically been a major deterrent for PWDs in Cameroon.^[42] This enables PWDs to access health care easily with the economic accessibility barriers which they often face.

A critical feature of the 2023–2026 UHC rollout is its reliance on existing identification mechanisms.^[43] To benefit from the Vulnerable Group status under UHC, a PWD must be registered and possess the National Disability Card. The card serves as the digital “key” for enrollment in the UHC database. Consequently, the efforts to streamline the issuance of the Disability Card during this period are directly linked to the success of UHC. There is however, a challenge in this perspective because not every PWD has the opportunity or ability to possess a Disability Card, especially PWDs in interior parts of Cameroon. This creates an unfair advantage for this group of PWDs as far as the implementation of the UHC is concerned. This does not in any way negate the fact that the integration of the UHC fund ensures that the protection promised by the Law of 2010 is finally backed by the financing.

One of the primary mechanisms through which UHC enhances access for PWDs is Financial Risk Protection. In Cameroon, a significant percentage of disabilities are exacerbated by catastrophic health expenditure, where families fall into poverty trying to pay for rehabilitation or chronic healthcare. The UHC mechanism (2023–2026) aims to pool these risks.^[44] For a PWD, this means that the contractual bargain with a health care provider is now backed by a state-guaranteed insurance fund, which assist PWDs in accessing health care. If a provider is part of the UHC network, they are contractually obligated to treat the enrolled PWD without demanding illegal up-front fees. This strengthens the patient’s position, allowing them to demand health care as a right-holder rather than a charity-seeker.

There is ongoing debate regarding whether the UHC package adequately covers specialized disability needs such as high-quality prosthetics, hearing aids, or specialized physiotherapy, which are often more expensive than standard medical acts. The integration of PWDs into UHC has profound implications for Contractual Liability. With UHC, the medical contract becomes a tripartite agreement between the Provider, the Patient (PWD), and the UHC Fund. If a hospital is a certified UHC provider but refuses to treat a PWD or demands extra-legal payments, the breach of contract is now twofold: a breach against the patient and a violation of the hospital’s agreement with the State UHC fund. This provides PWDs and their associations with more leverage to report and seek sanctions against non-compliant providers.

3. Community-Based Rehabilitation (CBR)

There is no gainsaying the fact that formal health care institutions are often concentrated in urban centers, leaving Persons with Disabilities (PWDs) in rural and peri-urban areas at a significant disadvantage. To bridge this gap, the Cameroonian government, in collaboration with international partners and civil society, have adopted Community-Based Rehabilitation

(CBR).^[45] Recognized as a multi-sectoral strategy within the framework of Law No. 2010/002,^[46] CBR serves as a critical mechanism for decentralizing health care. By moving rehabilitation services from the hospital ward to the heart of the community, CBR ensures that the right to health and access thereof, is a functional reality for PWDs across the national territory.^[47] This move helps enhance physical and economic accessibility, availability, and affordability of healthcare for PWDs in rural areas.

Worth noting is the fact that, historically, disability in Cameroon was addressed through a Medical Model, where PWDs were required to travel long distances to specialized centers like the Léger National Centre for the Rehabilitation of Persons with Disabilities (CNRPH) in Yaoundé. CBR represents a paradigm shift toward a Social Model. As implemented in Cameroon, CBR focuses on five pillars: health, education, livelihood, social, and empowerment. In the context of health care access, the CBR mechanism functions as a pre-contractual bridge. It identifies PWDs who are often hidden in their communities, provides them with primary rehabilitation, and facilitates their entry into the formal medical system.

CBR workers often train volunteers and staff from organizations like the Cameroon Baptist Convention (CBC) Health Services visit households to identify children and adults with disabilities. This early intervention is crucial for preventing secondary complications and is a key effort to fulfilling the state's duty under Section 27 of the 2010 Law.^[48] Perhaps the most vital function of CBR is the Referral Mechanism. When a PWD requires specialized surgery or advanced therapy that cannot be provided locally, CBR networks organize the logistics of the medical contract. They connect the patient with an accessible hospital, often negotiating the 50% fee reduction guaranteed by the Law of 2010 on behalf of the patient.

CBR brings basic physiotherapy and occupational therapy into the community. By using local materials to create assistive devices (e.g., parallel bars made of wood or locally forged crutches), CBR fulfills the Accessibility requirement of the law in resource-constrained environments. Under Cameroon’s Decentralization Laws, local councils (Mayors) are increasingly responsible for the social welfare of their populations.^[49] No wonder, Section 17 of the General Code on Regional and Local Authorities state that, “The State shall devolve to local authorities the powers necessary for their economic, social, health, educational, cultural and sports development.”^[50] To impose themselves, the mayor must not only be active, he/she must also hold together and separately at the same time, the various local spheres of development which includes health. CBR provides the framework for councils to fulfill their statutory obligations toward PWDs. Failure by a local council to support or facilitate CBR programs could be considered as an administrative fault.

CBR workers are increasingly being utilized as enrolment agents, ensuring that PWDs in remote villages are registered for UHC and possess their National Disability Cards.^[51] This integration ensures that the Community Effort is backed by Financial Guarantee, making the health care contract accessible to the most marginalized. CBR illustrates how the guarantee of Access is achieved through a decentralized network that combines the authority of the State with the agility of the community.

4. Medical Management and Disability Allocation for Persons with Disabilities

Medical Management and Disability Allocation for Persons with Disabilities simply refers to the special allocation made for PWDs seeking to access health care, in order to reduce the financial burden of paying medical bills for PWDs. The medical healthcare of indigent disabled persons consists of the reduction or exemption of fees, in proportion to their Permanent Potential Incapacity (PPI) rate for: Consultation; - laboratory examinations; radiography or medical imaging; hospitalization; medical evacuation; purchase of certain medicines, in specialized institutions and public or private health facilities. This measure is closely related to the UHC scheme which aids access to health care for PWDs by providing financial assistance. Article 26 and 27 of the 2018 Decree are to the effect that Indigent people with disabilities will receive disability allocation and medical healthcare. Article 27 goes further to provide that the disability allowance provided for in Article 26 above shall be granted to indigent persons with disabilities whose Permanent Impairment Incapacity rate is at least ninety-five^[95] percent and whose state of health requires constant medical supervision and healthcare based on the expert report of a specialist physician. The indigence mentioned here is established based on a social survey conducted by the relevant departments of the Ministry of Social Affairs.

The most striking feature of Article 27 is the 95% Permanent Impairment Incapacity (IPP) rate. In legal medicine, a 95% IPP signifies near-total loss of autonomy (e.g., total paralysis, severe multiple disabilities, or advanced neurodegenerative conditions): By setting the bar at 95%, the law creates a selective mechanism. This is because it guarantees intensive healthcare for the most severely disabled, but it implicitly leaves out a vast majority of PWDs^[52] who may still be indigent and in need of significant medical health care but do not meet this "near-total" threshold. This equally does not align with the provisions of article 2 of same Decree which is to the effect that "The provisions of this decree apply to persons with disabilities holding a National Disability Card and justifying a Permanent Potential Incapacity Rate (IPP) of at least fifty percent (50%)"^[53]. Of course it is understandable that article 27 is a special provision and thus derogates from the general provision which is article 2.

The provision also requires an expert report of a specialist physician which moves the health care contract from a simple patient-doctor relationship to a formal administrative-medical procedure. In the Cameroonian context, specialist physicians (Neurologists, Orthopedists, etc.) are heavily concentrated in urban centers like Yaoundé and Douala. For an indigent PWD living in a rural area, simply accessing the specialist to get the report required for this allowance is a massive logistical and financial barrier. Without the report, the right to constant medical supervision remains theoretical. Article 27 specifically mentions a state of health requiring constant medical supervision and healthcare. This changes the nature of health care provider's Duty of Healthcare. This is because for patients under this article, the Medical Contract is not for a single act (like a consultation) but for a continuous service. If the State or a designated public hospital fails to provide this constant healthcare to a 95% IPP indigent patient, the liability is much higher, because the health unit is statutorily bound. The failure is not just a simple breach; it is a violation of a Statutory Debt of Health care owed by the State to its most vulnerable citizens.

Barriers to Cameroons limited implementation of the AAAQ Framework on Access to Healthcare for PWDs

The efforts made by Cameroon in ensuring the implementation of the AAAQ framework cannot be underestimated. However, there have been persistent multi-dimensional barriers for PWDs to access the healthcare services across Cameroon, at individual, provider and health system level. The reasons for barriers can be found in lower levels of educational attainment, lower income, and employment rate, all of which are associated with lower use of health care services. The structural disadvantages have also an intersectional dimension which cannot be ignored because PWDs are more likely to face barriers in accessing health care services than any other group.^[54] Key challenges to the AAAQ framework in guaranteeing access to healthcare for PWDs in Cameroon is largely attributed to Physical and Geographical Barriers, Financial and Economic Barriers, Communication and Informational Barriers, and interestingly, the 95% IPP rate as a barrier.

1. The 95% IPP Threshold: A Barrier to Healthcare Access for Many Persons with Disabilities in Cameroon

The 95% Permanent Potential Incapacity Rate (IPP) threshold, as stipulated in Cameroon's legal framework for persons with disabilities (PWDs), presents a significant and often insurmountable barrier to equitable healthcare access, fundamentally undermining the nation's commitment to the AAAQ (Availability, Accessibility, Acceptability, Quality) framework. While Law N° 2010/002 on the Protection and Promotion of Persons with Disabilities and its 2018 Decree of application aim to operationalize rights for PWDs, the IPP requirement, particularly the 95% threshold in Article 27 of the 2018 Decree, creates a selective mechanism that prioritizes only the most severely disabled for intensive care and specific allowances.^[55] This narrow definition implicitly excludes a vast majority of PWDs who, despite having significant impairments^[56], are deemed ineligible for crucial medical and financial support, thereby creating a legal vacuum where their needs remain unaddressed.

The administrative process for obtaining the National Disability Card, which is intrinsically linked to the IPP threshold, further exacerbates these access issues, creating a Poverty-Disability Trap that disproportionately affects indigent PWDs. To qualify for the mandated 50% reduction in medical fees or integration into the Universal Health Coverage (UHC) scheme, PWDs must first acquire this card, a process that is often long, centralized, and requires specialist medical reports and laboratory tests.^[57] For a PWD in a rural area, the cost of consultations with specialists, diagnostic tests, and transport to regional delegations can easily exceed their monthly income, rendering the very mechanism designed to provide financial relief inaccessible. This procedural barrier effectively denies many PWDs the "digital key" to state-subsidized healthcare, trapping them in a cycle where they need affordability to get the card, but need the card to achieve affordability.

Even for PWDs who successfully navigate the arduous process of obtaining a Disability Card, institutional resistance and financial disincentives on the supply side continue to impede access. Public hospitals in Cameroon, operating on a cost-recovery model, often view PWDs benefiting from the 50% discount as loss-making patients due to slow state reimbursements by the State. This leads to frequent demands for full upfront payment or refusal to recognize the card for specialized treatments, constituting a

Contractual Fault and a violation of statutory price-fixing mechanisms.^[58]

The IPP threshold and its flawed implementation directly undermine all four pillars of the AAAQ framework. In terms of Availability, the restrictive criteria limit the effective reach of specialized services and financial aid to a small fraction of the PWD population. For Accessibility, the bureaucratic hurdles and the Poverty-Disability Trap create significant economic and informational barriers, while the reluctance of hospitals to honor discounts further restricts physical access. The Acceptability of care is severely compromised as PWDs are often treated with less dignity, viewed as a financial burden, or subjected to discriminatory practices, reinforcing stigma. Finally, the Quality of healthcare suffers when PWDs are denied timely and appropriate care due to these financial and administrative impediments, leading to delayed diagnoses, inadequate treatment, and worsened health outcomes.

2. Physical and Geographical Barriers

According to article 33 paragraph 1 of the Law No. 2010/002, Public and private buildings and institutions open to the public must be designed to facilitate access and use by persons with disabilities. Most infrastructures including health care facilities in Cameroon lack the necessary infrastructure to accommodate the needs of people with disabilities. The absence of adequately equipped facilities to meet the needs of people with disabilities limits their ability to access services like consultations, treatment, or rehabilitation. This includes physical barriers like the absence of ramps, accessible bathrooms, or appropriate signage in Braille. These barriers are more eminent in the interior parts of Cameroon where necessary infrastructure and logistics are absent.^[59]

Many hospitals, particularly in rural or semi-urban areas, lack ramps, elevators, or wide doorways. Even when a PWD can enter a ward, the toilets and bathrooms are often not adapted for wheelchairs, leading to hygiene and safety risks. This forces PWDs to be carried by relatives, which is undignified and potentially dangerous. Specialized rehabilitation and specialist physicians (neurologists, orthopedists, psychiatrists) are heavily concentrated in Yaoundé and Douala.^[60] For a PWD in the North, East, or Far North regions, the geographical distance creates a de facto exclusion from specialized healthcare. These long distances are compounded by poor road infrastructure. A journey that is merely uncomfortable for a non-disabled person can be life-threatening for a PWD with chronic conditions or spinal cord injuries. The lack of communication routes adapted for PWDs as mandated by Section 33^[4] of the 2010 Law^[61] means that for many, specialized health care is a geographical myth.

Geographical distance is exacerbated by the failure of the transport sector to accommodate PWDs. Under Section 35^[1] of the 2010 Law, transport companies are supposed to provide adapted equipment and priority access^[62]. In practice, the interurban buses and clandos (informal taxis) that dominate Cameroonian transit are not adapted for wheelchairs. Moreso, the Ministry of Public Health and the Ministry of Public Works have a statutory duty to ensure that building codes and transport regulations are disability-inclusive. By granting Authorizations to Operate to inaccessible clinics, the State fails in its oversight role, making it liable for the resulting exclusion. However, liability for such has never been enforced. Until the hospital is physically reachable, the legal right to health remains a dead letter for thousands of Cameroonians with disabilities.

Access is not a luxury; it is the physical prerequisite for justice.

3. Financial and Economic Barriers

The lack of financial resources constitutes a serious health care barrier to accessing services for people with disabilities and is a direct challenge to the economic accessibility requirement. This is because the cost of health care significantly increases with disability^[63]. It is worth noting that the majority of people with disabilities live in poverty, and the cost of health care services, along with transportation to and from facilities, makes it difficult for them to seek timely medical attention. With the declining economic situation in Cameroon, many more people with disabilities are unable to afford for basic health and social services^[64]. While Cameroon has made efforts to offer free or subsidized health care services to certain vulnerable groups, most of these programs do not adequately respond to the health needs of people living with disabilities. Building on results of a study conducted in 3 different countries, Pinilla contended that people with disabilities face significantly higher levels of poverty and the intensity of their poverty is higher.^[65]

As people with disabilities often find themselves excluded from the jobs market and with higher living costs, due to their needs, they often cannot pay for health care services out of pocket. In their study, Beatty et al^[66] found that people 'with the poorest health and with the lowest income were the least likely to receive all health services needed'. The cost associate with the treatment and general access to health care services is regularly named as one of the main obstacles to accessing health care services by people with different disabilities and impairments. There is a documented link between disability and poverty in Cameroon. While the law mandates a 50% reduction in medical fees, the implementation is inconsistent. Many public hospital administrators are either unaware of the 2010 Law or refuse to apply the 50% discount because the State does not adequately reimburse the hospital for the loss of revenue. The discount only applies to holders of the Disability Card. However, the administrative process to obtain this card is long, centralized, and often requires medical reports that the PWD cannot afford to pay for in most of the cases. From a legal perspective, the Poverty-Disability Trap undermines the validity of the medical contract. When a patient is destitute, their choice of treatment is dictated by price rather than medical necessity. If an indigent PWD with a 95% incapacity rate^[67] is turned away from a hospital because they cannot pay the user fees, the State and the hospital are in breach of a Statutory Debt of Health care.

4. Communication and Informational Barriers

For persons with disabilities, the right to access information, particularly concerning health care, transcends mere convenience; it is a fundamental principle that underpins their ability to exercise their right to health, access medical systems, and advocate for their own well-being.^[68] No wonder Section 32 of the 2010 Law is to the effect that "The State, Regional and local Authorities and civil society shall take all necessary measures to facilitate: access by persons with disabilities to information and communication technologies;..."^[69] However, the reality is that people with disabilities are often unaware of the health care services they can access in the mainstream health care centers^[70], despite the fact that people with disabilities have higher need for health care compared to people without disabilities.

There is also a significant difference between people with disabilities in whether they know where they need to go in case they need treatment. Signs and notices in health care facilities have been problematic for people with learning disabilities, low literacy levels, or sensory disabilities.

Persons with disabilities need informational tools like Braille, sign language interpreters among others to enable them have information in accessible formats. In this perspective, most hospitals lack these services which makes access to information for PWDs difficult. So far only few Cameroon Baptist Convention (CBC) hospitals like the Mbingo Annex Hospital Nkwen have these services though they are not directly integrated into the health services. However, the hospital makes use of these services through the CBC Educational Board which is the principal provider of the services. Our research indicates that government hospitals do not have these services which is a pointer to the difficulties faced by PWDs especially in government hospitals where they are supposed to benefit from reduced medical fees.

If a patient cannot receive information, they cannot give informed consent. Most Cameroonian hospitals lack sign language interpreters. This leads to frequent misdiagnosis, as the doctor and patient cannot communicate symptoms or dosage instructions accurately. Medical records, prescriptions, and hospital signage are rarely available in Braille or large print. Visually impaired patients often have to rely on third-party escorts to read their medical files, which violates the principle of medical confidentiality. For Persons with Disabilities (PWDs) in Cameroon, this fundamental exchange is frequently sabotaged by communication and informational barriers. When a patient with speech impairment cannot speak to their doctor, or a visually impaired patient cannot read their prescription, the informed consent required by Section 32 of Law No. 2010/002 becomes impossible.^[71] These barriers are not merely misunderstandings; they are systemic failures that lead to misdiagnosis, a breach of medical confidentiality, and a de facto exclusion from the right to health.

Conclusion

This paper has critically addressed Cameroon's compliance to the availability, accessibility, acceptability and quality health goods, services and facilities (AAAQ) framework on access to healthcare for PWDs. This analysis was on the basis of Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which effectively provides the above requirement on healthcare access in its UN Committee on Economic, Social and Cultural Rights General Comment No. 14. Our analysis in the context of PWDs hinged on Article 25 of the CRPDs 2006 read alongside provisions of the 2010 Law and its 2018 Decree of implementation in Cameroon. While commending the efforts made by Cameroon to ensure the respect of the AAAQ framework is concerned through the establishment of National Disability Card, UHC and Community-Based Rehabilitation (CBR) and Medical Management and Disability Allocation for Persons with Disabilities among others, the paper notes that implementation has been far from realistic. This is largely due to Physical and Geographical Barriers, Financial and Economic Barriers, Communication and Informational Barriers, and interestingly, the 95% IPP threshold rate as a barrier. It is therefore recommended that the Universal Health Coverage scheme should be strengthened to provide specialized vulnerability-based subsidies, with 100% waivers for essential health services for PWDs.

The Decentralization of Specialized Rehabilitation and Mental Health Services for PWDs is equally needed, to enhance access. It is equally recommended that the State, through the Ministry of Public Health and the Ministry of Posts and Telecommunications, leverages digital technologies and e-health solutions as a primary strategy to bypass the persistent physical and geographical barriers that currently hinder persons with disabilities (PWDs). Ultimately, this article contends that Cameroon must transition from broad legislative commitments to concrete, targeted policy interventions to achieve genuine compliance with the AAAQ framework.

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56. For example, 50-90% IPP rate.
57. Many specialized services, such as those provided by the CNRPH (Cardinal Paul Emile Léger National Centre), are tied to the possession of the card, ensuring that state-subsidized prosthetic and rehabilitation services reach the intended demographic.
58. This is a testimony of one of the PWDs interviewed by the researcher.
59. Most health units in interior parts are health centers and lack necessary infrastructural equipments. For instance the Kuvlu Intergrated Health Center in Nkum Subdivision.
60. This is why in most of the cases, PWDs are either referred to these specialists in these cities or they are hired to come and perform the intervention.
61. "... (4) The construction of passages shall take into consideration facilities reserved for persons with disabilities".

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