Report: Women's Health Study, Djohong District, Cameroon

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Table of Contents

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Executive Summary

The Central African Republic (CAR) has been long been embroiled in a number of internal political and military conflicts that have led to the displacement of over 80,000 of its citizens into Cameroon. The Mbororo tribe, most severely affected by this upheaval, has sustained severe losses not only in their numbers but also in their quality of life, level of security and personal health. As they have attempted to flee this conflict, they have become targets of bandits, rebels and soldiers alike. In this setting, many women and children have become the targets of gender-based violence.

IMC Djohong

The International Medical Corp (IMC) is currently working in Djohong District, an area of Cameroon where recent refugees have settled. Djohong District is located far from the capital, Yaounde— an approximately two-day journey by car. IMC operates far from UNHCR offices in Bertoua (one day by car from Djohong) and without the advantage of having other NGOs in the area. The refugee settlements in Djohong District are located inside and on the periphery of established Cameroonian villages and are not associated with organized UNHCR supported camps. IMC is working toward the goals of improving access to quality health care for female host community and refugee victims of violence, as well as educating the community in efforts to reduce stigma and discrimination against these victims of violence.

Currently, IMC Djohong has a Sexual and Gender-Based Violence (SGBV) team that provides medical and basic psychiatric support to women and men who have survived rape and other forms of sexual and non-sexual violence. This team travels daily to villages in Djohong District and conducts basic sexual health education, and then speaks confidentially to women and men who have survived GBV (the vast majority of those served are women). Detailed histories are confidentially recorded from each client. Those who have survived sexual assault are given treatment for STIs and tested for HIV. Those who test HIV positive are sent to a hospital in Ngoundere, a town several hours away by car, for access to anti-retroviral therapy if needed. As of March 2010, 54 women have tested positive for HIV (out of 99 tested), and 20 victims of sexual violence are being treated for HIV as a result. The SGBV team returns on a regular basis to provide ongoing, basic psychological support.

Recently, IMC Djohong opened a “counseling room” at Djohong Hospital. This inpatient ward has three beds, located directly adjacent to three antenatal care beds to protect confidentiality. Women who are suffering from severe depression or PTSD as a result of rape may stay in this inpatient ward for intensive psychological care and observation. The IMC GBV program employs two trained psychologists who provide care to these women. All victims of sexual violence receive, on average, three counseling sessions with a psychologist or trained IMC GBV staff.

With the help of several Cameroonian government initiatives, security in the Djohong District remains high. Until 2008, the major security threat from the CAR often took the form of regional road bandits (*coupeurs de route*) who attacked travelers, raped women, and stole possessions. The most effective initiative has proven to be the formation of a group of undercover Cameroonian soldiers called the Rapid Intervention Brigade (RIB), who arrest or kill these road bandits. The road bandits have all but disappeared in Cameroon, but remain the driving force behind the flight of refugees from CAR. There are, however, several reports in March 2010 of rape by *coupeurs de route,* rebels, or soldiers on Cameroonian soil in the last 6 months, a finding that merits further investigation in collaboration with local authorities.

Findings of this Evaluation

This March 2010 study is the second phase of an evaluation of the health of refugees and the host community with particular focus on gender-based and domestic violence. It was conducted by means of a population-based survey done using cluster sampling methodology. Local staff conducted interviews in local native languages. The findings of this follow-up to the June 2009 study are summarized below.

A total of 600 women from both Cameroonian and refugee households were surveyed over an eight-day period. Based on the March 2010 quantitative assessment, approximately 32% (37% June 2009) of the population in Djohong District is refugee, while the other 67% (63% June 2009) is native to Cameroon. This sample included 392 Cameroonians, 197 refugees, and 7 "other," 3 who did not provide consent to participate in the survey, and one who was accidentally included but is 17 years old (this data was not included). The sample closely matches the population distribution based on census data from the local government and UNCHR (69% host population, 31% refugee based on census data). UNCHR data in January 2010 shows 7,486 additional refugees in Djohong District versus the 2008 data. Discussions with the UNCHR office in Bertoua and IMC staff suggest that this dramatic increase in registered refugees in the region is a result of more thorough registration drives—a finding supported by both the June 2009 and March 2010 surveys.

The rate of sexual violence in Djohong District has more than doubled since the June 2009 survey. Lifetime prevalence of sexual violence among the Djohong commune population sampled is now 35% (n=209). The June survey found a lifetime prevalence of 16%. Though this dramatic increase is alarming, it very likely resulted from the extensive, region-wide education campaign on sexual violence by the IMC SGBV team throughout Djohong District. According to local key informants, *coupeurs de route* activity remains rare, and there are no new reports of massive numbers of rape—therefore it is unlikely that this increase in prevalence of rape is due to an actual increase. Most likely, this increase in prevalence is due to an increase in women reporting rape to surveyors. As a result of this education campaign, it is likely that women feel more comfortable discussing sexual violence than they did in June 2009.

Sixty-four percent of all women who have been raped in Djohong were raped by their husbands. Based on this, we can estimate that 22% of all women who live in Djohong District have been raped by their husbands.

The percentage of Cameroonian women reporting rape by a partner or spouse remained stable and very high between the two surveys (78% in June 2009 versus 71% in March 2010). The percentage of refugee women reporting rape by a partner or spouse increased by 15% (37% June 2009, 52% March 2010). Though it is unclear what accounts for this increase among refugees, 60% of refugees who reported rape by their husbands were raped in the past six months.

The percentage of Cameroonian women who reported rape by a member of the community nearly doubled between June 2009 and March 2010 (9.8% June 2009, 18.8% March 2010,). The percentage of refugee women reporting rape by a member of the community increased (2.2% June 2009, 11.7% March 2010).

The percentage of refugee women reporting rape by soldiers, rebels, or *coupeurs de route* decreased slightly, dropping from 59% to 49%, however the absolute number of rapes by these perpetrators increased among both refugees and Cameroonians. Thus, this decrease in percentages is due to increased reporting of rape by other types of perpetrators.

Forty percent (17/43 total) of those raped by *coupeurs de route*/soldiers/rebels were raped in the last 6 months. All of these women were recent arrivals from CAR, however 8 confirmed in a different survey item that their rape had occurred in Cameroon (19%).

Local officials report only rare *coupeurs de route* activity in Djohong District. However, these results suggest that in the past 6 months, multiple rapes by soldiers/rebels and *coupeurs de route* have occurred on Cameroonian soil. This concerning finding warrants discussion with local authorities and an investigation into ongoing activity along the border to determine whether these events may herald a return to violence in the region. Additionally, the upcoming election in CAR may lead to a further increase in rebel/soldier and *coupeurs de route* activity in Djohong District.

Thirty-nine percent of women who report rape in their lifetimes were raped in the last 6 months. This percentage is similar for both Cameroonians and refugees (38.3% Cameroonian, 39% refugee). **Thus, we can conclude that rape is an ongoing problem in Djohong District.** Refugees were asked if they had been assaulted before leaving CAR, en route to Cameroon, or after arriving in Cameroon. Approximately 56% of refugees were sexually assaulted in CAR, prior to arrival, and 5% were assaulted en route to Cameroon. These percentages are similar to those from June 2009. When refugees were asked how secure they feel since arriving in Cameroon, 92% said they felt much more secure since their arrival. Still, 38% of refugees who have been sexually assaulted were assaulted *after* they had arrived in Cameroon.

The HHI research team conducted an analysis of factors associated with higher rates of sexual and non-sexual violence during the past 6 months only. **This analysis found that women with higher income and those who are able to do math have far lower rates of sexual violence in the past 6 months.** Someone who cannot do math had a 7.7 times greater odds of being a victim of sexual violence in the past 6 months. Though this is just a correlation and cannot identify a causal link, this may mean that education and income generating activities for women in Djohong District will lead to lower rates of sexual and non-sexual violence over the coming years.

Of the 209 women in the sample who had been assaulted, only 27 (8 Cameroonian, 19 refugee) reported their sexual assault. Twelve of these women reported that something was done about their rape, including 4 who said the man paid damages (usually livestock) to her family, 4 said she was forced to marry the perpetrator as a result, and only 3 perpetrators were put in jail. **In other words, only one percent of reported rapes in this survey resulted in imprisonment for the perpetrator.**

In stark contrast, when asked if other women would report rape or sexual assault to the local authorities, 75% of women believed that other women would report sexual violence. This percentage was 61% in June 2009. This increase is a direct result of education campaigns by the IMC team, and a strong sign of success of this program—unfortunately it does not appear these education campaigns have changed behavior of women in the community yet. The assessment team recommends that the IMC Djohong GBV program expand to provide legal support to encourage reporting and legal prosecution of rape.

The *lifetime* prevalence of non-sexual violence in June 2009 was 40%. The March 2010 survey found that 31% of women in Djohong experienced non-sexual violence *in the last 6 months.* The percentage of respondents with access to counseling services has increased (20% March 2010, 15%, June 2009). This is likely a result of an expansion of GBV counseling activities in Djohong District. There is still, however, a large unmet need for mental health services in Djohong District.

Cameroonians (86%) and refugees (91%) most often cited a lack of funds as the reason they were unable to obtain health care. Ten percent more refugees cited this reason in March 2010 than in June 2009. Although registered refugees are provided with certain medications by UNCHR and IMC free of charge, not all medications are free, and those that are free are not always available. Additionally, refugees are not provided with money to pay for transportation to the hospital, food while in the hospital and a place family to stay with them during their hospitalization. Thus refugees with UNHCR cards often still must pay a substantial amount of money in order to obtain health care.

Marriage at an early age remains the norm in Djohong District. The mean age of marriage for women in Djohong is 14.9 (14.7 refugees, 14.9 Cameroonian). This is not significantly different than what was found in June 2009. In Djohong District, early marriage is thought to prevent sexual promiscuity and teenage pregnancy but results in lower rates of school attendance and higher rates of complicated, teenage pregnancies. Working to support girls

in delaying sexual activity and to stay in school could help prevent some early marriages. Also, alternative training programs for young women in sewing and crafts may give them some opportunity to generate income for their families.

Mean daily income for households in the region is 1065 CFA (2.18 USD), however household income differs considerably between those native to Cameroon and for refugees. Mean daily income for Cameroonian households is 1173 CFA (2.40 USD), while mean daily income for a refugee household in Djohong District is 842 CFA (1.73 USD). Mean income fell slightly for Cameroonians and rose slightly for refugees between June 2009 and March 2010. Eighty-three percent of Cameroonians and 82% of refugees have access to a farm or garden for household use. However, many more Cameroonians (88%) than refugees (68%) own land. This trend was the same during the last assessment; however, more refugees claim to own land in March 2010 than in June 2009.

Food scarcity remains a significant problem in Djohong District, though the situation seems to have improved in the past 8 months. Women heads of household in the region eat, on average, 2.5 meals per day (2.2 in June 2009). Twenty-five percent of Cameroonian women and 30% of refugee women responded that they or their families had gone without food during the last month, which is significantly decreased from 8 months ago when 36% of the host population and 63% of refugees went without food at least one day during the last month. This dramatic decrease for refugees may be due to increased registration, making these refugees eligible for World Food Program (WFP) food distributions. The increase in WFP food rations throughout the District has likely increased the availability of food for all residents of the region.

Residents of Djohong District use a variety of water sources. Refugees get water from protected wells 56% of the time, while Cameroonians get water 47% of the time from moving bodies of water, 35% from a protected well and 18% of the time from an unprotected well. This is different from 8 months ago when Cameroonians got water from protected wells 40% of the time, and refugees obtained water from protected wells only 22% of the time. The advantage of a protected well is that they are sealed and therefore not prone to contamination with pathogens that may cause diarrheal diseases. This difference in water source over the past 8 months suggests that agencies tasked with improving living conditions for the population may have focused on refugee populations as opposed to the entire population as a whole. The assessment team recommends that protected wells be placed in both host and refugee communities in order to prevent tensions in the local population.

The household survey included several questions to assess community integration and support. In general, these questions indicated that refugees were well integrated into the community and plan to stay where they have settled. In particular, refugees were somewhat more likely than Cameroonians to respond “yes” to questions asking if they and their children are likely to settle permanently in their current village. The percentage of refugees who said yes to these questions also increased over the past 8 months, suggesting

that refugees in Cameroon still plan to live there permanently. However, as in June 2009, Cameroonians appear to have more support and resources in the community than refugees.

Key Recommendations:

- *Recommendation:* **An expansion of the current SGBV program is strongly recommended.** The number of women who admit to sexual violence in their lifetimes has doubled since the June 2009 study. This increase is due at least in part to an increased comfort level discussing sexual violence among women in Djohong as a result of the IMC GBV program. According to the March 2010 study, thirty-five percent of women in Djohong District have experienced sexual violence in their lifetimes, and 31% of women in Djohong have been beaten by their husbands in the past 6 months.

- *Recommendation:* The results of the March 2010 survey show that women who have higher incomes and better education (who are able to do math) have lower rates of sexual and non-sexual violence. Interventions that keep young girls in school and teach women ways to generate income may lead to a decrease in incidence of GBV over the long term. **The SGBV program should expand its focus on livelihood and economic development for the women of Djohong,** including expansion of the school reintegration program for school-age victims of violence, vocational training for women in Djohong, and the construction of a shelter for victims of violence to enable women to leave dangerous households.

- *Recommendation:* Both the June 2009 and March 2010 studies confirm that husbands, members of the community or friends are the most common perpetrators of rape in Djohong District. Over 1 out of every 5 women in Djohong has been raped by her husband. **The SGBV program must create a community education program that focuses on religious leaders, schools, and community leaders, and identifies male "champions" to speak out on violence against women.** Aims of this program would include 1) reduce stigma against women who have been raped 2) combat permissive community attitudes that rape and non-sexual violence against women is "normal."

  An ongoing monitoring and evaluation program should include anonymous surveys to monitor the attitudes of men in the community, officials (*gendarearie*, *lamido*, etc), and community leaders toward sexual and non-sexual violence.

- *Recommendation:* Given the high rate of sexual and non-sexual violence perpetrated by men who are members of the community and husbands, the

assessment team strongly recommends an education program targeting men and boys in Djohong district on SGBV.

- *Recommendation:* The SGBV program in Djohong currently has a lawyer on-staff serving as a counselor and can expand to advocate for women who are victims of rape or non-sexual violence who are interested in filing criminal charges. The vast majority of survivors in Djohong do not report rape. When rape is reported, the perpetrator rarely faces legal consequences. **The IMC GBV program should support and encourage prosecution of rapists in Djohong District as a part of their ongoing GBV program; successful prosecutions of rapists and batterers will help deter future crimes and protect women throughout the region.**

- *Recommendation:* According to Cameroonian national laws, a husband cannot legally rape his wife. [1] **IMC is in a unique position to advocate on the behalf of hundreds of women who are being raped regularly by their husbands.** Of the women who admitted to suffering rape in the last 6 months, 82% were raped by their husbands.

- *Recommendation:* The percentage of women in Djohong with access to mental health services has increased from 15% in June 2009 to 20% in March 2010, likely as a result of the IMC GBV counseling program expansion [see **Section 8**]. Despite the expansion of the mental health program however, less than one half of women who need mental health services state that they have been able to access it. **Thus, further expansion of the GBV counseling program is recommended.**

- *Recommendation:* As noted in June 2009, a dedicated reproductive health program is needed. To support this program, Djohong hospital's surgical capacity must be built, and a dedicated physician/director is recommended. Additionally, IMC should consider training community health workers and TBAs to provide family planning services and education.

[1] http://sosviolcameroun.org/librairie/Constraints_in_Seeking_Justice_New2.pdf

1. Introduction

1.1 The Refugee Situation in Djohong District

Figure 1. Map of Cameroon

Since early 2006, insecurity in the Central African Republic (CAR) has driven more than 80,000 refugees, largely of the Mbororo tribe, across the country's western border into Cameroon. Perceived as wealthy pastoralists in their home country, the Mbororo became targets of armed bandits *(coupeurs de route)* who stole their livestock or kidnapped their family members and forced them to pay large ransoms from their livestock assets. Crossing the border bereft of possessions, the refugee population has been considerably dependent on the international aid community and the host population. Aid agencies, however, have not been able to provide full support to the refugee population as refugees have integrated into the host population and settled in peripheral areas of towns and villages across a broad remote area of Eastern Cameroon. Ongoing concerns of this displaced population include access to shelter, food, sustainable livelihoods, and health care.

Until the most recent UN High Commissioner for Refugees (UNHCR) registration in January 2010, segments of the refugee population had been left off the registration rolls and out of the collective sight of the humanitarian aid community. Updated population data collected by UNHCR demonstrate an increase of 7,486 refugees in the Djohong area since the last census. A significant number of those new registrations settled in the town of Ngoui, several kilometers from the border with the CAR. However, in conversations with UNHCR staff, it

appears that this increase in numbers should not be attributed to a large influx of new refugees to the area, but instead to the UNHCR registration process which appears to have caught up with the population that already migrated to the area.

1.2 IMC Activities in Djohong District

Refugees from the continuing migration have settled in border settlements of the Adamaoua Region, Mbéré Division, Djohong District—a significant distance from the UNHCR offices in Bertoua, East Region. The international NGO International Medical Corps (IMC) is the only NGO (local or otherwise) currently working in this area. With funding from the UN Development Fund for Women (UNIFEM) and its Trust Fund in Support of Actions to Eliminate Violence Against Women, IMC launched its "Critical Health Support for Survivors of Gender-based Violence (GBV) Amongst Central African Republic Refugees in Eastern Cameroon" project with the specific goals of 1) improving access to quality GBV and reproductive health services for female refugees and host community victims of violence in the Djohong District and 2) reducing the stigma and discrimination around GBV and ensuring community participation in GBV prevention activities. The project complements an ongoing emergency primary health care project that uses mobile health clinics. IMC's mobile clinic program provides immunizations, growth monitoring, basic medical treatment, and supplemental feeding. The IMC mobile clinics also make emergency referrals to Djohong Hospital.

Refer to **Section 8** for a description of the IMC GBV program and its development over the past 8 months.

1.3 Security in the region

The major security threat in Djohong District over the last two years has been ongoing attacks by regional road bandits from the CAR, the *coupeurs de route.* The *coupeurs de route* are the primary perpetrators displacing the Mbororo. Generally thought to be militia or ex-soldiers, they are bands of roving outlaws from different tribal and national origins, who attack, beat, and rape villagers they encounter. Typical *coupeurs de route* attacks in CAR involve the killing of husbands and often children in front of their wives and mothers. These women are commonly gang-raped by the soldiers during the attack, often in front of family or community members. While some attacks have been limited to these acts of violence, the *coupeurs de route* are usually also in search of support for their forces in the form of material goods and money.

Since late 2008, the *coupeurs de route* problem in Djohong District has largely resolved due to the Cameroonian government's deployment of the Rapid Intervention Brigade (RIB). The RIB is an Israeli-trained group of elite undercover Cameroonian soldiers who seek out and arrest or kill the *coupeurs de route.* The efforts of the RIB have affected a new sense of security throughout Djohong District, and most locals report that the *coupeurs de route* problem has significantly improved, though occasional incidents do occur. Security is

currently maintained through the presence of two or three undercover RIB soldiers in most villages of notable size in Djohong District, and the local *gendarmerie* forces claim to have reassuring ongoing intelligence of little *coupeurs de route* activity in the region. It should be noted that the insecurity may return to its previous dangerous state if the RIB forces ever withdraw from the region, especially since the *coupeurs de route* remain active across the nearby border with the CAR. A resurgence of *coupeurs de route* activity may also develop as a result of instability associated with upcoming elections in CAR. Local authorities report that there are no current plans for withdrawal of the RIB.

1.4 Objectives of this assessment

IMC asked the Harvard Humanitarian Initiative (HHI), a university-based center that provides population-based research support to humanitarian relief agencies operational in conflict-affected areas, to assist their efforts under the UNIFEM grant. HHI was asked specifically to conduct a population-based assessment of women's health with an emphasis on the prevalence of GBV and domestic violence and its associated societal stigmatization, fears of abandonment and retaliation; the forced marriage of young girls; current reproductive health services; the perceptions of human security and livelihoods; education; household income; and household food security.

Since the refugee population is essentially integrated within the host population and shares the same resources, both populations are targeted in this assessment. This second quantitative assessment was undertaken to understand the impact of IMC's GBV programming and to better elucidate changes in the population with regards to the same variables that were quantified during the first phase (June 2009). It also identifies the needs and gaps in GBV services and prevention in order to guide program development and establish foundational information from which IMC can monitor and evaluate community knowledge, attitudes, and practices around GBV and women's health and livelihood issues.

1.5 Assessment methodology

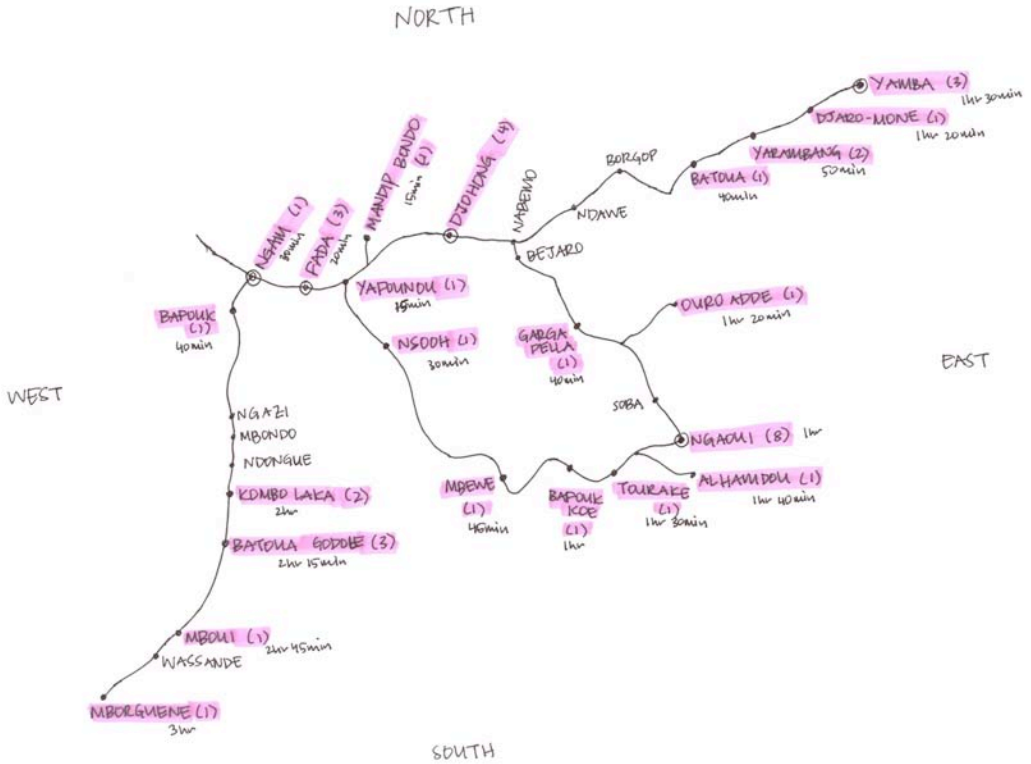
The assessment was done through a quantitative survey as described below. A qualitative assessment was conducted during the initial assessment in June 2009 in order to inform the quantitative tool. HHI assisted IMC in establishing an ongoing monitoring mechanism for GBV programming in Djohong Commune and engaged in capacity-building activities for IMC and local Ministry of Health (MoH) staff. This follow-up evaluation was conducted eight months after the initial assessment to reassess the population and IMC's project outcomes. All studies undertaken by HHI are in accordance with the highest ethical standards for data collection and the protection of respondents' identities and safety and are approved by the Committee on Human Subjects Research of the Harvard School of Public Health.

1.5.1 Quantitative

The quantitative assessment consisted of a two-stage household cluster sample of host and refugee women. The first stage included a random selection of villages, weighted by refugee and host population as provided by UNHCR and local government officials, respectively. Based on an estimated prevalence of domestic violence of 20-30% from previous studies of GBV in Africa, a precision of 0.05, and a design effect of 2.0, we estimated a sample size between 500 and 650. This size assumed a non-response rate of 5%. In order to achieve this, the second stage included 15 randomly selected women (head of households) per cluster for a final sample size of 600 respondents. Since the prevalence of violence and measures of household insecurity outcomes experienced by refugee women were likely to "cluster"— be experienced communally in sampled groups—we opted to sample 15 women per cluster to minimize the effect of homogeneity and lack of variation within clusters (statistically referred to as "design effect").

Clusters were defined as villages. As some communities were disproportionately large, probability proportional to size sampling was used so that women in larger communities had the same chance of being selected as women who live in smaller villages. Since the refugee population does not live in separate camps but rather interspersed among the host villagers, we reasoned that random sampling in each village would result in a sample demographic similar to the population demographic. All villages in Djohong District were included for consideration and selection **(see map below).**

Figure 2. Map of Djohong District



HHI used the World Health Organization's Extended Program on Immunization (EPI) method for randomly choosing respondent households in each village. According to the EPI method, a central location within a cluster is located. A random direction is then chosen by spinning a bottle (or similar method), and households are listed in that direction from the central point to the end of the cluster. One household from those listed in the direction is selected at random using a randomly generated number. Subsequent households are selected by visiting the nearest door. A pre-visit announcement was sent to each community to request the presence of all adult women in the village in their homes on the day of the survey to ease the efficiency of random second stage sampling and minimizing non-response. HHI trained IMC medical and GBV staff, MoH medical staff, and community health workers on the survey instrument and sampling techniques. The sampling frame was implemented by HHI in the field, and each day's data collection was overseen by HHI staff accompanying data collectors on site. Women heads of households were interviewed in the language of their choice, most often Fulfulde, with the assistance of local translators.

1.5.2 Timeline

Due to the short time frame of IMC's cooperative agreement with UNIFEM, the quantitative assessment commenced February 26, 2010 and was completed in less than two weeks. During the three days, HHI consultants trained IMC staff, as well as selected MOH staff and community health workers on the use of the quantitative survey instrument. HHI worked with the IMC site director to discuss the quantitative sampling methodology and establish the sampling frame. During the subsequent 8 days, HHI and IMC conducted the quantitative survey.

1.6 Limitations of this assessment

Time limited the possibility of conducting any additional qualitative focus group discussions (FGDs) with members of the community. However, given that the population in the area has not changed significantly, there was no reason to believe that any further FGDs would provide additional detail or insight into GBV issues in the area. Similar rates of answers on many questions in the quantitative tool confirm this suspicion.

Though data collectors were trained extensively in the administration of the survey tool, it is possible that questions were asked differently and understood differently by each data collector. One data collector, a trained psychologist, discovered significantly more cases of GBV than any other data collector, which is likely a result of her extensive experience in speaking to victims of violence. Another limitation of data collection is the need for translation. In several cases, our data collectors did not speak the local language and had to use a community health worker to translate the survey for them. Though the community health workers were also trained in administration of the survey, this could also have affected the way in which questions were asked. The presence of this additional person could also have reduced women's willingness to speak about sexual violence. Similarly, several data collectors were men. These men were able to uncover many cases of sexual

violence, however many women might have been reticent to divulge personal experiences with violence to men. Finally, women were interviewed in their homes. Despite our best efforts to ensure a private environment, women might have felt uncomfortable honestly answering questions about sexual and non-sexual violence in their homes for fear that their families might hear.

2 Demographics, reproductive health, and mortality

2.1 Basic demographics

As in June 2009, the assessment team surveyed a total of 600 women heads of household. This included 392 Cameroonians, 197 refugees, and 7 "other," and 3 who did not provide consent to participate in the survey[2]. The sample consisted of approximately 67% Cameroonians (63% June 2009) and 32% refugees (37% June 2009), which closely matches the population distribution based on census data from the local government and UNCHR (69% host population, 31% refugee). The survey targeted female head of households over the age of 18. Women surveyed ranged from age 17 to 99. While the mean age of Cameroonian respondents was 34, the mean age of refugee respondents was 35.

This reflects population estimates by UNCHR (January 2010) and projections from the most recent Cameroonian census (2006), and confirms that recent UNCHR efforts to register refugees have effectively enrolled the majority of the local refugee population. UNCHR data in January 2010 shows 7,486 additional refugees in Djohong District versus the 2008 data.

Discussions with the UNCHR office in Bertoua and IMC staff in-country also suggest that this dramatic increase in refugees in the region is not due to a massive influx, but due to more thorough registration drives—a finding supported by both the June 2009 and March 2010 surveys.

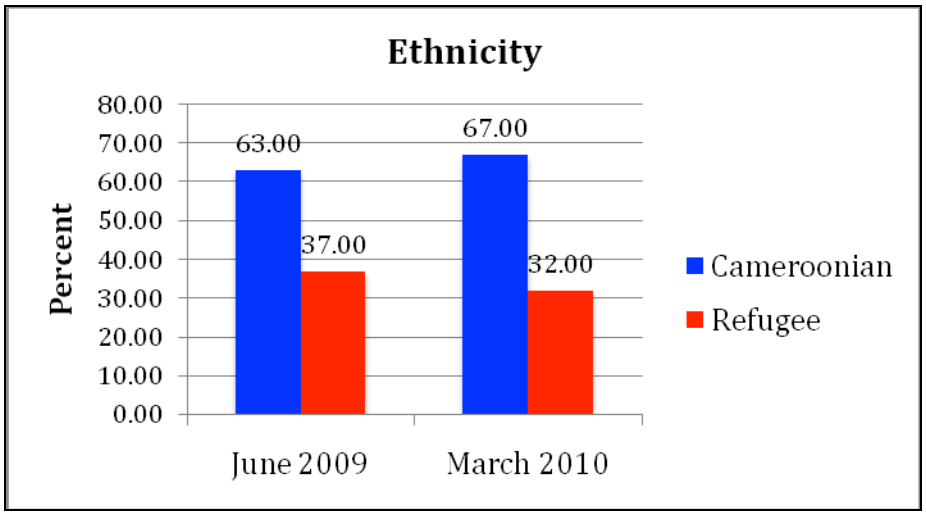


Figure 3. Survey population by ethnicity

During the March 2010 survey, respondents were asked if the size of their household had changed in the past 6 months. Twenty-seven percent of Cameroonians and 28% of refugees

[2] The 8 described as "other" were included in analysis of the entire population but not in analyses broken down by ethnicity. One participant was 17, and thus this data was excluded.

responded that their household size had changed in the past 6 months. Twelve percent of Cameroonian and 10% of refugee homes had at least one household member die in the past 6 months, suggesting similar death rates between both groups. Not surprisingly, slightly more refugee homes stated at least one member of their household moved into their home in the past 6 months (14% refugees, 10% Cameroonian). This further supports the theory that the additional 7,486 refugees registered by UNCHR in January 2010 have been here for some time, and did not recently arrive.

The percentage of homes with new births in the past 6 months was higher for refugees. While 20% of refugee homes had a new birth in the past 6 months, 14% of Cameroonian homes had a new birth in the past 6 months.

2.2 Household Size, Age distribution

Mean household size in Djohong District is 6.11 (6.45 in June 2009) persons; mean household sizes for Cameroonians and refugees are 5.91 (6.33 in June 2009) and 6.59 (6.66 in June 2009) persons respectively. Household size ranged from 1 to 17 in March 2010 (1-25 in June 2009). These results are not significantly different between the two studies. For the purposes of this survey, a household is defined as a group of people living under the same roof who also eat from the same pot.

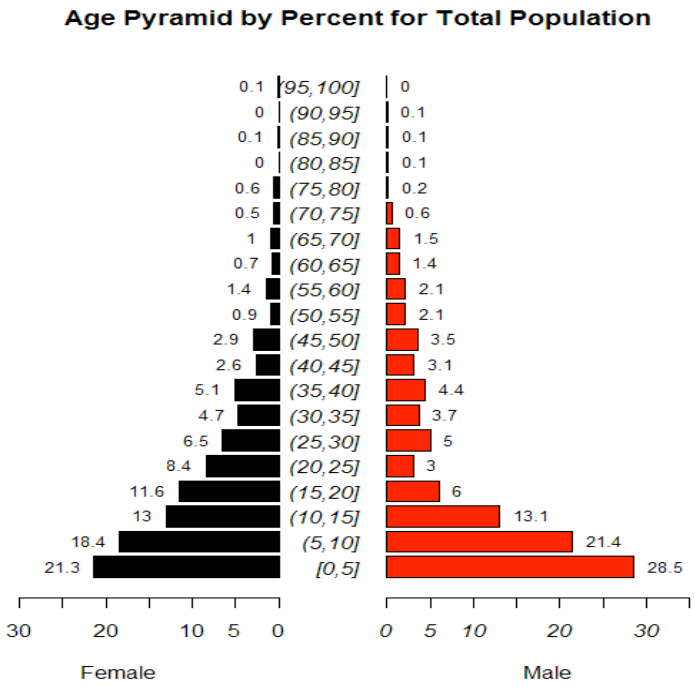


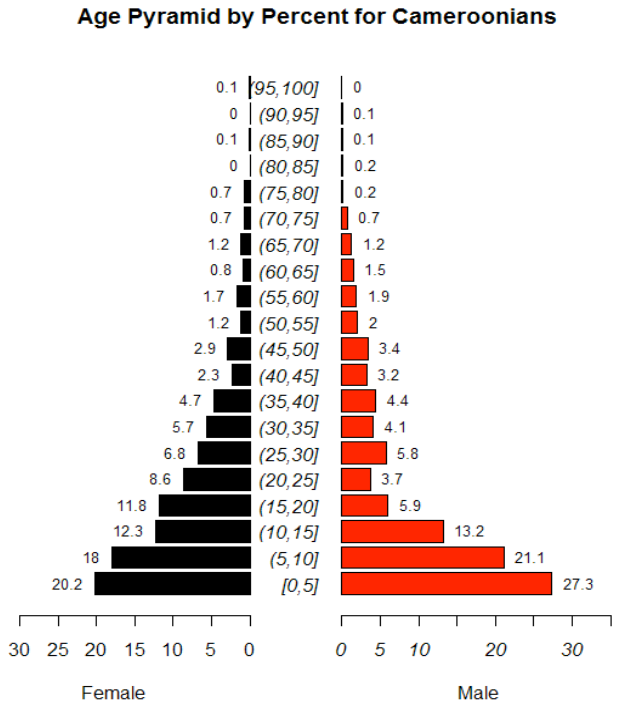
Figure 4. Age breakdown by gender

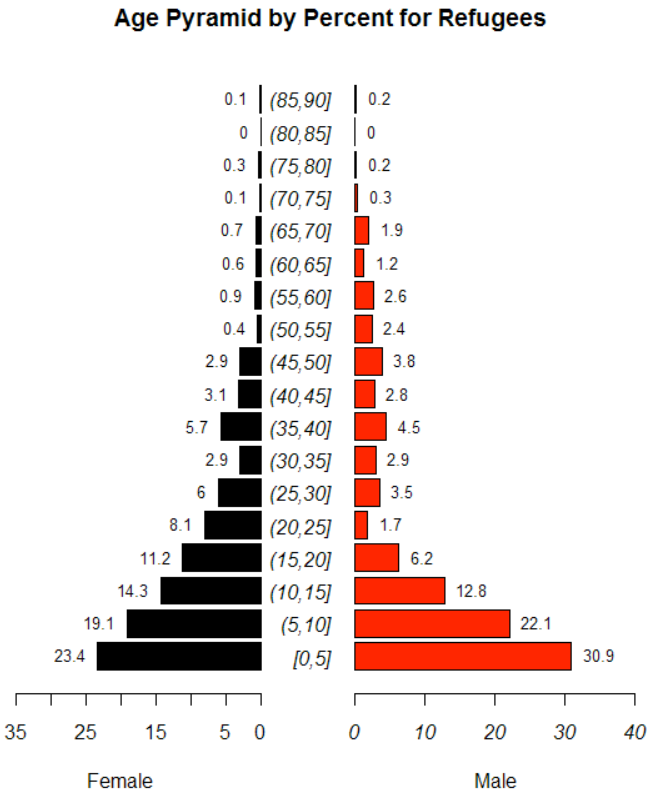
The majority of the population in Djohong District is under 25. Approximately 27% of all refugees and 24% of all Cameroonians are under the age of 5, and 48% of all refugees and

43% of all Cameroonians are below the age of 10. Only 36% of the host population and 32% of the refugee population is between the ages of 18-55. This relatively small group carries the burden of supporting the remainder of the population, both young and ageing. This population distribution is similar to that found in June. While 30% of Cameroonian's are males between the ages of 18 and 55, only 26% of refugees are males 18-55.

As in June 2009, statistical analysis confirms that there are fewer refugee men than Cameroonian men between the ages of 20 and 40 years. The HHI assessment team's focus group with refugee women in June 2009 suggested that young men in CAR are being targeted by soldiers/rebels. The vast majority of women in this group were widows, and had been widowed prior to flight from CAR. Though certainly a focus group in one village is not a representative sample, this finding, along with reports of targeted killings of young men, make this lower number of refugee men in Djohong District in this age group potentially significant, and may be a result of the targeted killing of men of military age. There is a similar, smaller loss of men in this age group among host population men, and the reasons for this are unclear. This lack of working age males among the population may limit the ability of both refugees and Cameroonians to generate income.

Figure 5. Age distribution of host and refugee populations





2.3 Tribal, ethnic, and religious affiliations

The majority of the refugee and host population belong to four major tribes. Approximately 55% of the refugee population in Djohong District is Mbororo, and 14% are Gbaya and 10% are Fulbe. In contrast, the Cameroonian population is 10% Mbororo, while 54% is Gbaya and 21% is Fulbe. Eleven percent of the refugees in Djohong District are Poulo, while only 6% of Cameroonians are Poulo. These numbers are similar to those found during June 2009.

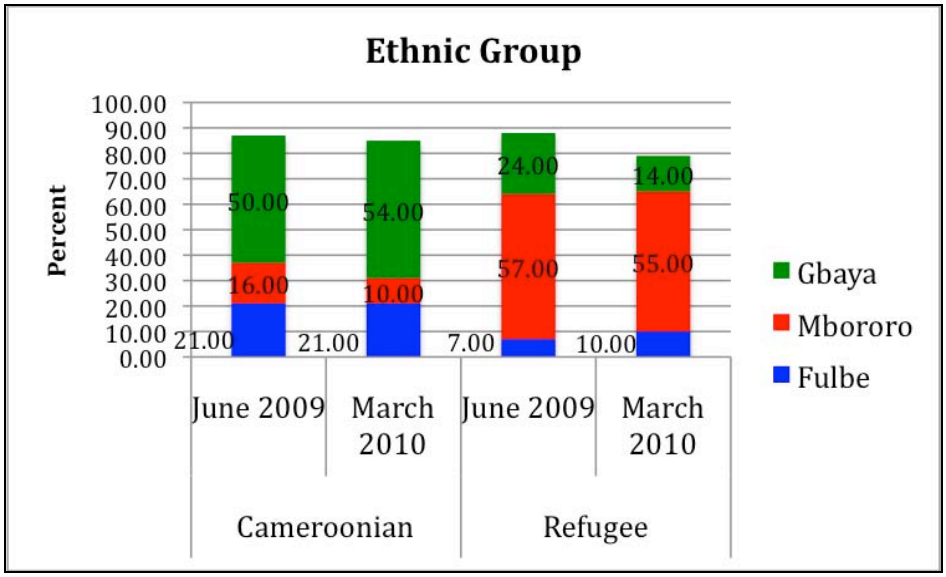


Figure 6. Ethnic groups

The majority of the population in the region is able to communicate in Fulfulde. However, when asked about mother's language, the majority of refugees (51%) cite Mbororo, while a large proportion of Cameroonians cite Gbaya (53%). This reflects the higher proportion of Mbororo in the refugee population, and the higher proportion of Gbaya in the host population.

While 83%of refugees are Muslim, 48% of Cameroonians are Muslim. Christians make up approximately 17% of refugees and 52% of local Cameroonians. These numbers are also similar to those found during June 2009.

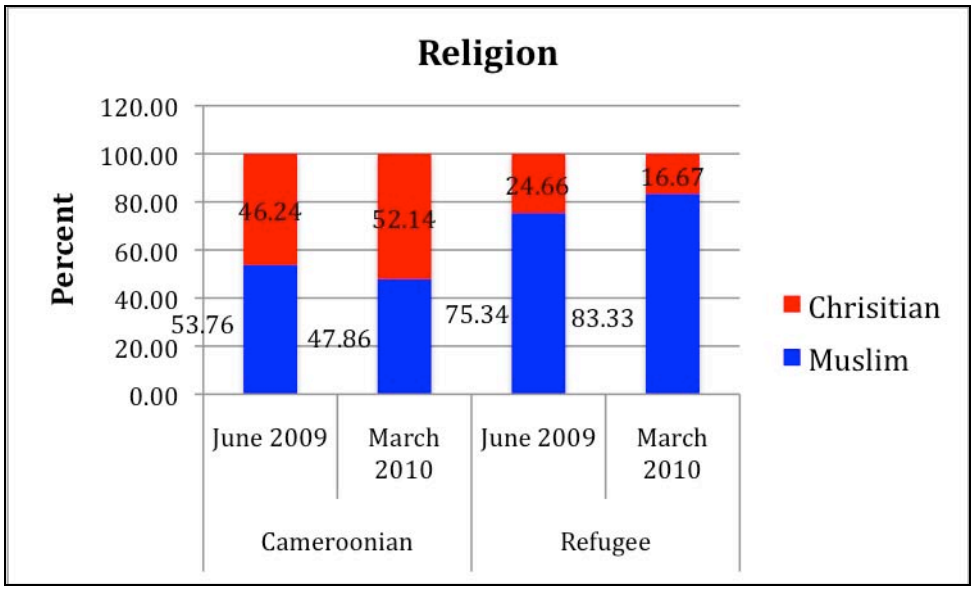


Figure 7. Religion

2.4 Marital status and age at marriage

- ***Recommendation:*** **Early marriage is a common feature of the life of young girls in Djohong, with the mean age of marriage at 14.9 (14.8, June 2009). This fact, and early childbearing, can have serious consequences for the health of young women and keeps young girls out of school. The SGBV program should incorporate programs to address early marriage, and support young women in school and vocational training.**

Approximately 81% of female heads of household in Djohong are married. Eleven percent of the entire female population is widowed. A small percentage is divorced—6% of the local population, and only 4% of the refugee population. Three percent of the husbands of refugee women are missing. These figures are similar to those found in June 2009, and similar between refugee and Cameroonian populations.

Marriage at an early age is the norm in Djohong District. The mean age of marriage for women in Djohong is 14.9 (14.7 refugees, 14.9 Cameroonian), with a range from 10 to 30 years old. This is not significantly different than what was found in June 2009.

In Djohong District, early marriage is thought to prevent sexual promiscuity and teenage pregnancy but results lower rates of school attendance and higher rates of medically complicated teenage pregnancies. Working to support girls in delaying sexual activity and to stay in school could help prevent some early marriages. Also, alternative training programs for young women in sewing and crafts may give them some opportunity to generate income for their families. As noted in **Section 3**, education and higher income are associated with lower rates of sexual and gender-based violence **[see Section 3]**.

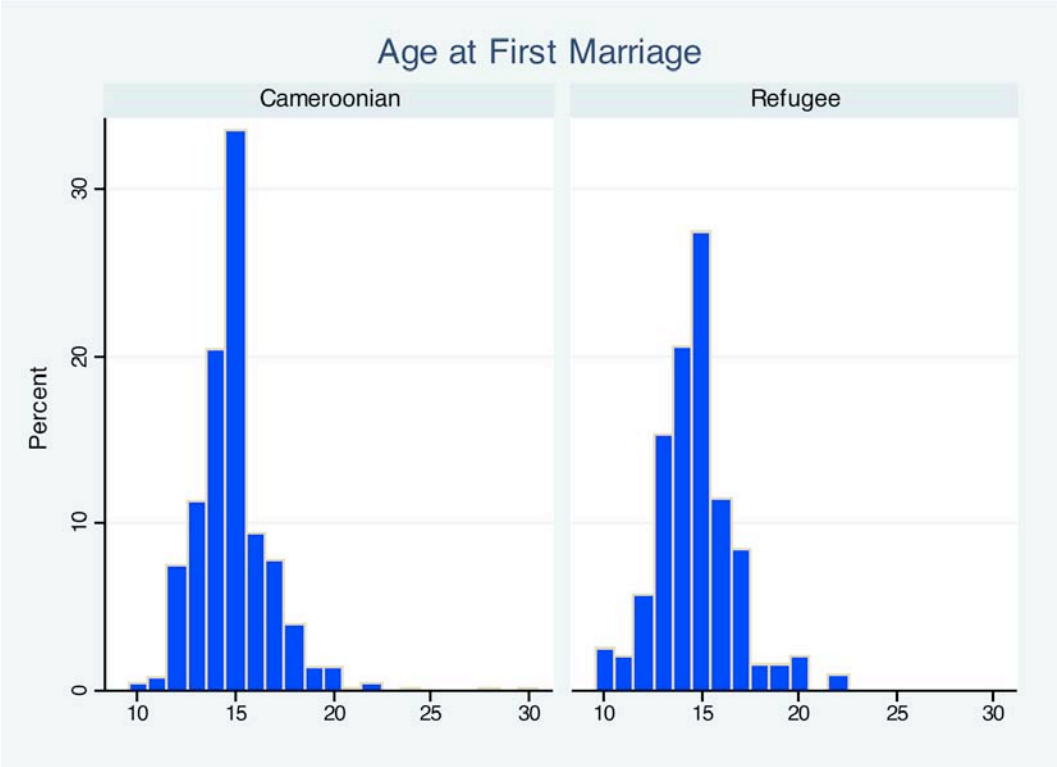


Figure 8. Age at First Marriage

2.5 School attendance

- ***Recommendation:*** **Girls are less likely to attend secondary school than boys. Incentives to support girls attending and completing secondary school may necessary.**

Most families cite funds as the primary limitation in sending their children to school. In order to allow girls to complete secondary school, incentives such as grain or payment of fees for school may be necessary (qualitative data from June 2009 suggests this has worked in the past). This intervention may help prevent also early marriage and multiple early pregnancies. Women who know how to do math and who have higher incomes are far less likely to fall victim to sexual and gender-based violence (see **Section 3**), suggesting that increasing access to education may drop the prevalence of rape and domestic violence over the coming years.

Demographic data collected during the quantitative survey in March 2010 show that 69% of all children between the ages of 6 and 17 attend school (68%, June 2009). This includes 76% of all boys (74%, June 2009) and 63% of girls (61%, June 2009) in this age range. However, older girls are far less likely to attend school than older boys. While it appears that similar numbers of girls and boys attend school between the ages of 6 and 10, only 58% of girls between the ages of 11 and 17 attend school while 77% of boys in the same age range attend school. This is most likely due to the phenomenon of early marriage, with most girls

being married by the age of 15. These findings are not significantly different from those of the June 2009 study.

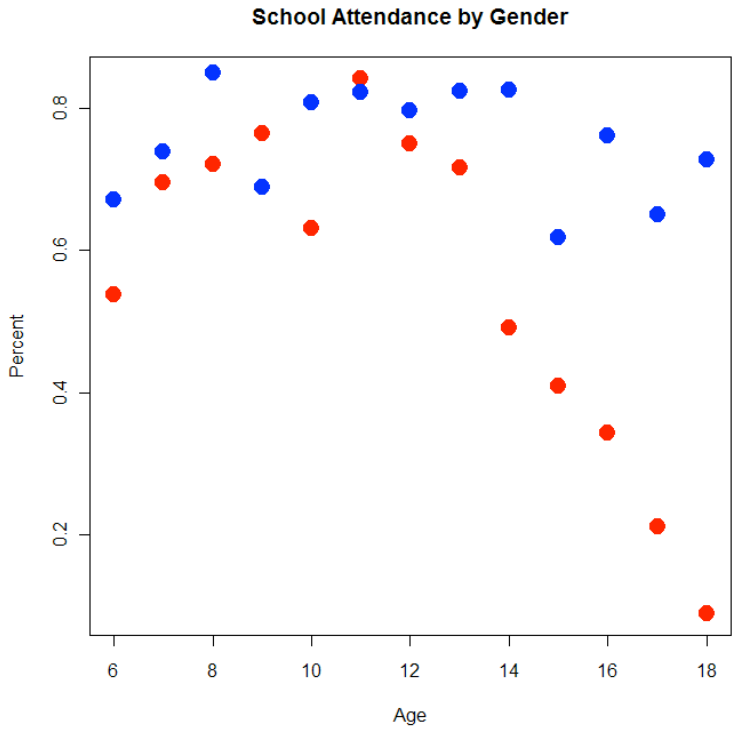


Figure 9. Percentage of children going to school by age (red = female, blue = male)

When asked "Do *all* of your children attend school?" 56% of Cameroonian women and 42% of refugee women said yes, which is a significant increase from the 34 and 29% respectively from the last survey.

2.6 Reproductive health

- ***Recommendation:*** **As noted in June 2009, a dedicated reproductive health program is needed. To support this program, Djohong hospital's surgical capacity must be built, and a dedicated physician/director is recommended. Additionally, IMC should consider training community health workers and TBAs to provide family planning services and education.**

A comprehensive reproductive health program, including medications for emergency obstetric care, contraception/family planning, antenatal/postnatal care, emergency obstetric care, and appropriate staff would need a separate coordinator and substantial funding. Additionally, a reproductive health program needs a local surgical referral center. Djohong District hospital in Djohong town would be the most appropriate location. In order to become surgically ready, at a minimum, this hospital would need consistent supplies of electricity, clean water, capacity for sterilization, medications for emergency obstetric care,

a surgeon, nurse anesthetist, and an ultrasound machine. Also, the operating theater needs to be reconstructed in order to be functional. In order to coordinate all of these changes, a separate reproductive health director would be needed at IMC Djohong.

The mean age at which women in Djohong District have their first child is 16.9 (16.8, June 2009) years, with a range from 12 to 38. The mean age at which Cameroonian women have their first child is 16.8, while the mean age at which refugee women had their first children is 17.0 years old. When asked "How many total pregnancies have you had?", the mean answer is 5.6, with a range from 0 to 15. Most women denied miscarriage, however some had as many as six miscarriages. The mean miscarriage rate per woman in Djohong is 0.6, and is similar for both refugees and Cameroonians. Not surprisingly, early marriage leads to a very high number of live births per woman, with women having as many as 15 live births in this sample. The mean number of live births for Cameroonian and refugee women is about five. This high rate of births occurs in an environment with little or no reproductive health support—the only obstetrician in Djohong District was the director of the IMC GBV program, who has recently left. Though their numbers have grown as a result of IMC trainings, traditional birth attendants (TBAs) have little or no training to deal with complicated deliveries. There is still limited access to family planning services, antenatal care, and emergency obstetric care (see **Section 4.2**). These findings are not significantly different than those found in June 2009.

2.7 Mortality

Below is a graphical representation of causes of mortality among the population in Djohong District in the past 6 months. For refugees, these deaths may have occurred in Djohong District or in CAR if they have arrived recently. Of all deaths in the past 6 months, 6% are attributed to old age (18% June 2009), 30% to fever (20% June 2009), and 46% to "other" causes (43% June 2009). HIV testing facilities are scarce in the region, and it is thought that the majority of those infected do not know. As a result, mortality due to HIV cannot be estimated from these results. These percentages are similar for refugee and Cameroonian populations. Only 1% of household report someone having died as a result of murder.

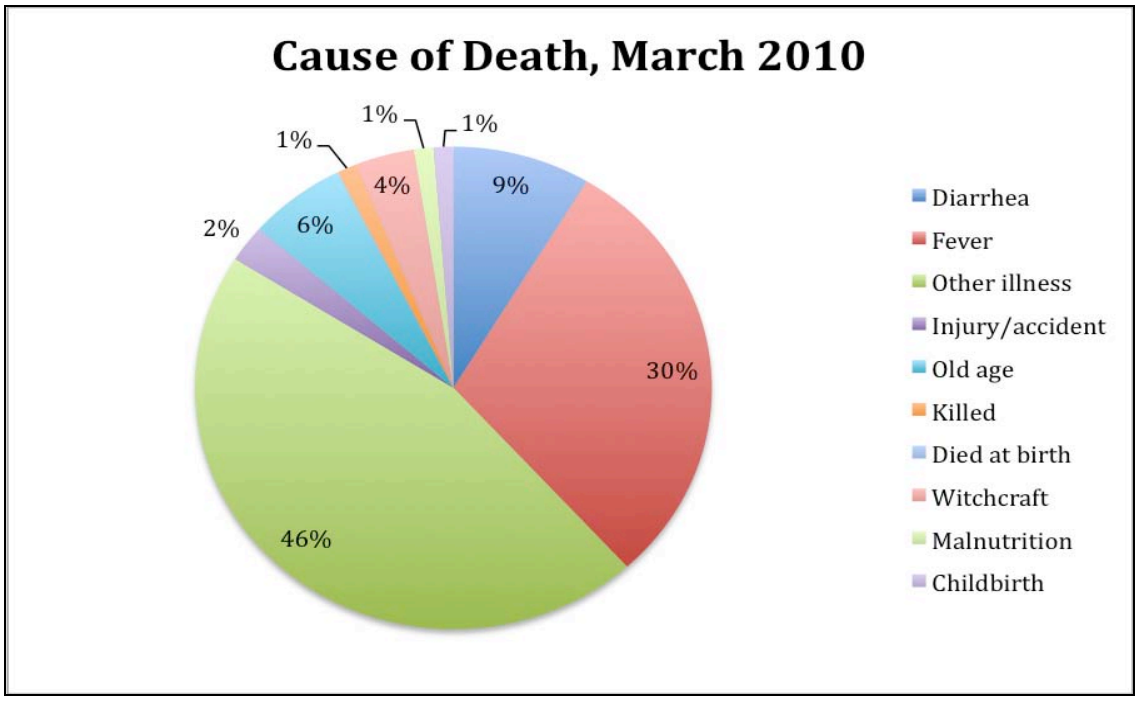


Figure 10. Causes of Death

The 600 households surveyed reported a total of 81 deaths, 48 male and 33 female, many fewer than the 135 deaths reported for the previous 6 months. As the graph below demonstrates, a peak in mortality occurs between the ages of 0-5, and another peak around the age of 25-30 for refugees and between 30-35 for those native to Cameroon. This peak in mortality among those of working age may have implications for a population that depends on agriculture as a means of survival. The reasons for these peaks are unclear.

The crude mortality rate (CMR) for this population, based on this data, is 1.22/10,000 persons/day. Further investigations into the causes of this high mortality rate are needed.

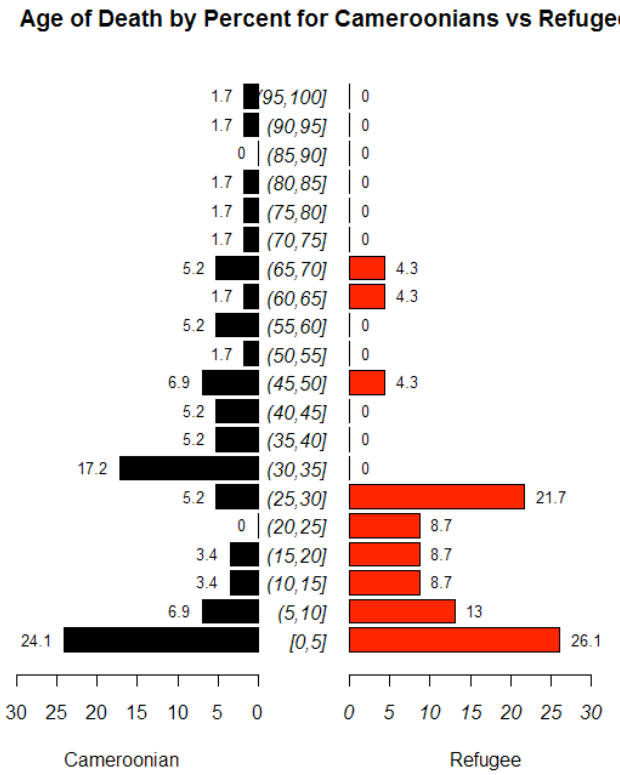


Figure 11. Mortality Pyramid by Percentage

3. Violence and Mental Health

3.1 Sexual Violence

3.1.1 Prevalence

- ***Recommendation:*** **An expansion of the current SGBV program is strongly recommended. The number of women who admit to sexual violence in their lifetimes has <u>doubled</u> since the June 2009 study. This increase is due at least in part to an increased comfort level discussing sexual violence among women in Djohong as a result of the IMC GBV program. According to the March 2010 study, thirty-five percent of women in Djohong District have experienced sexual violence in their lifetimes.**

- ***Recommendation:*** **The results of the March 2010 survey show that women who have higher incomes and better education (who are able to do math) have lower rates of sexual and non-sexual violence. Interventions that keep young girls in school and teach women ways to generate income may lead to a decrease in incidence of GBV over the long term. The SGBV program should expand its focus on livelihood and economic development for the women of Djohong, including expansion of the school reintegration program for school-age victims of violence, vocational training for women in Djohong, and the construction of a shelter for victims of violence to enable women to leave dangerous households.**

The rate of sexual violence in Djohong District has more than doubled since the June 2009 survey. Sexual assault is defined as forced undressing, molestation, or any other non-consensual sexual activity. Lifetime prevalence of sexual violence among the Djohong commune population sampled is 35% (n=209). The June survey found a lifetime prevalence of 16%.

Though this dramatic increase is alarming, it most likely resulted from the extensive, region-wide education campaign on sexual violence by the IMC SGBV team throughout Djohong District. As a result of this education campaign, it is likely that women feel more comfortable discussing and have a better understanding of sexual violence than they did in June 2009—though it is also possible that part of this increase in reported rape is due to an increase in real numbers of rape in the past 6 months.

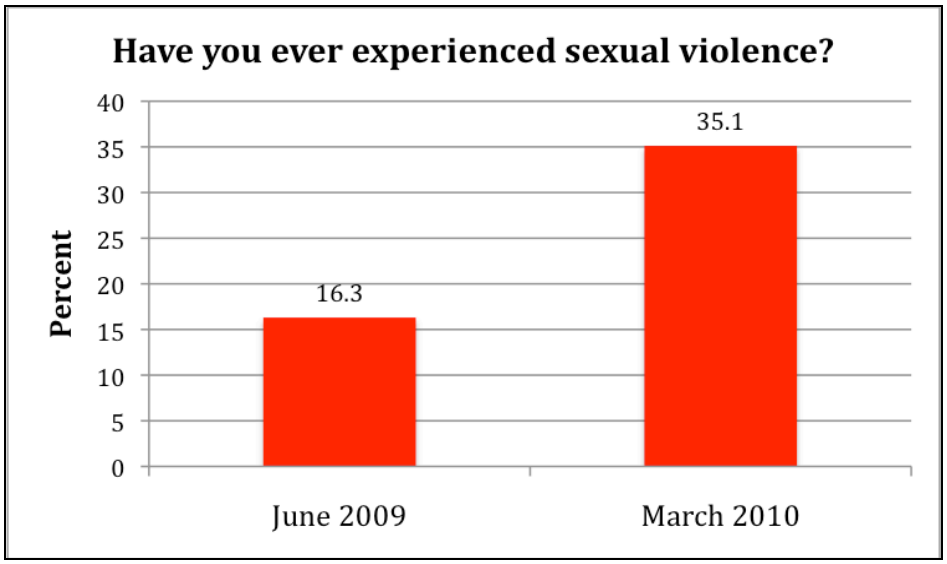


Figure 12. Prevalence of Sexual Violence

The lifetime prevalence of sexual violence among Cameroonians is approximately 32% (n=128), while the prevalence among refugees is estimated at 41% (n=78), according to the March 2010 survey. In June 2009, the lifetime prevalence of sexual violence among Cameroonians was 14% (n=51), while the prevalence among refugees was estimated at 21% (n=46).

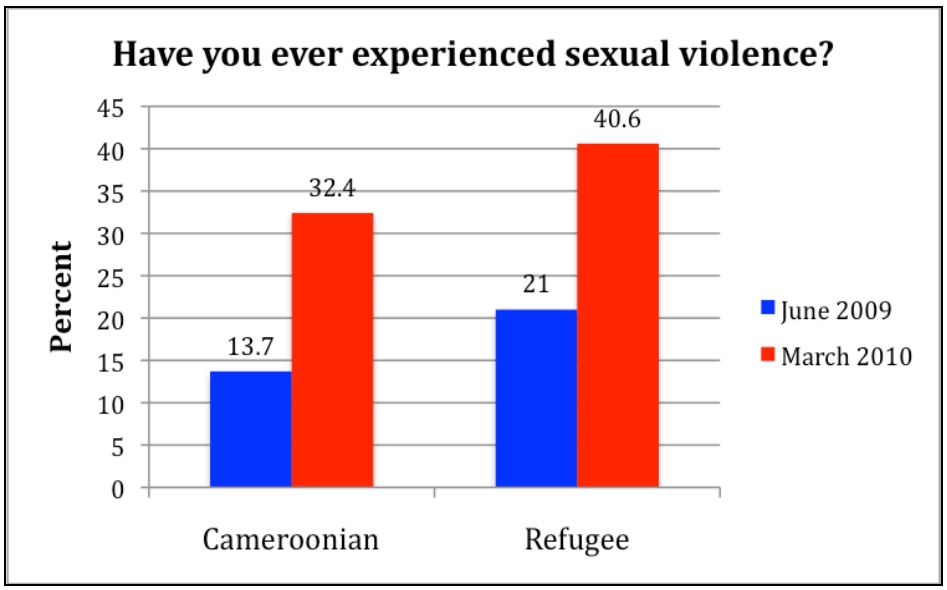


Figure 13. Prevalence of Sexual Violence by Ethnicity

The HHI research team conducted an analysis of factors associated with higher rates of sexual and non-sexual violence during the past 6 months only. The team performed a logistic regression on the entire population with sexual violence in the past 6 months as an outcome, and income, ability to read, ability to do math, and age at first marriage as predictive factors. The regression found that women with higher income and who are able

to do math have *far lower* rates of sexual violence in the past 6 months. Someone who cannot do math had a 7.7 times greater odds of being a victim of sexual violence in the past 6 months. Though this is just a correlation and cannot identify a causal link, this may mean that education and income generating activities for women in Djohong District will lead to lower rates of sexual and non-sexual violence over the coming years.

This correlation is plausible as education and ability to make money may enable women to leave violent households, thus reducing 6-month incidence of sexual and non-sexual violence. Thus, an expansion of current school reinsertion programs, and programs to support young girls remaining in school and an expansion of programs training women in various vocations is warranted.

3.1.2 Patterns of attack

- ***Recommendation:*** **Both the June 2009 and March 2010 studies confirm that husbands, members of the community or friends are the most common perpetrators of rape in Djohong District. Over 1 out of every 5 women in Djohong has been raped by her husband. The SGBV program must create a community education program that focuses on religious leaders, schools, and community leaders, and identifies "champions" to speak out on violence against women. Aims of this program would include 1) reduce stigma against women who have been raped 2) combat permissive community attitudes that rape and non-sexual violence against women is "normal."**

  An ongoing monitoring and evaluation program should include anonymous surveys to monitor the attitudes of men in the community, officials (*gendarmerie*, lamido, etc) and community leaders toward sexual and non-sexual violence.

- ***Recommendation*: This study uncovered several rapes by coupeurs de route or soldiers/rebels within the last 6 months. Though locals report minimal activity by rebels/soldiers/coupeurs de route from CAR since the Rapid Intervention Brigade (RIB) came to Djohong, an investigation into this ongoing violence should be launched. The upcoming election in CAR may lead to a further increase in rebel/soldier and coupeurs de route activity in Djohong District, and warrants discussion with local authorities.**

Survivors of rape were asked about the details of their assault, including perpetrator and location. Refugees were asked if the assault occurred prior to leaving CAR, on their way from CAR to Cameroon, or in Cameroon since their arrival. Survivors were asked about the most recent assault, as many had been assaulted more than once.

Sixty-four percent of all women who have been raped in Djohong were raped by their husbands. Many women commented that rape in marriage is still considered normal.

Based on this study, we can estimate that 22% of all women who live in Djohong District have been raped by their husbands.

Table 1. Perpetrator of sexual violence, June 2009 vs. March 2010

Who was the perpetrator?	Cameroonian % yes (total n)			Refugee % yes (total n)		
	June 2009	March 2010	6m increase (n)	June 2009	March 2010	6m increase (n)
Husband	78.4 (40)	71.1 (91)	51	37.0 (17)	52.0 (40)	23
Member of my family	2.0 (1)	0. (1)	0	2.2 (1)	0 (0)	-1
Friend	3.9 (2)	3.4 (7)	5	2.2 (1)	0 (0)	-1
Member of the community	9.8 (5)	18.8 (24)	19	2.2 (1)	11.7 (9)	8
Soldier/rebel or coupeurs de route*	2.0 (1)	3.9 (5)	4	58.8 (27)	49.4 (38)	11
Unknown	5.9 (3)	2.34 (3)	0	10.9 (5)	3.9 (3)	-2

**Soldiers/rebels were combined with* coupeurs de route *for the purposes of this analysis. This is based on qualitative data that* coupeurs de route *often wear military uniforms, and are often confused with soldiers/rebels—and often are soldiers/rebels from CAR. Highlighted numbers represent perpetrators responsible for the highest number of reported rapes in this community.*

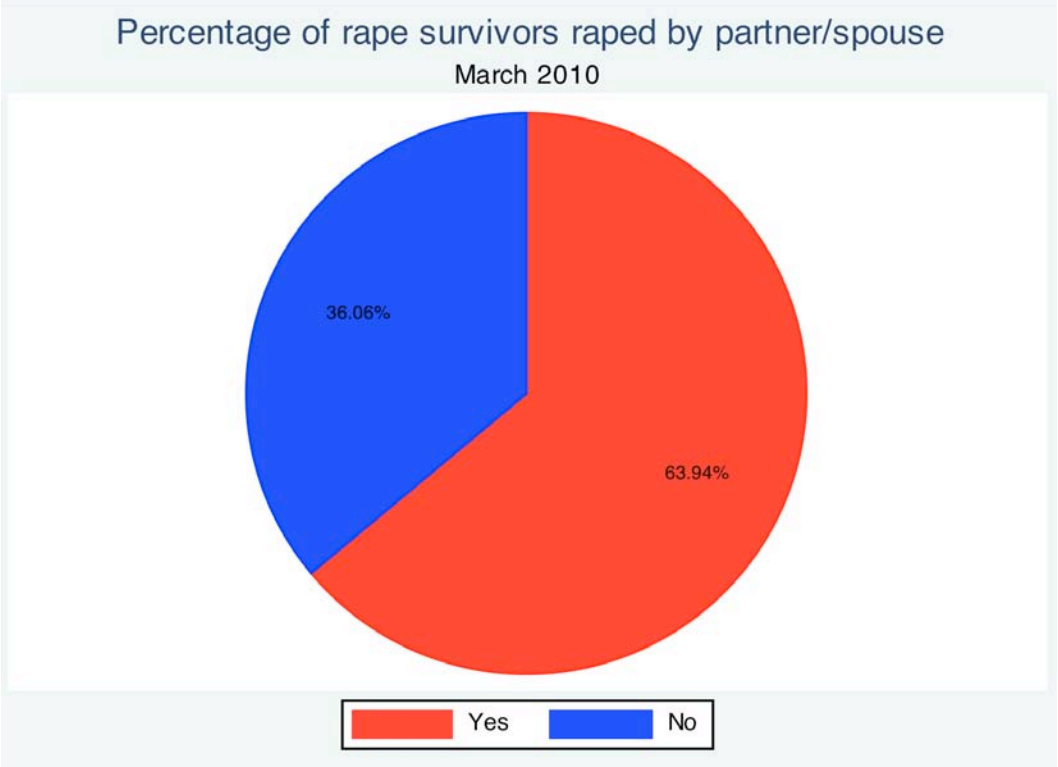


Figure 14. Percentage of Rape by Partner/Spouse

The percentage of Cameroonian women reporting rape by a partner or spouse remained stable and very high between the two surveys (71% March 2010, vs 78% in June 2009).

The percentage of refugee women reporting rape by a partner or spouse increased by 15% (37% June 2009, 52% March 2010). Though it is unclear what accounts for this increase among refugees, 60% of refugees who reported rape by their husbands were raped in the past 6 months.

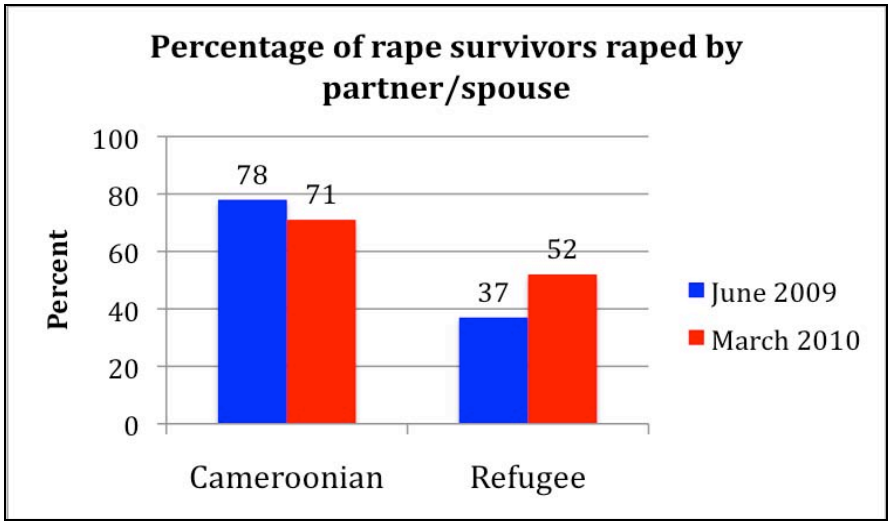


Figure 15. Percentage of Rape by Partner/Spouse by ethnicity

Sixteen percent of women in Djohong District who have been raped were raped by a member of the community.

The percentage of Cameroonian women who reported rape by a member of the community nearly doubled between June 2009 and March 2010 (18.8% March 2010, 9.8% June 2009). The percentage of refugee women reporting rape by a member of the community increased (2.2% June 2009, 11.7% March 2010).

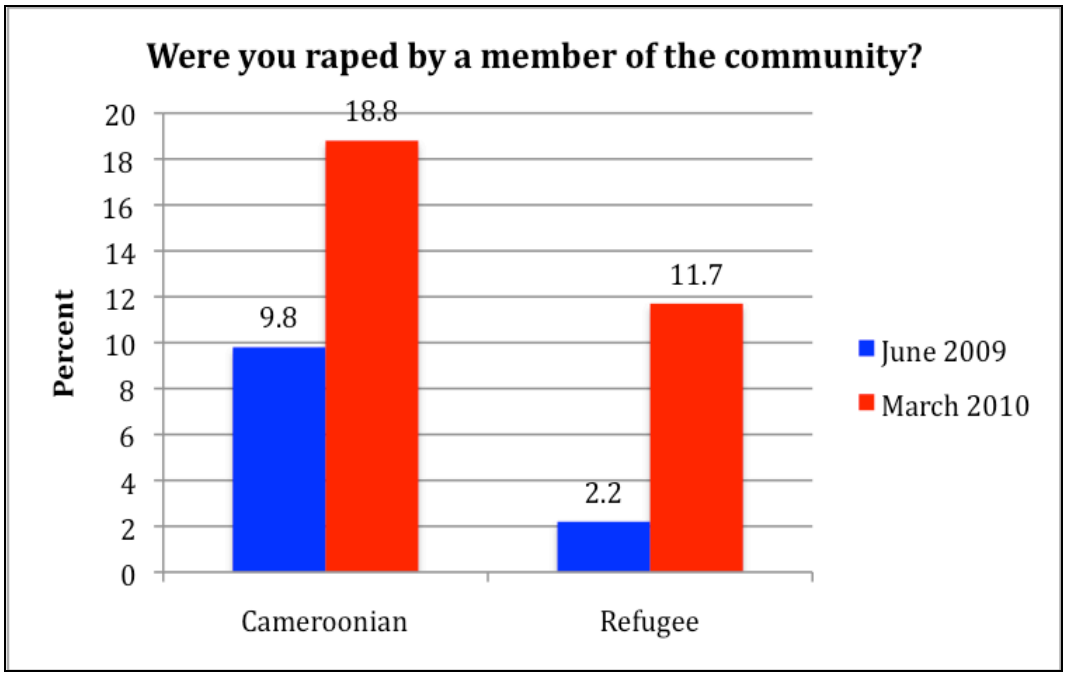


Figure 16. Percentage of rape by a member of the community

The percentage of refugee women reporting rape by soldiers, rebels, or coupeurs de route decreased slightly, dropping from 59% to 49%, however the absolute number of rapes by these perpetrators increased among both refugees and Cameroonians. Thus, this decrease in percentages is due to increased reporting of rape by other types of perpetrators.

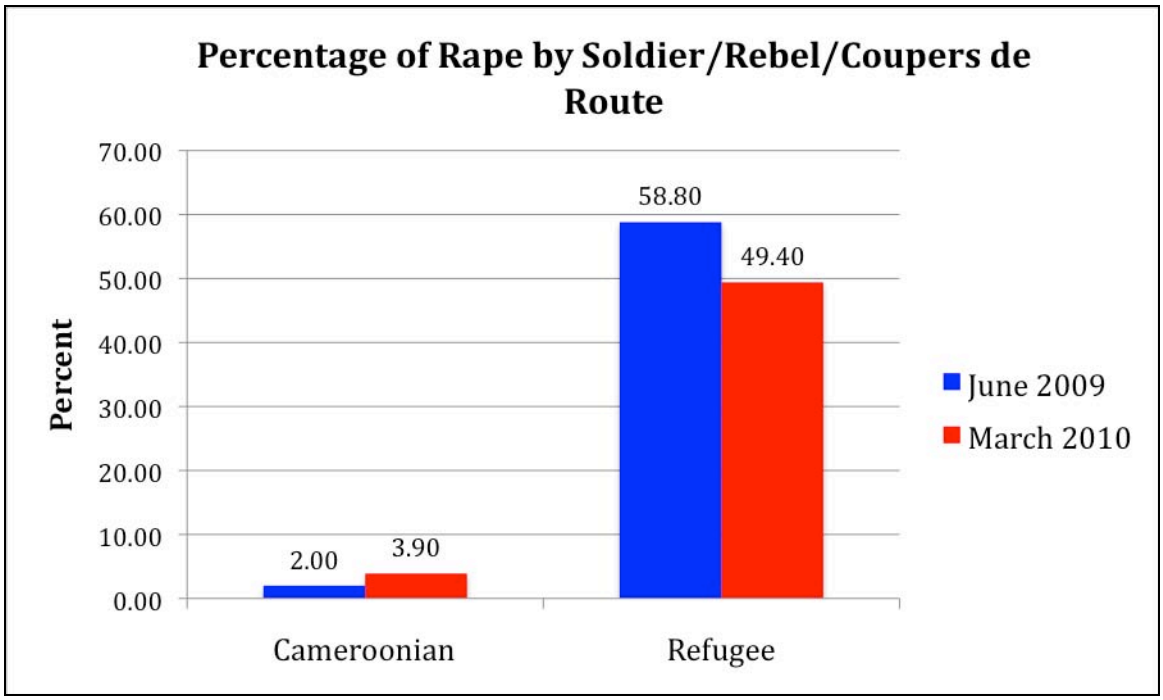


Figure 17. Percentage of rape by soldier/rebel/*coupeurs de route*

During the previous assessment, qualitative data suggested that women are more reluctant to report partner/spouse or community member rape, and more likely to report soldier/rebel/*coupeurs de route* rape. It is likely that, as a result of District wide education on sexual violence by the IMC GBV team, women have become more comfortable discussing rape regardless of the perpetrator's identity—even if it is their husband.

Forty percent (17/43 total) of those raped by *coupeurs de route*/soldiers/rebels were raped in the last 6 months. All of these women were recent arrivals from CAR, however 8 confirmed in a different survey item that their rape had occurred in Cameroon (19%).

Local officials report only rare *coupeurs de route* activity in Djohong District—however these results suggest that in the past 6 months, multiple rapes by soldiers/rebels and *coupeurs de route* have occurred on Cameroonian soil. This concerning finding warrants discussion with local authorities and an investigation into ongoing activity along the border to determine whether these events may herald a return to violence in the region. Additionally, the upcoming election in CAR may lead to a further increase in rebel/soldier and *coupeurs de route* activity in Djohong District, and warrants discussion with local authorities.

Table 2. Rapes That Occurred in Last 6 Months

Perpetrator	Percentage	Total number
Partner/Spouse	49.6	66
Community Member	23.5	8
Soldier/Rebel	60	9
Coupeurs De Route	28.6	8
Unknown	50	3

Thirty-nine percent of women who report rape in their lifetimes were raped in the last 6 months. This percentage is similar for both Cameroonians and refugees (38.3% Cameroonian, 39% refugee). Thus, we can conclude that rape is an ongoing problem in Djohong District.

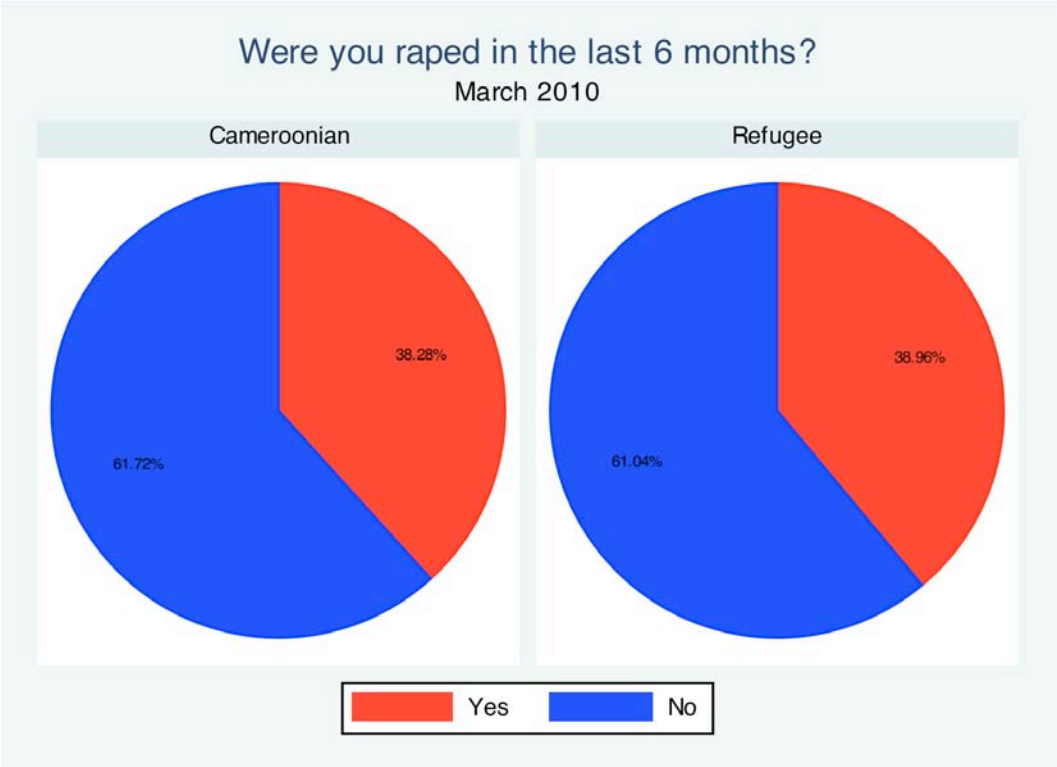


Figure 18. Percentage of rape in Past 6 Months

Fifty percent of women raped by their husbands were raped in the last 6 months, while 24% of those raped by a community member were raped in the last 6 months.

Similar percentages of Cameroonians and refugees report rape by multiple perpetrators in both the June 2009 and March 2010 studies. This reflects the higher percentage of refugees who are raped by soldiers/rebels and *coupeurs de route*.

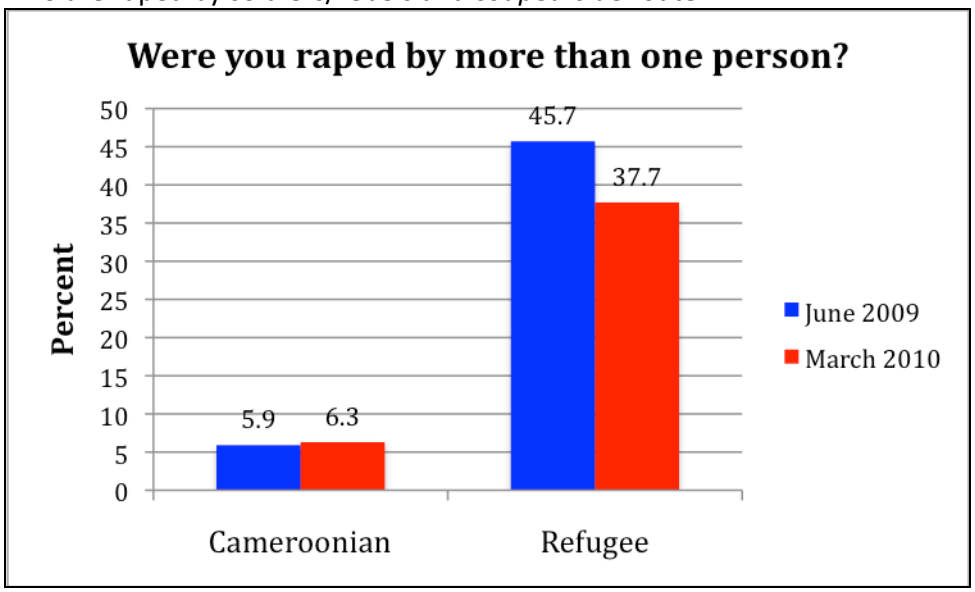


Figure 19. Percentage of rape by multiple perpetrators

As before, the vast majority of women were raped while either sleeping or working in their homes (75% Cameroonian, 78% refugee). This is not surprising given the high percentage of partner/spouse rape in both refugee and host population. A larger percentage of rapes reported in March 2010 occurred while on the way to market/fields (12% vs 4% Cameroonian, 14% vs 13% refugee). This may reflect the larger proportion of Cameroonian women reporting rape by a member of their community.

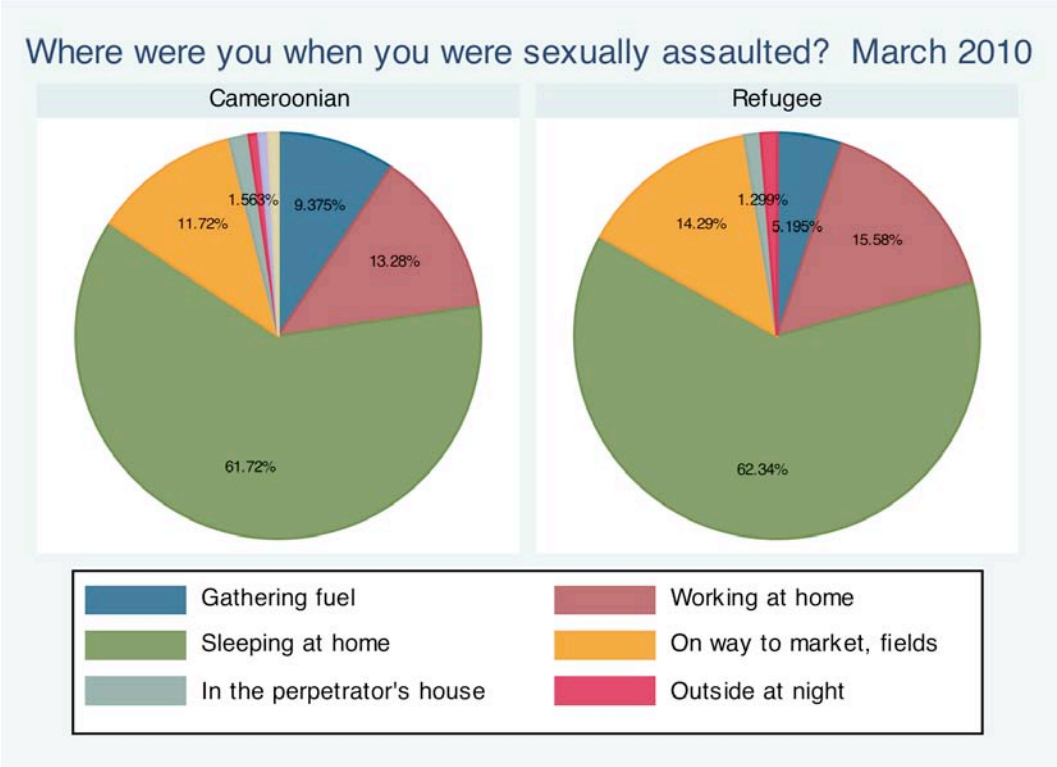


Figure 20. Location of Rape

Refugees were asked if they had been assaulted before leaving CAR, en route to Cameroon, or after arriving in Cameroon. Approximately 56% (n= 4) of refugees were sexually assaulted in CAR, prior to arrival, and 5% (n=4) were assaulted en route to Cameroon. These percentages are similar to those from June 2009. When refugees were asked how secure they feel since arriving in Cameroon, 92% said they felt much more secure since their arrival. Still, 38% (n=30) of refugees who have been sexually assaulted were assaulted *after* they had arrived in Cameroon.

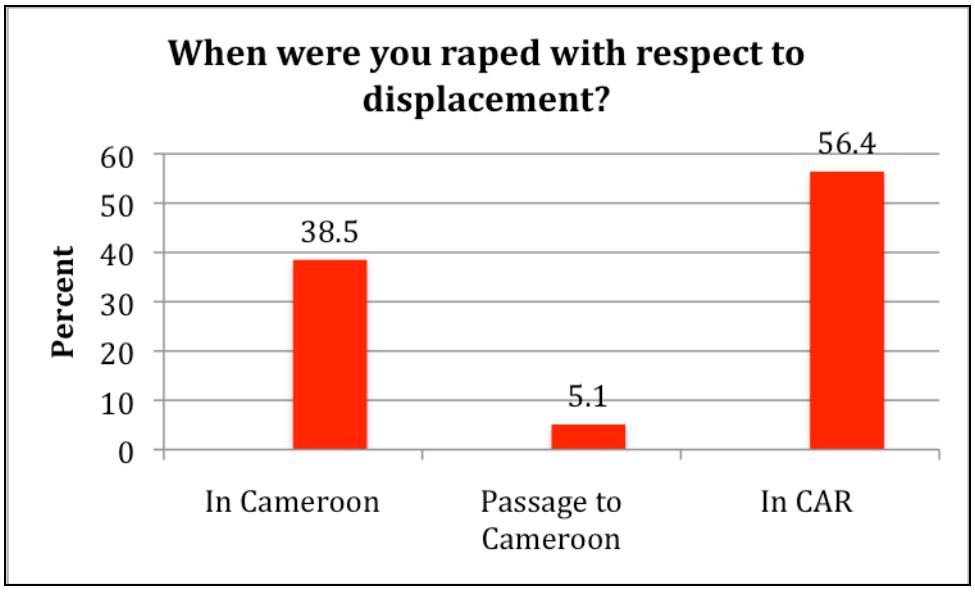


Figure 21. Rape in relation to displacement, refugees

3.1.3 Reporting and consequences

- ***Recommendation:*** **The SGBV program in Djohong currently has a lawyer on-staff serving as a counselor and can expand to advocate for women who are victims of rape or non-sexual violence who are interested in filing criminal charges. The vast majority of survivors in Djohong do not report rape. When rape is reported, the perpetrator rarely faces legal consequences. Successful prosecutions of rapists and batterers will help deter future crimes and protect women throughout the region.**

- ***Recommendation:*** **According to Cameroonian national laws, a husband cannot legally rape his wife.[3] IMC is in a unique position to advocate on the behalf of hundreds of women who are being raped regularly by their husbands. Of the women who admitted to suffering rape in the last 6 months, 82% were raped by their husbands.**

Only 6% of Cameroonians and 25% of refugees (13% combined) reported their rape to local authorities. In June 2009, 12% of women who had been assaulted reported their rapes with similar breakdown by ethnicity. As with the June 2009 study, the differential in reporting between refugees and Cameroonians appears to be due to the different types of assault faced by each community, and perceptions of each type of assault. Focus group discussions and key informant interviews in June 2009 and March 2010 suggest that rape in marriage is largely not considered a crime. In fact, multiple key informants confirm that in Cameroon, a husband still cannot be prosecuted for raping his wife. The underreporting of rape of wives by their husbands is likely due to the fact this is an acceptable practice in marriage in this

[3] http://sosviolcameroun.org/librairie/Constraints_in_Seeking_Justice_New2.pdf

region. One religious leader in Djohong suggested that the Bible forbids that a woman deny her husband sex. The survey team in June 2009 and March 2010 noted that rape on the first night of marriage is the considered normal.

In contrast, women who are raped in war by soldiers are seen as "innocent" victims in their communities. These distinctions between the two groups may explain the reason why more refugee women have reported their assaults to a local authority (local authority can include military, police, *gendarmerie*, village chief, or other authority in a position to act on the information).

In stark contrast, when asked if other women would report rape or sexual assault to the local authorities, 75% of women believed that other women would report sexual violence. This percentage was 61% in June 2009. While this increase is a direct result of education campaigns by the IMC team, and a strong sign of success of this program, it does not appear these education campaigns have changed behavior of women in the community yet.

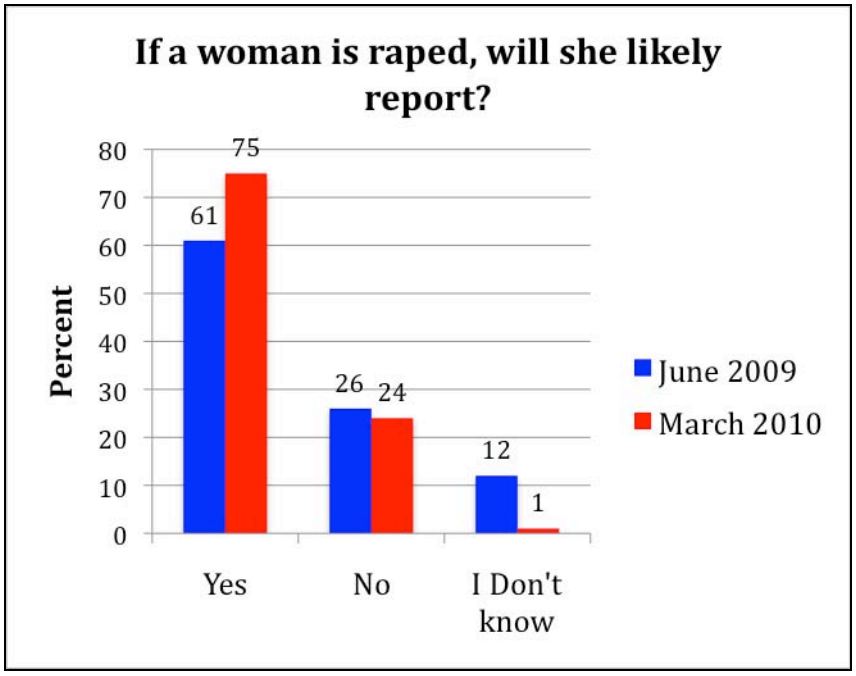


Figure 22. Perception of reporting of rape

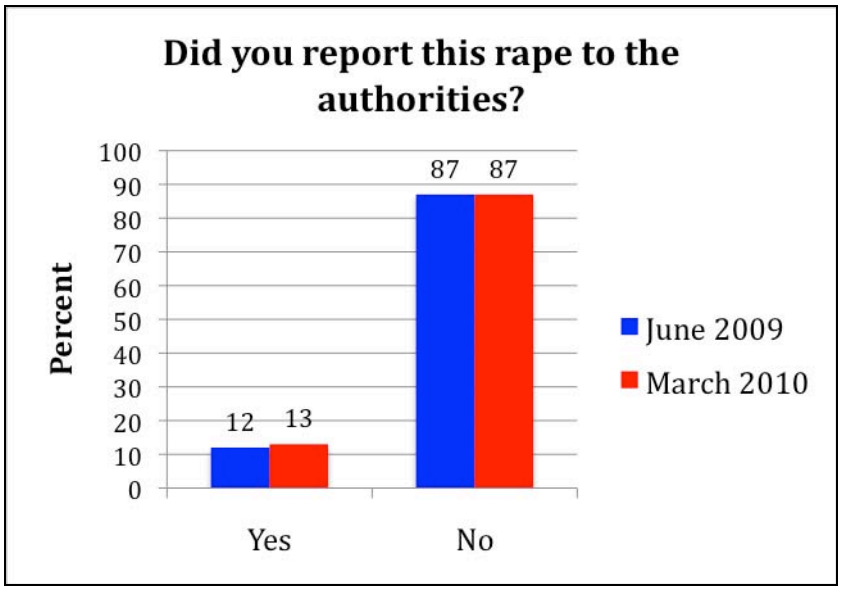


Figure 23. Actual reporting of rape

Women were asked whom, if anyone, they had told about their most recent sexual assault. **Seventy percent of all women who were sexually assaulted had never told anyone about it prior to the interview** (not significantly different from 65% in June 2009). While 52% of refugees stated they'd never told anyone about the assault, 80% of Cameroonian women stated they'd never told anyone about the assault. For the questions in the table below, women may have responded "yes" to more than one question.

In general, women do not discuss rape with authorities—occasionally they will tell family, friends, or their spouse.

Table 3. Knowledge about assault

Who knows about your experience of sexual assault?	**Cameroonian % yes (total n)**				**Refugee % yes (total n)**			
	June 2009		March 2010		June 2009		March 2010	
Nobody (before this interview)	84.3	(43)	79.7	(102)	43.5	(20)	52.0	(40)
Husband/partner	9.8	(5)	3.9	(5)	39.1	(18)	32.5	(25)
Other members of the family	11.8	(6)	14.8	(19)	39.1	(18)	32.5	(25)
Friend	2.0	(1)	7.0	(9)	8.7	(4)	18.8	(14)
Chief of the village	3.9	(2)	7.0	(9)	17.4	(8)	28.6	(22)
Religious leader	2.0	(1)	3.1	(4)	13.0	(6)	18.4	(14)
Health care worker	2.0	(1)	1.6	(2)	2.2	(1)	14.3	(11)
Aid worker	0.0	(0)	0.8	(1)	2.2	(1)	1.3	(1)
Teacher/principal	0.0	(0)	0.8	(1)	2.2	(1)	0	(0)
Soldier/*gendarmerie*	0.0	(0)	3.1	(4)	10.9	(5)	10.4	(8)

As with the June 09 study, the differential in reporting between refugees and Cameroonians appears to be due to the different types of assault faced by each community, and perceptions of each type of assault.

Increased Physical Consequences of Rape Noted in March 2010

As in the June 2009 study, women were asked about the consequences of the sexual assault. The results of this portion of the questionnaire are summarized below, and women could answer "yes" to more than one question listed below:

Table 4 . Repercussions of sexual assault

Has this assault resulted in….?	Cameroonian % yes (total n)		Refugee % yes (total n)	
	June 2009	March 2010	June 2009	March 2010
Fear of physical retaliation by the perpetrator	49.0 (25)	37.5 (48)	54.4 (25)	46.8 (36)
Rejection/abandonment by husband	13.7 (7)	8.6 (11)	19.6 (9)	9.1 (7)
Physical violence by husband or family	7.8 (4)	5.5 (7)	13.0 (6)	2.6 (2)
Rejection/abandonment by other members of the family	5.9 (3)	6.3 (8)	10.8 (5)	7.8 (6)
Rejection by friends or community	2.0 (1)	1.6 (2)	2.2 (1)	7.8 (6)
Pregnancy	17.7 (9)	25.0 (32)	10.9 (5)	32.5 (25)

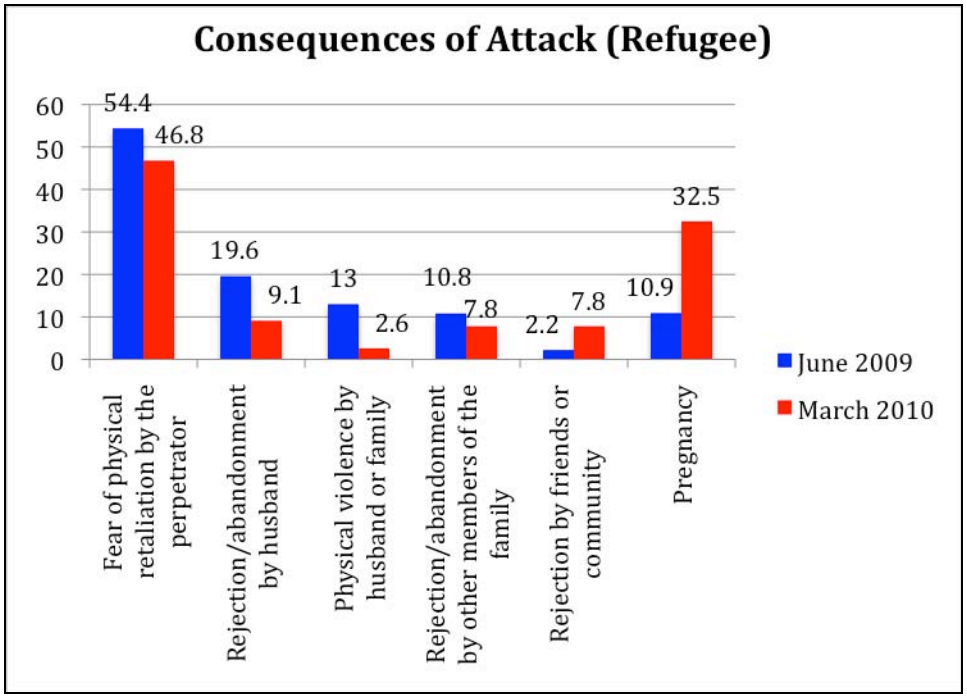


Figure 24. Social consequences of rape, refugee

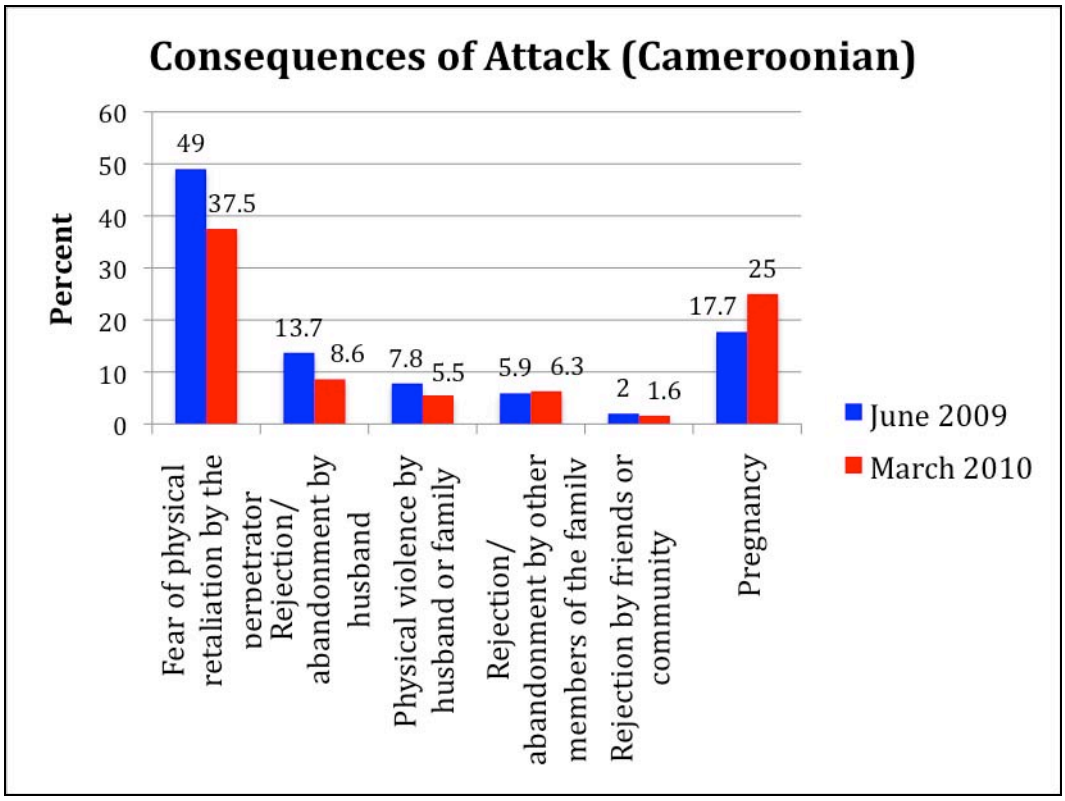


Figure 25. Social consequences of rape, refugee

Both Cameroonian and refugee women remain afraid of physical retaliation by the perpetrator in similar rates. The rate of pregnancies that resulted from the rape is notably higher when compared to June (up from 18% to 25% for Cameroonians, and up from 11% to 33% for refugees). Fear of physical retaliation by the perpetrator and rejection or physical violence by husband or family has also decreased in both populations in the past 6 months. It is likely that the increase in pregnancy and decrease in the above fears is a result of increased reporting of partner/spouse rape.

Women were asked about the following physical consequences of their assault:

Table 5. Physical consequences of sexual assault

Did this sexual assault result in the following physical consequences?	**Cameroonian % yes (total n)**				**Refugee % yes (total n)**			
	June 2009		March 2010		June 2009		March 2010	
Scars/deformities	9.80	(5)	18.8	(24)	26.09	(12)	45.5	(35)
Chronic abdominal pain	7.84	(4)	24.2	(31)	10.87	(5)	48.1	(37)
Urinary problems	1.96	(1)	12.5	(16)	6.52	(3)	22.1	(17)
Problems defecating	0.00	(0)	3.9	(5)	4.35	(2)	22.1	(17)
Pelvic infections	3.92	(2)	18.8	(24)	15.22	(7)	33.8	(26)

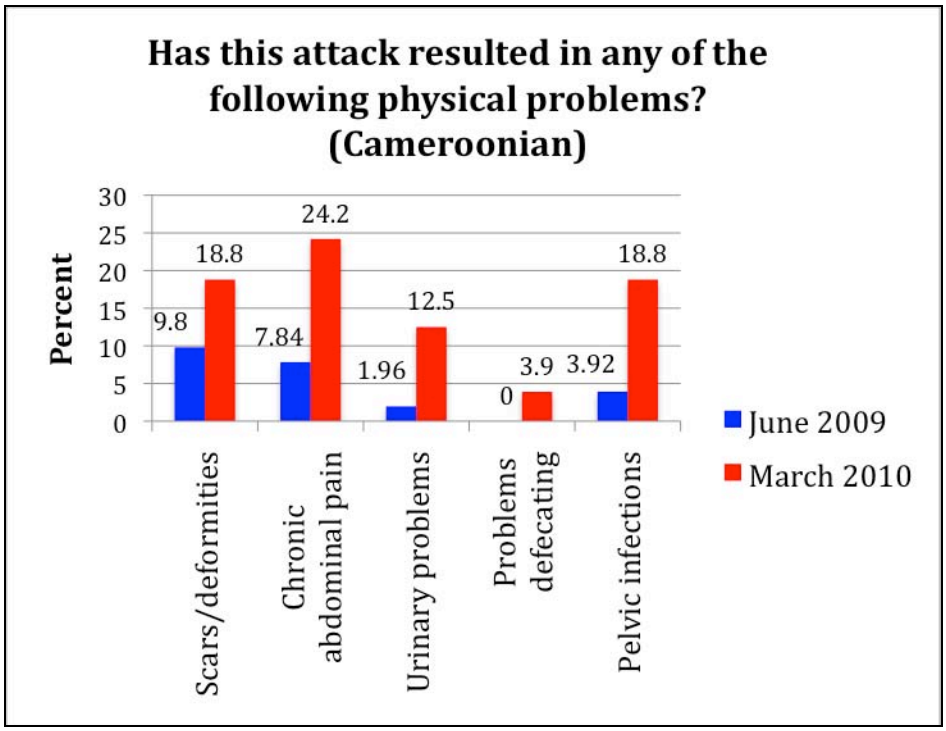


Figure 26. Physical consequences of rape, Cameroonian

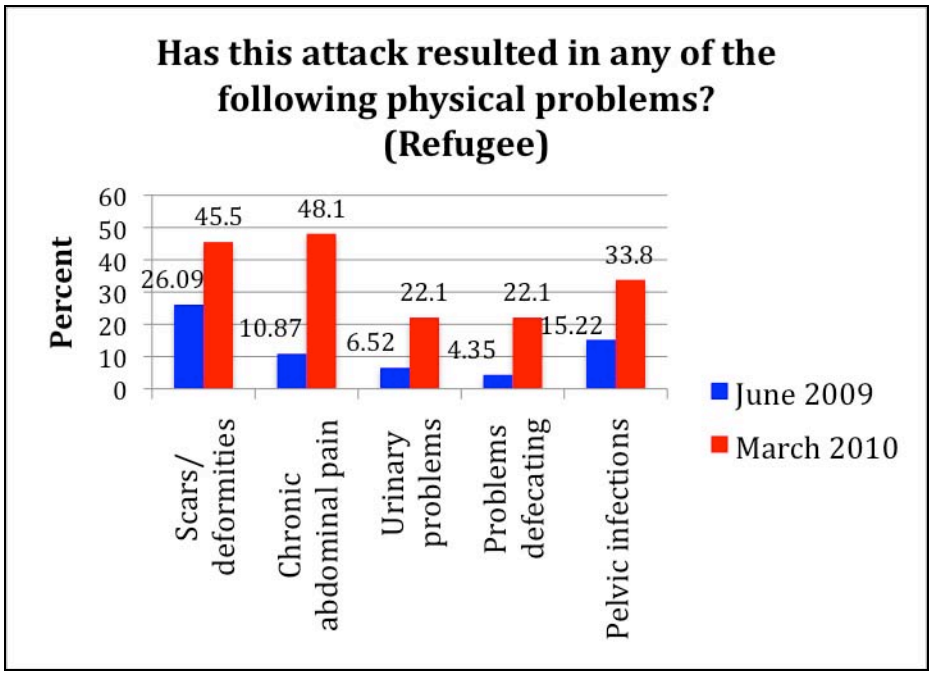


Figure 27. Physical consequences of rape, refugee

Many more women reported scars/deformities, chronic abdominal pain, urinary problems, problems defecating and pelvic infections as a result of rape in March 2010 than in June 2009. This is an alarming finding, and suggests that much more resources need to be

dedicated to medical aid to survivors of rape. The reasons for this increase are not entirely clear. As in June 2009, refugees tended to have higher percentages of all physical consequences than Cameroonian survivors, most likely as a result of a higher percentage of soldier/rebel/*coupeurs de route* and multiple perpetrator rape.

Social Stigma against Rape Unchanged since June 2009

Respondents who had suffered sexual assault but did not report were asked to list the main reason they did not report. As in June 2009, feelings of shame and social stigma, and fear of violence or abandonment by husband and/or family were the main reasons assaults were not reported. A large percentage of women still feel that reporting would do no good, and that "violence is normal." When compared to June 2009, refugee women were far more likely to respond that violence is normal, and there is no need to complain. The reason for this increase is unclear, though it may be associated with the increase in partner/spouse rape reported in this community.

Women were able to respond "yes" to more than one of the reasons below.

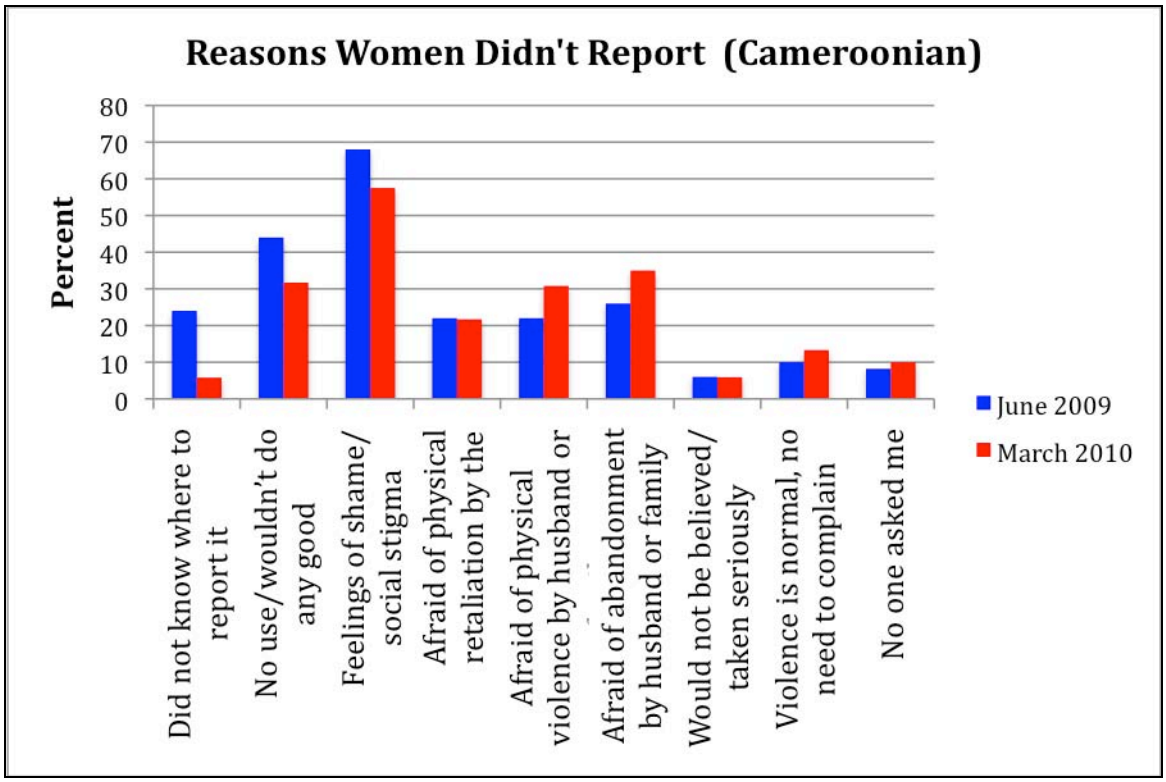


Figure 28. Reasons women didn't report rape, Cameroonian

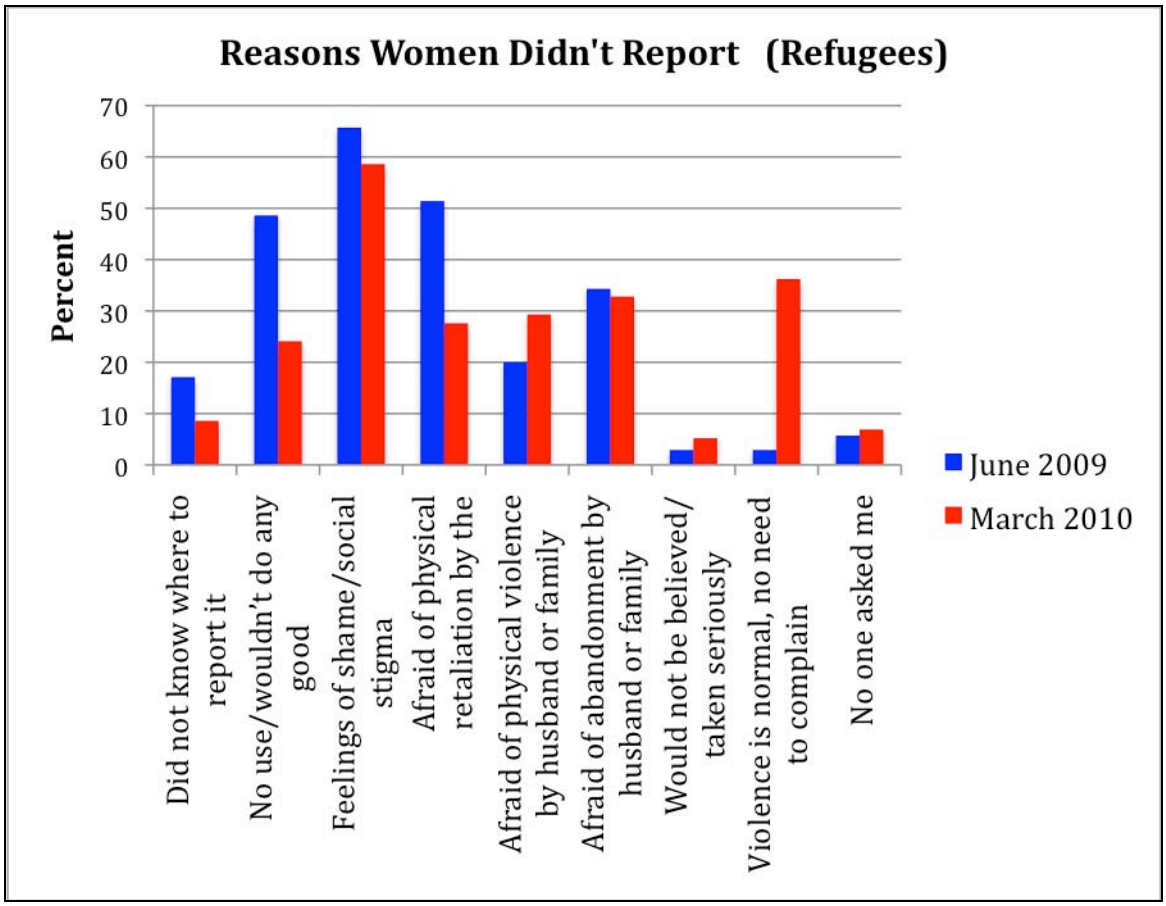


Figure 29. Reasons women didn't report rape, Refugee

Table 6. Reasons to not report sexual assault

If you did not report your sexual assault, what were your reasons?	**Cameroonian % yes (total n)**		**Refugee % yes (total n)**	
	June 2009	March 2010	June 2009	March 2010
Did not know where to report it	24.0 (12)	5.8 (7)	17.1 (6)	8.6 (5)
No use/wouldn't do any good	44.0 (22)	31.7 (38)	48.6 (17)	24.1 (14)
Feelings of shame/social stigma	68.0 (34)	57.5 (69)	65.7 (23)	58.6 (34)
Afraid of physical retaliation by the perpetrator	22.0 (11)	21.7 (26)	51.4 (18)	27.6 (16)
Afraid of physical violence by husband or family	22.0 (11)	30.8 (37)	20.0 (7)	29.3 (17)
Afraid of abandonment by husband or family	26.0 (13)	35.0 (42)	34.3 (12)	32.8 (19)
Would not be believed/taken seriously	6.0 (3)	5.9 (7)	2.9 (1)	5.2 (3)
Violence is normal, no need to complain	10.0 (5)	13.3 (16)	2.9 (1)	36.2 (21)
No one asked me	8.2 (4)	10.0 (12)	5.7 (2)	6.9 (4)

When women were asked why other women might not report a sexual assault, similar reasons were cited—though as noted above, a significant percentage (75%) of women from both populations feel that women will report a sexual assault, despite true reporting rates being very low (13%).

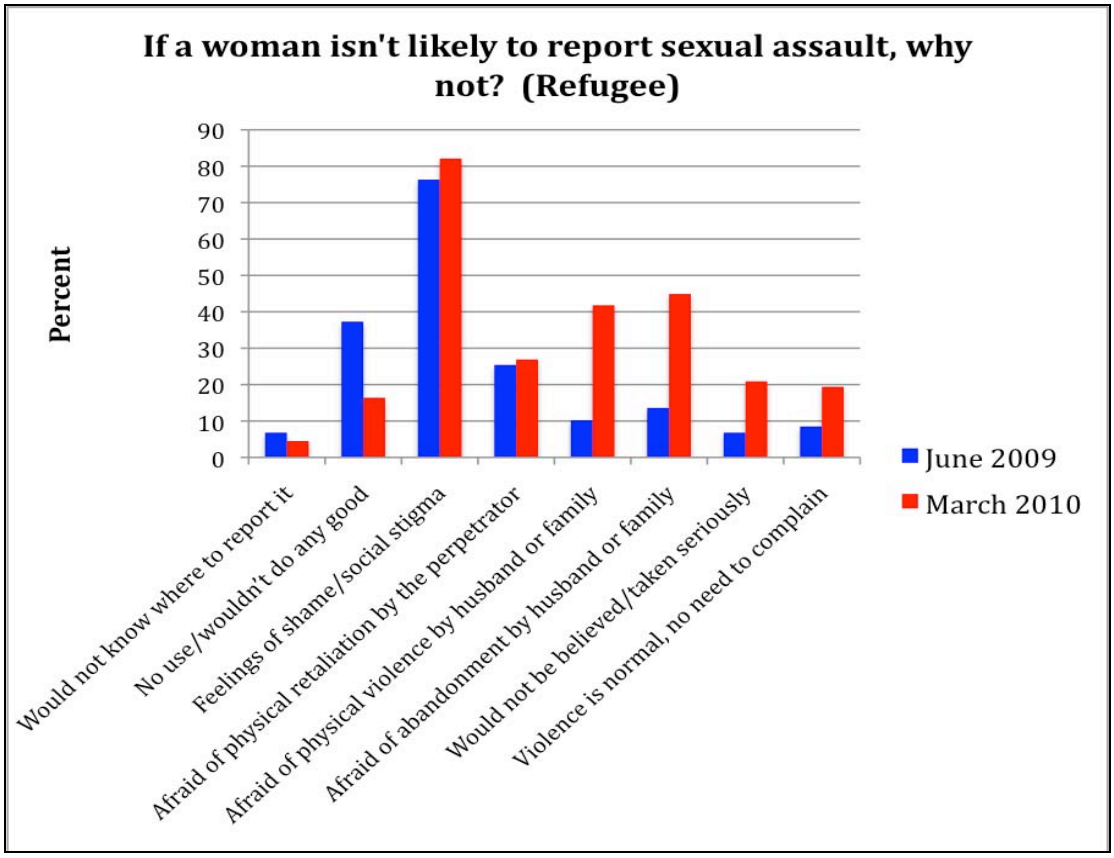


Figure 30. Reasons a woman wouldn't report, refugee

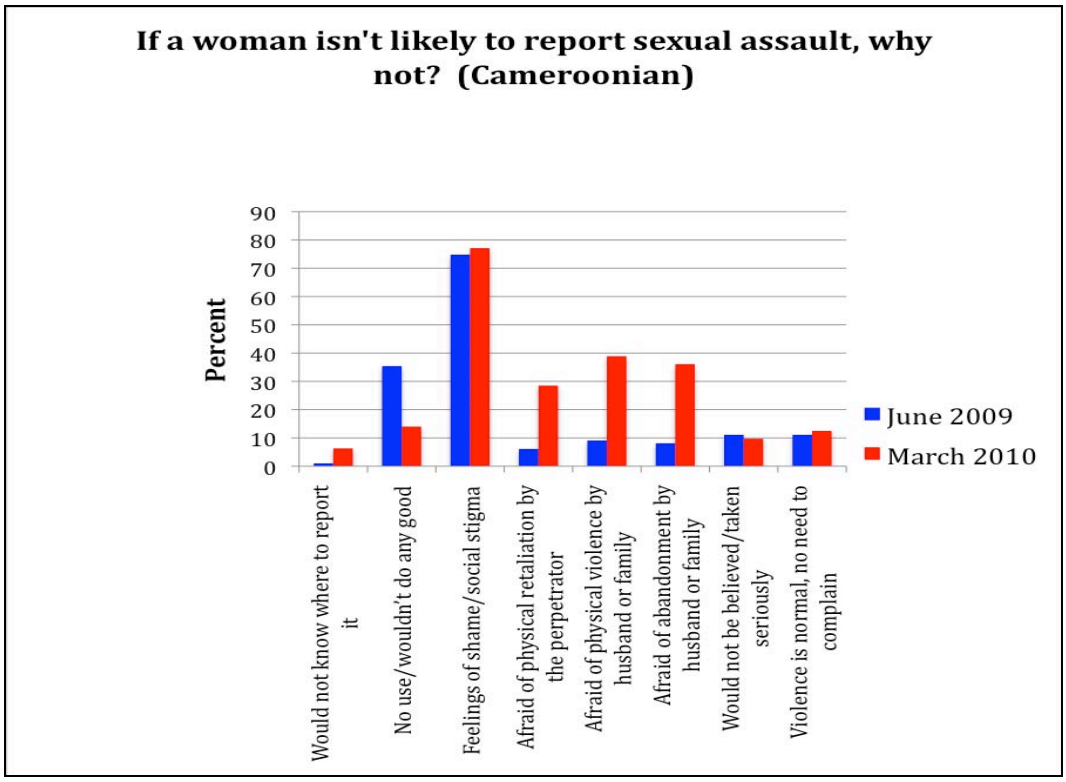


Figure 31. Reasons a woman wouldn't report, Cameroonian

Table 7. Why women don't report assault

If a woman isn't likely to report sexual assault, why not?	Cameroonian % yes (n)		Refugee % yes (n)	
	June 2009	March 2010	June 2009	March 2010
Would not know where to report it	1.0 (1)	6.3 (9)	6.8 (4)	4.5 (3)
No use/wouldn't do any good	35.4 (35)	14.0 (20)	37.3 (22)	16.4 (11)
Feelings of shame/social stigma	74.8 (74)	77.1 (111)	76.3 (45)	82.1 (55)
Afraid of physical retaliation by the perpetrator	6.1 (6)	28.5 (41)	25.4 (15)	26.9 (18)
Afraid of physical violence by husband or family	9.1 (9)	38.9 (56)	10.2 (6)	41.8 (28)
Afraid of abandonment by husband or family	8.1 (8)	36.1 (52)	13.6 (8)	44.8 (30)
Would not be believed/taken seriously	11.1 (11)	9.7 (14)	6.8 (4)	20.9 (14)
Violence is normal, no need to complain	11.1 (11)	12.5 (18)	8.5 (5)	19.4 (13)

When survivors were asked, "Do you feel your assailant should be punished?", 30% of Cameroonian and 62% of refugees said yes. This dramatic difference between these two populations is almost certainly due to the fact that the vast majority of rape and sexual assault suffered by Cameroonian women was perpetrated by their husbands. These percentages are similar to those found in June 2009 (31% Cameroonian, 70% refugee).

The consequences of rape for perpetrators and victims very likely affect reporting patterns. Focus groups in June of 2009 suggested that if a woman is raped, not only is she likely seen to be at fault and not report, when she reports most likely nothing will be done. If reported to the village chief, he will bring survivor and perpetrator before him, and if he decides that the girl or woman was raped, the family of the girl or woman will be paid with a cow, goat, or other item of value. If the perpetrator can afford the fee, he will not be sent to jail—however if he can't pay he is taken to the *gendarmerie*. If the perpetrator agrees to marry the victim, he is similarly forgiven.

In a situation where the appropriate "fee" has been paid, the man can continue to function in society, farming, owning a business, marrying, etc. The woman on the other hand, is considered damaged. These women are generally abandoned by their husbands. They sometimes return to their families; however a woman's family will often refuse to take her back—in which case she must find a way to take care of herself. In Cameroon, women functionally have no legal right to their children or property, and the vast majority of women in Djohong have never been to school which makes finding a means to make a living once a woman has been abandoned extremely challenging. Unfortunately, the March 2010 study suggests that these attitudes have not significantly changed yet.

Women who did report their sexual assault to police or a local authority were asked, "If you reported this assault, was anything done?" and "If something was done, what was done?" Of the 209 women in the sample who had been assaulted, only 27 (8 Cameroonian, 19 refugee) reported their sexual assault. Twelve of these women reported that something was done about their rape, including 4 who said the man paid damages (usually livestock) to her family, 4 said she was forced to marry the perpetrator as a result, and only 3 were put in jail. In other words, only **one percent** of reported rapes in this survey resulted in imprisonment for the perpetrator.

3.2 Non-sexual violence

3.2.1 Prevalence

- ***Recommendation:*** **An expansion of the current SGBV program is strongly recommended. Thirty-one percent of women have been beaten by their husbands in the past 6 months.**

The lifetime prevalence of non-sexual violence in June 2009 was 40%. The March 2010 survey found that 31% of women in Djohong were beaten **in the last 6 months.**

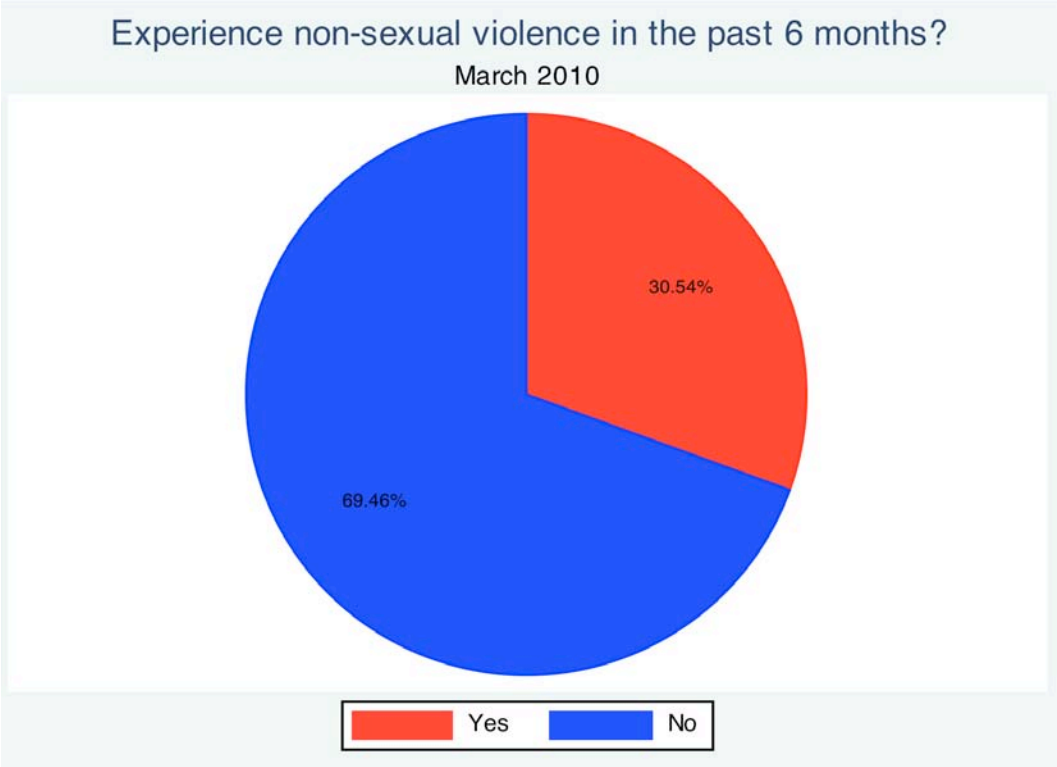


Figure 32. Non-sexual violence in past 6 months

3.2.2 Reporting and perceptions

Thirty-one percent of women have experienced non-sexual violence in the last 6 months. A majority of women, however, feel non-sexual violence is occasional or rare. Attitudes toward the prevalence of non-sexual violence have not changed in the past 6 months.

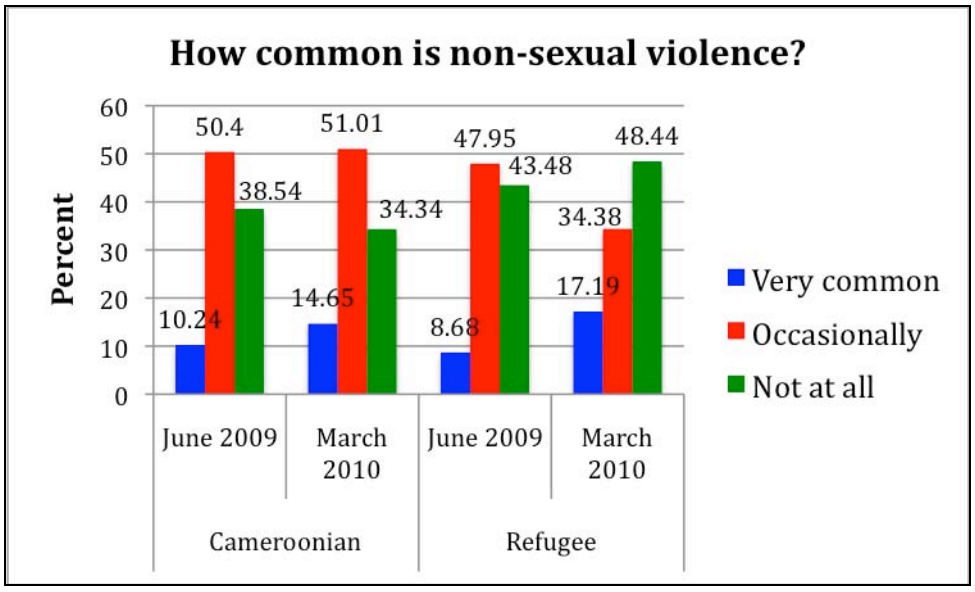


Figure 33. Perception of prevalence of non-sexual violence

Fifty-six percent of women surveyed believe women would report physical abuse. For those who felt women would not report, the most common reason cited was social stigma, followed by reporting would be of no use (41% and 20%, respectively; these did not vary between refugees and host population).

3.3 Mental health

- ***Recommendation:*** **The percentage of women in Djohong with access to mental health services has increased from 15% in June 2009 to 20% in March 2010, likely as a result of the IMC GBV counseling program expansion [see Section 8 for a description]. Despite the expansion of the mental health program, however, less than one half of women who need mental health services state that they have been able to access it. Thus, further expansion of the GBV counseling program is recommended.**

The percentage of respondents with access to counseling services has increased (20% March 2010, 15%, June 2009). This is likely a result of an expansion of GBV counseling activities in Djohong District. The IMC GBV team has recently expanded counseling to victims of violence and sexual assault. IMC built a Counseling Room at the Djohong Hospital to provide space for short inpatient stays for women suffer from severe depression or PTSD. All victims of violence are given an average of 3 counseling sessions with either trained peer counselors or two trained psychologists (available for more complicated cases). Additionally, counseling is given during field visits. Please see **Section 8** for a complete discussion of this SGBV expansion.

When asked to rate their mental health prior to arrival in Cameroon, 75% of refugees answered “poor” in March 2010.

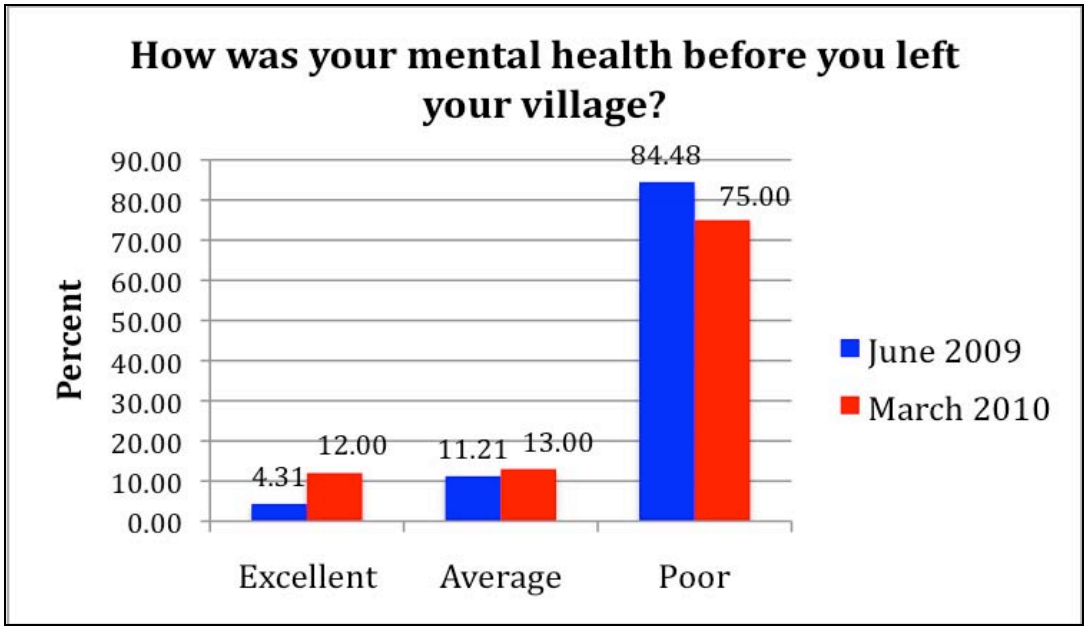


Figure 34. Self-reported mental health status prior to leaving CAR, refugees

All women were asked to rate their current mental health on a scale of 1-3, 1 being “poor”, and 3 being “excellent.” Sixty-six percent of all women rated their mental health as “excellent,” and 33% rated their mental health as average in March 2010. Only 1% rated their current mental health as poor. The distribution of answers was similar for both refugees and the host population, in June 2009 and March 2010.

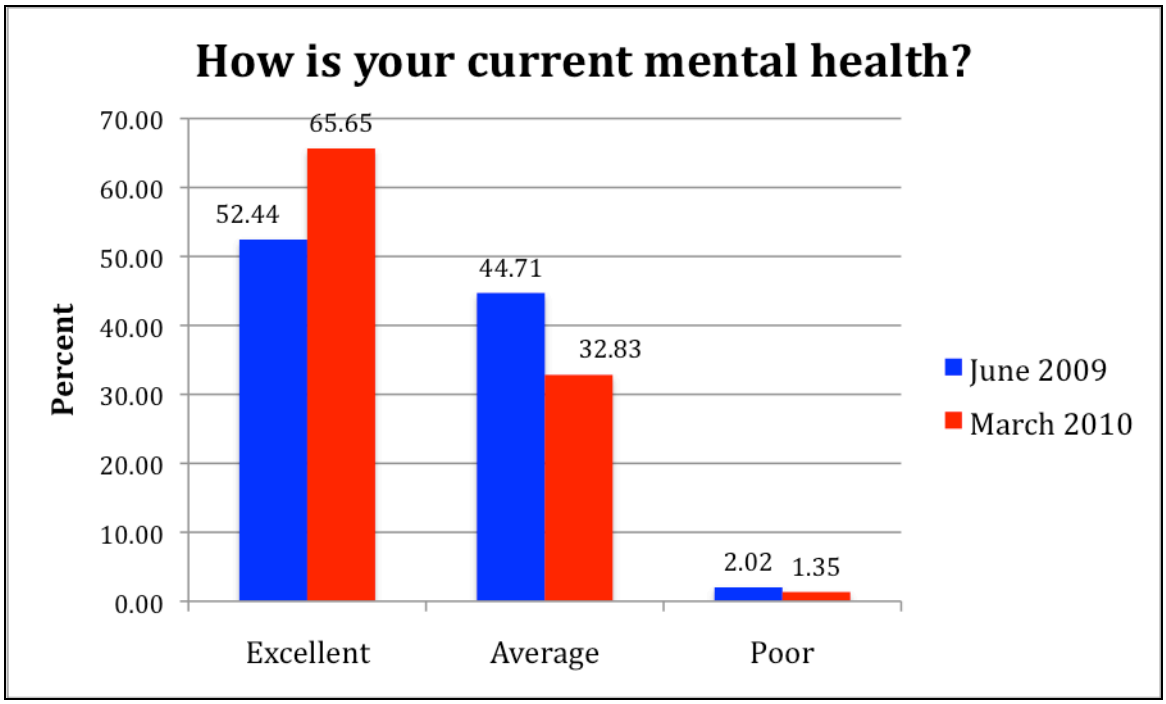


Figure 35. Self-reported current mental health status

When asked, "Have you needed mental health care or counseling?" 57% of the population answered yes (similar for both refugees and host population), though only 25% of women stated they were able to get it. When asked why they have not sought mental health care if they needed it, 68% of both the host population and refugees stated that it was not available at the local health center. This was the barrier cited most often by both populations. Affordability and fear of divulging personal information were also often cited reasons for not accessing counseling services.

3.4 Conclusions

We can conclude from the March 2010 study that sexual and non-sexual violence are ongoing epidemics in Djohong District, most commonly perpetrated by husbands and members of the community. A smaller number of rapes are perpetrated by soliders/rebels and *coupeurs de route*, most often in CAR however on occasion on Cameroonian soil.

There is still a large, unmet need for mental health services, though the recent expansion of the IMC GBV Counseling program has improved the current situtation substantially.

Ongoing monitoring of the program could include:

1) Studies that continue to monitor the incidence of rape and non-sexual violence to evaluate the success of the program. This incidence is likely to continue to rise as the IMC SGBV team continues it's education campaign—however it should then plateau and begin to fall over the coming years. IMC Djohong may also consider monitoring SGBV rates among

women who present to the mobile medical clinics in lieu of repeated population based surveys, as long as all towns are also visited by the GBV team.

2) Periodic anonymous surveys that monitor knowledge, practices, and attitudes toward rape by not only women but also men in the community—in particular community and religious leaders, police, and husbands.

3) An education program on sexual and gender-based violence that targets men in the community.

Further investigation into soldier/rebel/*coupeurs de route* activity on Cameroonian soil is recommended.

4 Health Care

4.1 Health needs

4.1.1 Health Services in Djohong District

HHI was asked to briefly assess what types of medical services the refugees and host population were aware of, what services were being used, and reasons for not accessing services that were available. Over the past eight months, people are more aware of available services, however the cost of transportation continues to limit access to health care. More people are now using hospitals than they used to.

The Djohong District has 7 health posts (located in Ngoui, Garga Pella, Yamba, Batua Godole, Yarambang, Kombo Laka, and Bafouk) and one hospital in Djohong proper. Health posts offer a limited range of services including antenatal care, nutrition services for women and children, vaccinations, and basic treatments for common infectious illnesses. These services, however, vary widely in quality and availability.

IMC continues to run a Mobile Medical Clinic, which takes health care practitioners and educators to different towns in Djohong District every day. The Mobile Clinic takes medications and supplies for screening and treatment of basic illness, and provides health education and health care to both refugees and Cameroonians in villages throughout Djohong District.

There are no surgeons in Djohong; the only obstetrician and SGBV specialist, who also directed the IMC SGBV program in Djohong, has recently left the area and no replacement has been appointed to date. Critical surgical patients are therefore transported to Meiganga (the nearest large city approximately 2 hours away by car) where there is a District hospital. Though IMC Djohong acquired an operating table for Djohong hospital, the hospital is still not equipped to care for surgical cases as it has no operating theater (OT), working generator, sterilization capacity, source of clean water, blood transfusion capability, or any necessary surgical staff (a nurse anesthetist or anesthesiologist) necessary to perform surgery.

Although the hospital has a delivery room, the majority of women in the region deliver at home with the help of a midwife or family member. The therapeutic feeding center (TFC), housed at the hospital, has an average patient load of 10-15 children, and operates with donations from IMC, UNCHR, and WFP. (The TFC is currently run by Paul Ngong, a pharmacist from the MoH who also assisted in translation during this assessment).

A welcome expansion to the Djohong hospital is the IMC Counseling Center. This building houses patients who suffer from particularly severe cases of depression and PTSD, and allows them to have intensive counseling and observation until they are safely able to leave.

A trained psychologist, who also served as a surveyor for the March assessment, runs this center.

4.1.2 Access to Health Care

Cameroonians (86%) and refugees (91%) most often cited a lack of funds as the reason they were unable to obtain health care. Ten percent more refugees cited this reason in March 2010 than in June 2009.

Although registered refugees are provided with certain medications by UNCHR and IMC free of charge, not all medications are free, and those that are free are not always available. Additionally, refugees are not provided with money to pay for transportation to the hospital, food while in the hospital and a place family to stay with them during their hospitalization.[4] Thus refugees with UNHCR cards often still must pay a substantial amount of money in order to seek health care.

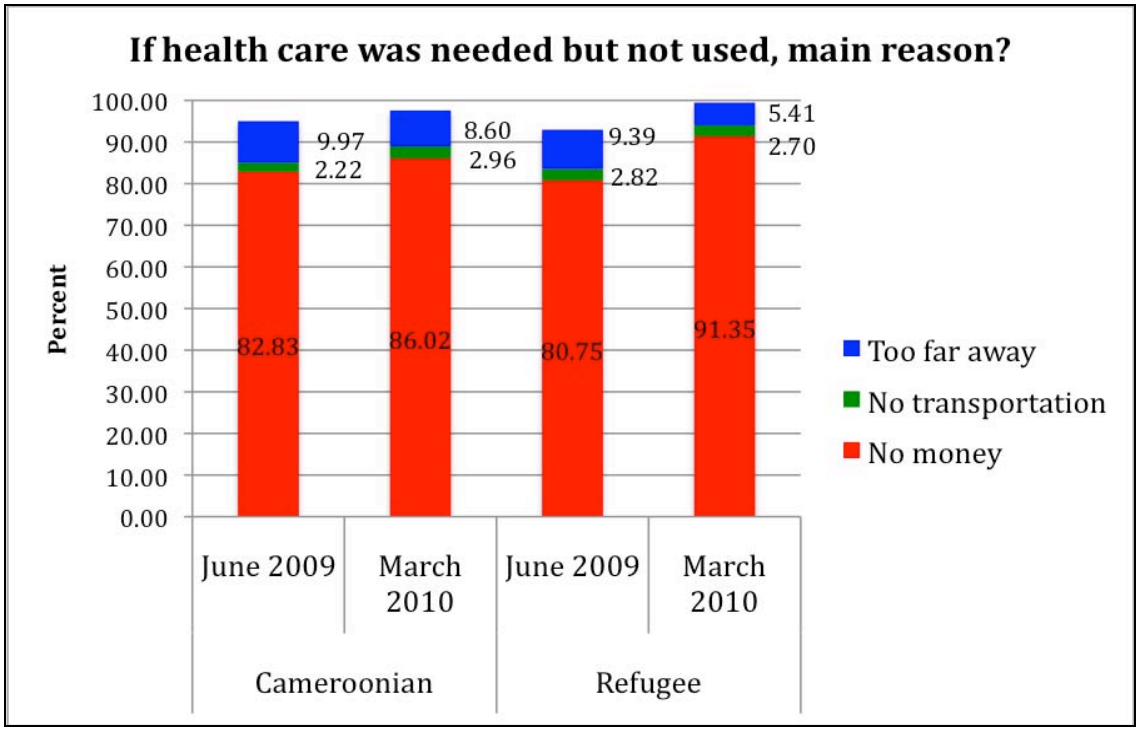


Figure 36. Main reason health care not obtained when needed

All respondents were asked how much time it took them to walk to their nearest health care provider. Fifty-seven percent of Cameroonians and 63% of refugees said less than one hour, while 27% of Cameroonians and 16% of refugees responded 2-6 hours. These numbers are not significantly different from the last assessment.

[4] In Cameroon, family play a critical role in patient care—providing feedings and basic nursing care that overwhelmed hospital staff cannot provide. Thus, having family stay with a patient is a critical part of patient care.

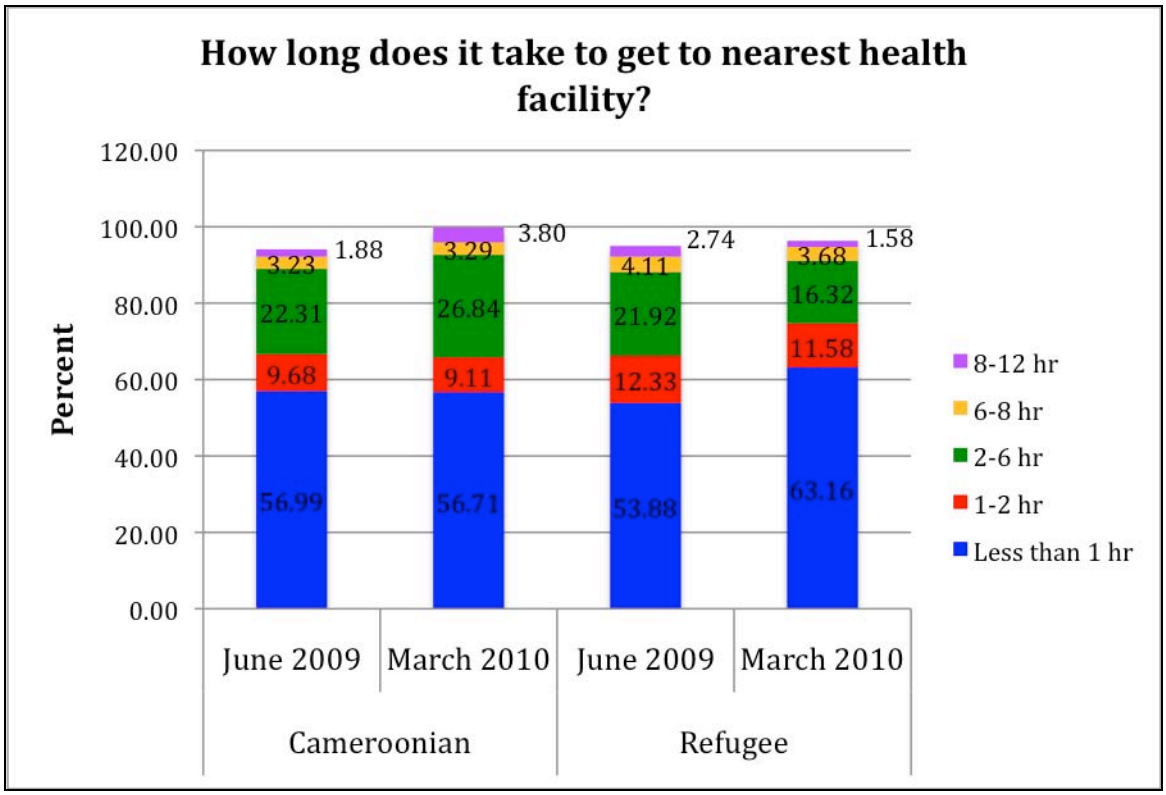


Figure 37. Time to nearest health care facility

About 60% of both refugees and Cameroonians that they have ready access to some kind of transportation to get them to a health facility. This indicates improved access to transportation access for refugees than 8 months ago (48% June 2009), and a similar level of access for Cameroonians (59% June 2009).

4.2 Health care availability and usage

Respondents were asked about access to a number of medical services. Overall, both Cameroonians and refugees appear to have greater access to medical services in March 2010 than in June 2009. The majority of the population state that they have access to vaccines for children, obstetric care, weights & measurement for children, and care for fever and infections. Cameroonians stated that they had access to HIV testing and care after an accident or assault more often than refugees. Since these populations are essentially integrated, there appears to be a difference in the perception of available services or the ability to pay for those services.

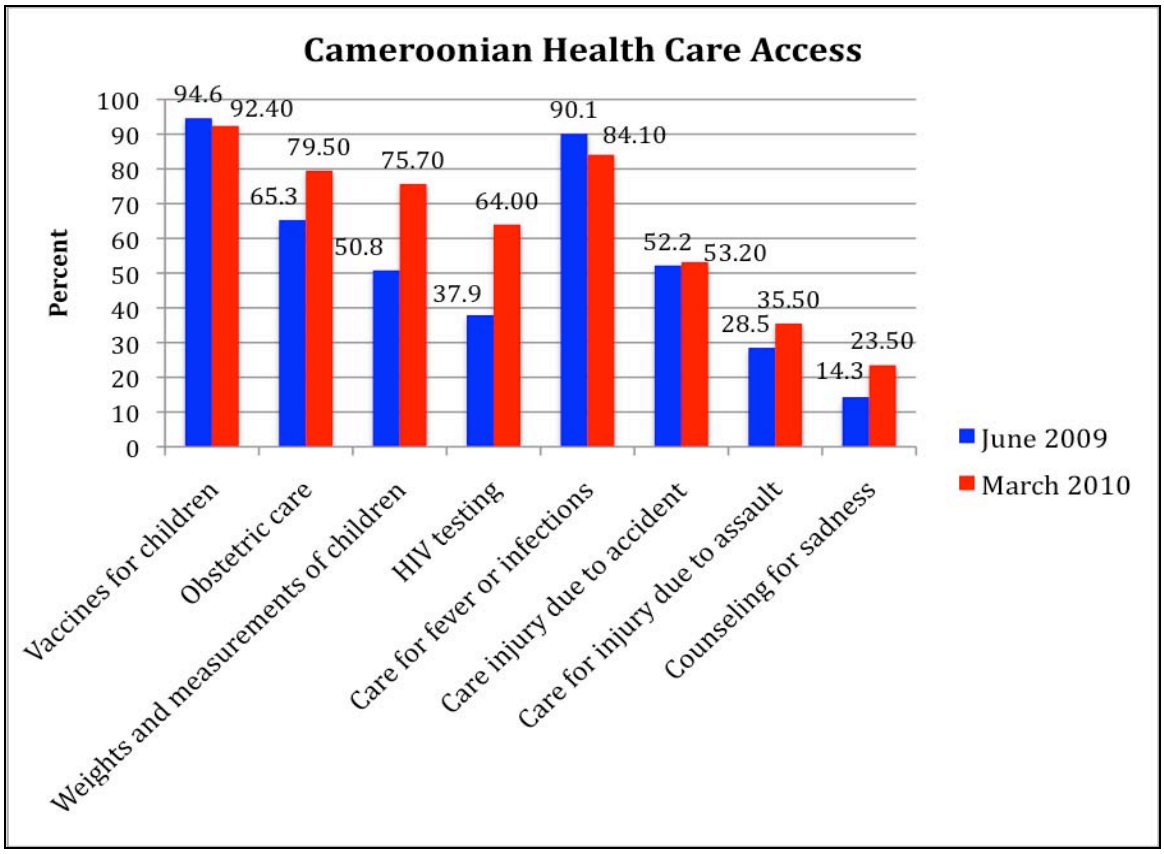


Figure 38. Cameroonian Health Care Access

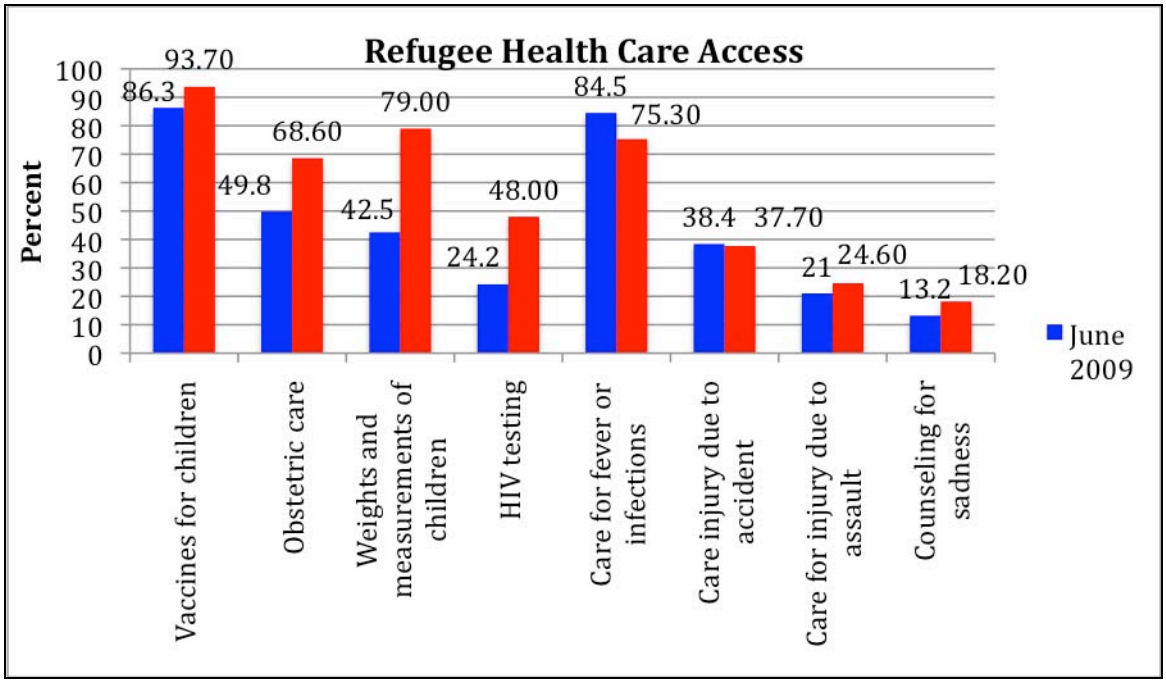


Figure 39. Refugee Health Care Access

Since the last assessment, a larger percentage of both Cameroonians and refugees stated that they had access to obstetric care, weights and measurements for children and HIV testing.

When asked which medical services they have used, both refugees and Cameroonians appear to be using hospitals more often in March 2010 than in June 2009. Refugees tend to use health posts more often than Cameroonians. The population as a whole is infrequently using community health workers and nutrition centers for their health needs.

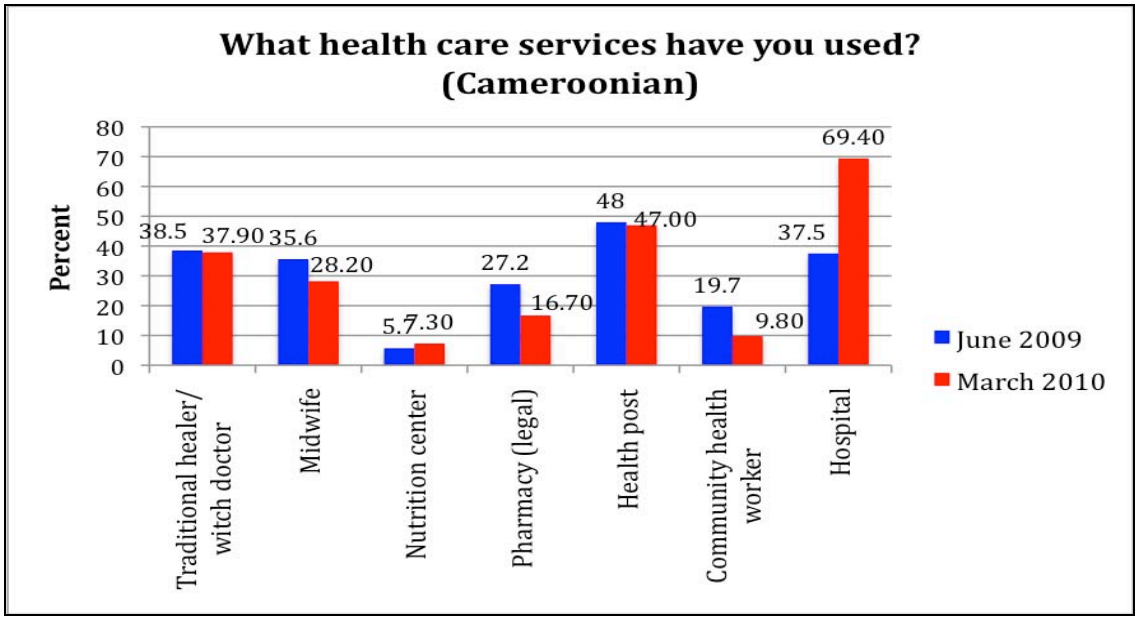


Figure 40. Health care services used, Cameroonian

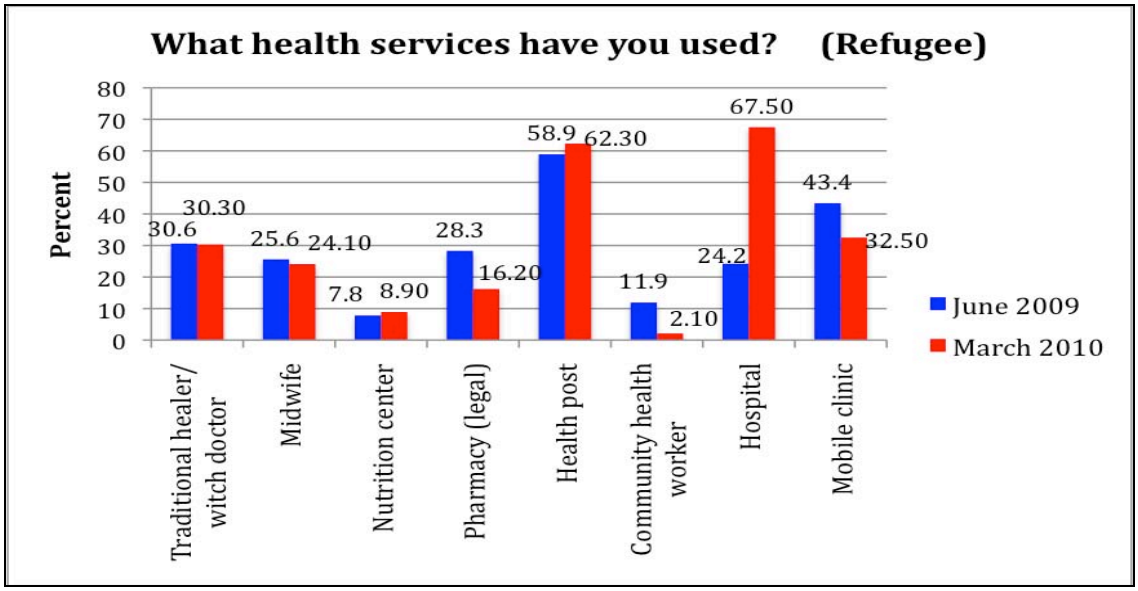


Figure 41. Health care services used, refugee

4.3 Use and perceptions of IMC mobile clinics

- ***Recommendation:*** **IMC Mobile Clinics serve both Cameroonians and refugees, however far more refugees use IMC clinics. Community outreach and education may help the population understand that IMC services are a resource for entire communities.**

As was seen 8 months ago, a substantially higher percentage of refugee respondents (64%, n=124), have used IMC mobile clinics compared to the host population (34%, n=136). This may be due to perceptions that NGOs and UN organizations in the region are primarily interested in helping refugees. Alternatively, although similar percentages of host and refugee population cited a lack of money as a primary reason for not seeking health care, it is still possible that Cameroonians are able to afford health post/hospital care more often than refugees due to their higher daily income on average (See **Section 5**).

When asked about the quality of care in IMC clinics, as before, the majority of Cameroonians and refugees who had used IMC services responded "Excellent" (80% refugees n=99, 73% Cameroonians n=98). Two percent of refugees (n=3) and 2% of Cameroonians (n=2) remarked that health care by IMC clinics was poor. As it was widely known that IMC was directing this survey, these results may be biased. These results are similar to those found in June 2009.

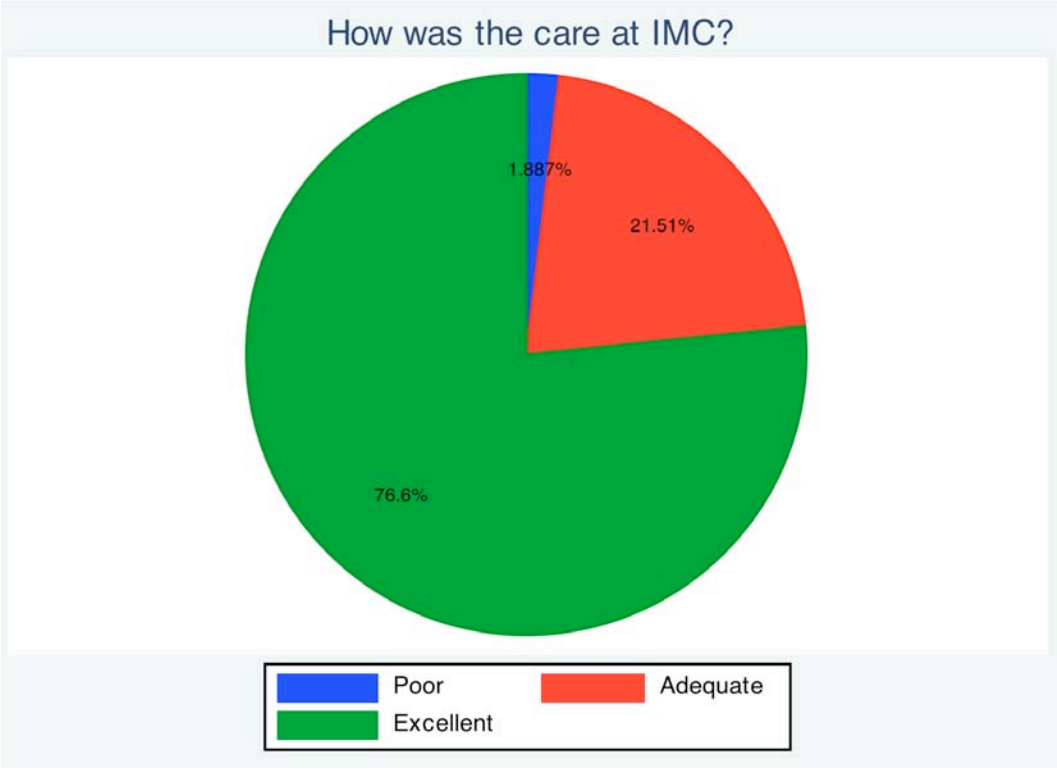


Figure 42. Perceived quality of care at IMC clinics

5. Income and education

5.1 Land ownership and household assets

As in the June 2009 study, 83% of Cameroonians and 82% of refugees have access to a farm or garden for household use. However, many more Cameroonians (88%) than refugees (68%) own land. This trend was the same during the last assessment, however, more refugees claim to own land in March 2010 than in June 2009. The disparity in land ownership, though narrowing, could be due in part to a financial arrangement common in the area where refugees and poorer Cameroonians help large landowners farm their land in return for a share of the crop they grow, or other payment.

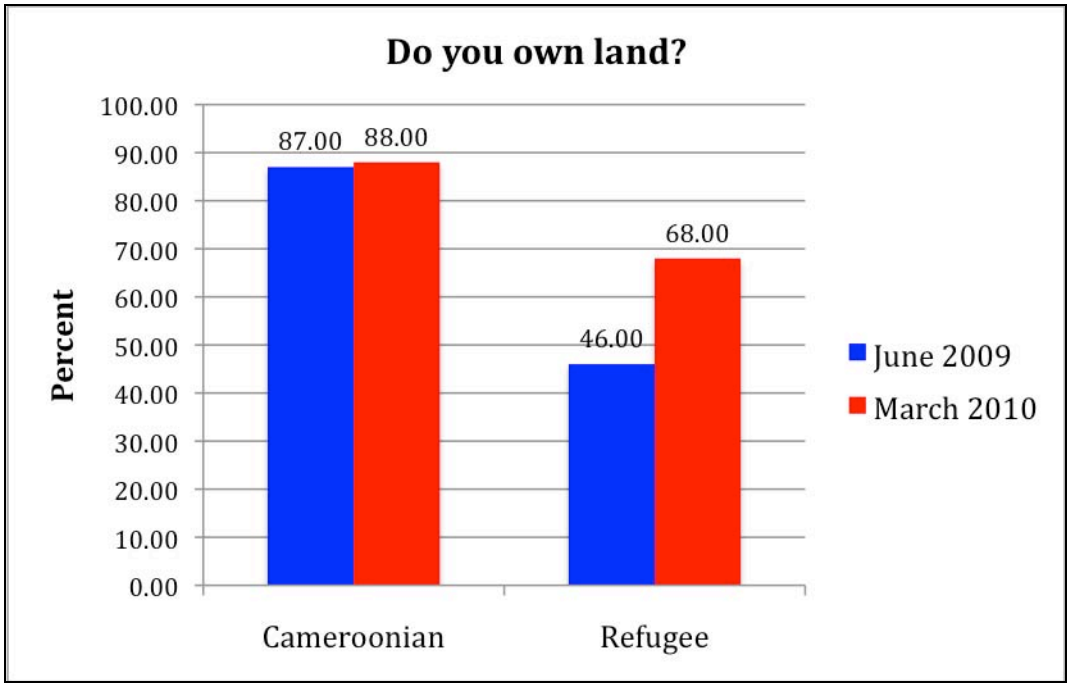


Figure 43. Land Ownership

Eighty-three percent of Cameroonians and 82% of refugees raise food for household consumption. In contrast, 37% of Cameroonians sell food in the local market while only 8% of refugees sell food in the local market. In June 2009, 54% of Cameroonians and 22% of refugees grew crops to sell in the market. It is unclear what has caused this decrease in sale of crops in the market, though it is likely this is a seasonal effect. June is the rainy season and generally more types of crops are found in the market while March is the end of the dry season.

Ninety-eight percent of both refugee and host populations state they will use their land in two years. As was found last year, Cameroonians own more land than refugees (.90 hectares on average for refugees, and .97 hectares for Cameroonians), though it appears the disparity land ownership has closed significantly since June 2009. Perhaps, as a result of better registration of the population by UNCHR, refugees have more resources to buy land.

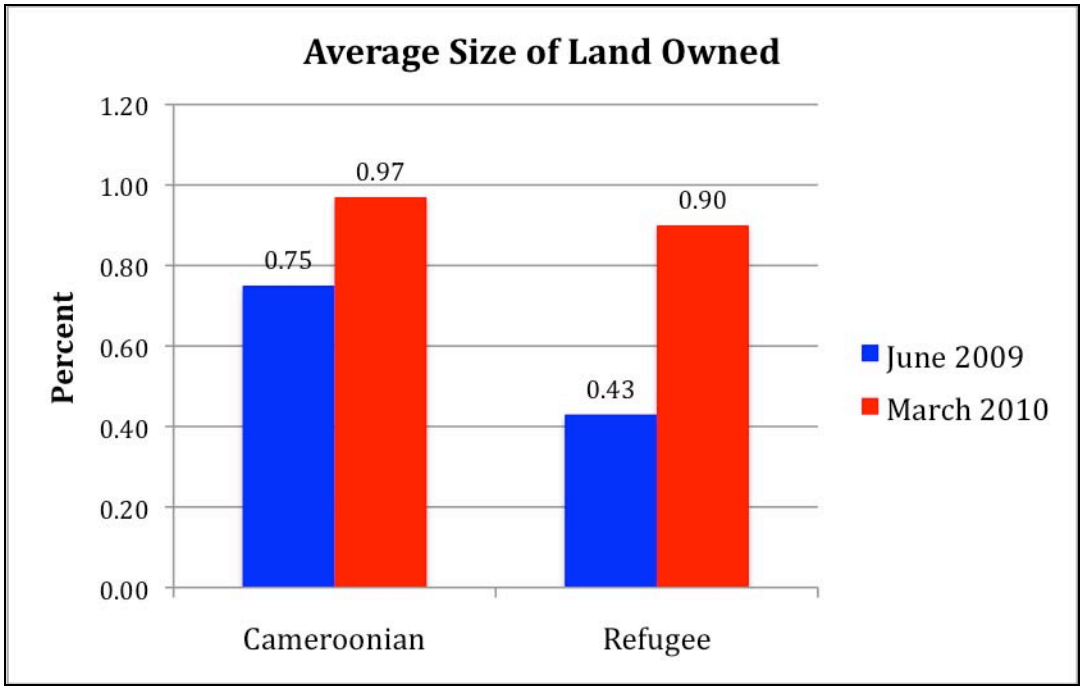


Figure 44. Average size of land owned

It is common to own and raise animals in Djohong. Animals raised include chickens, goats, cows, ducks, sheep, donkeys, horses, dogs and cats. Surprisingly, Cameroonian and refugee households had more similar number of cows and chickens in March 2010 than in June 2009. This suggests increasing equality in income between these two populations.

Table 8. Animals by household

Animal	Mean #/Cameroonian Household		Mean #/Refugee Household	
	June 2009	March 2010	June 2009	March 2010
Chickens	2.10	2.3	0.81	2.3
Ducks	0.12	0.10	0	0.21
Rabbits	0.002	0.02	0	0
Pigs	0.08	0.03	0	0
Goats	0.75	0.83	0.36	0.96
Sheep	0.75	0.96	0.18	0.60
Cows	9.29	6.20	2.44	6.58
Donkeys	0.04	0.03	0.04	0.05
Horses	0.03	0.13	0.04	0.09

Respondents were also asked about items of value owned in the home. Commonly owned items of value include radios, plates, suitcases, and beds/mattresses. Nineteen percent of Cameroonians own a radio while only 12% of refugees own a radio. Six percent of Cameroonians own a motorcycle while only 3% of refugees do. This trend holds for other items of value including cell phones, bicycles, generators, and TVs, all of which are rarely owned throughout the community.

5.2 Daily household income

Mean daily income for households in the region is 1065 CFA (2.18 USD), however household income differs considerably between those native to Cameroon and for refugees. Mean daily income for Cameroonian households is 1173 CFA (2.40 USD), while mean daily income for a refugee household in Djohong District is 842 CFA (1.73 USD). Mean income fell slightly for Cameroonians and rose slightly for refugees between June 2009 and March 2010.

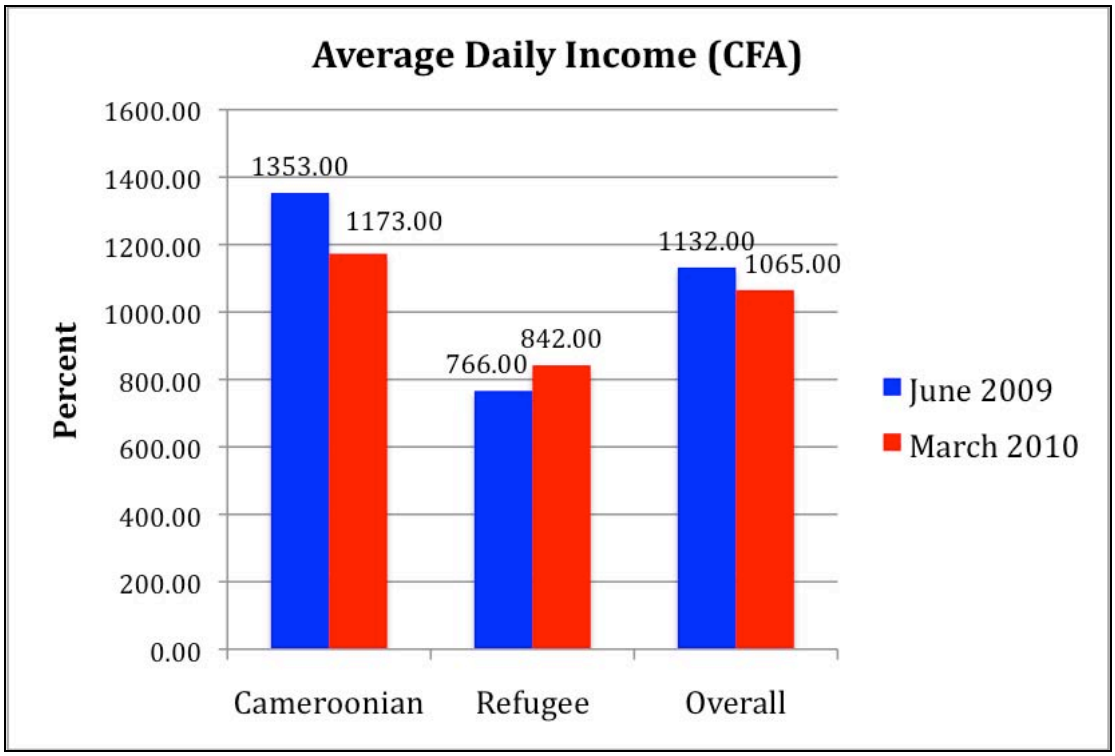


Figure 45. Average Daily Income

5.3 Education, literacy, and vocational training

The vast majority of women in Djohong District are unable to read (67% of Cameroonians, 75% of refugees). Thirteen percent of the entire population can read without difficulty. Women in Djohong also speak a myriad of languages. Any program in the region must take this into account, by providing all information both verbally and in written form, and possibly in multiple languages. IMC programs do an excellent job of communicating appropriately with host and refugee populations.

A majority women in the region, both refugee and host population, are able to add and subtract (94% Cameroonian women, 83% refugee women). This is also unchanged from 8 months ago (91% Cameroonian and 84% refugee June 2009). According to the assessment team's analysis, women who know how to do math have significantly lower rates of sexual and non-sexual violence [See **Section 3**].

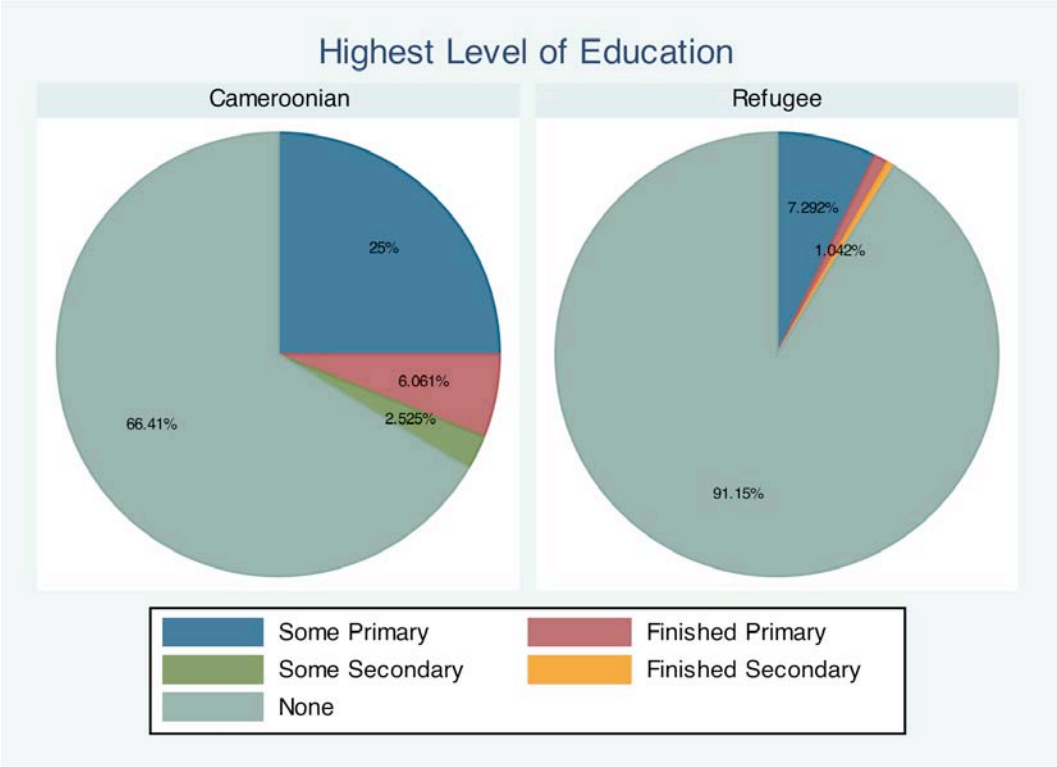


Figure 44. Highest level of education

As in June 2009, refugee women have achieved significantly lower levels of education than women in the host population—although in both groups the vast majority has never been to school. This is in stark contrast to current demographic data, which suggests that the majority of girls (roughly 60%) attend primary school. The reasons for this are unclear. The lower levels among refugees may potentially be due to lower income and recent flight, however the majority of refugees have recently migrated and their current situation does not likely affect the reasons why they did not have access to education as children. This differential may reflect lower levels of education among women who live in CAR.

A small percentage of both Cameroonian (16%) and refugee (12%) women have had vocational training.

6. Food security, water, fuel and shelter

6.1 Food availability, sources, needs and coping mechanisms

Food scarcity remains a significant problem in Djohong District, though the situation seems to have improved in the past 8 months. Women heads of household in the region eat, on average, 2.5 meals per day (2.2 in June 2009). Twenty-five percent of Cameroonian women and 30% of refugee women responded that they or their families had gone without food during the last month, which is significantly decreased from 8 months ago when 63% of refugees and 36% of the host population went without food at least one day during the last month. This dramatic decrease for refugees may be due to increased registration, making these refugees eligible for WFP food distributions. The increase in WFP food rations throughout the District has likely increased the availability of food for all residents of the region.

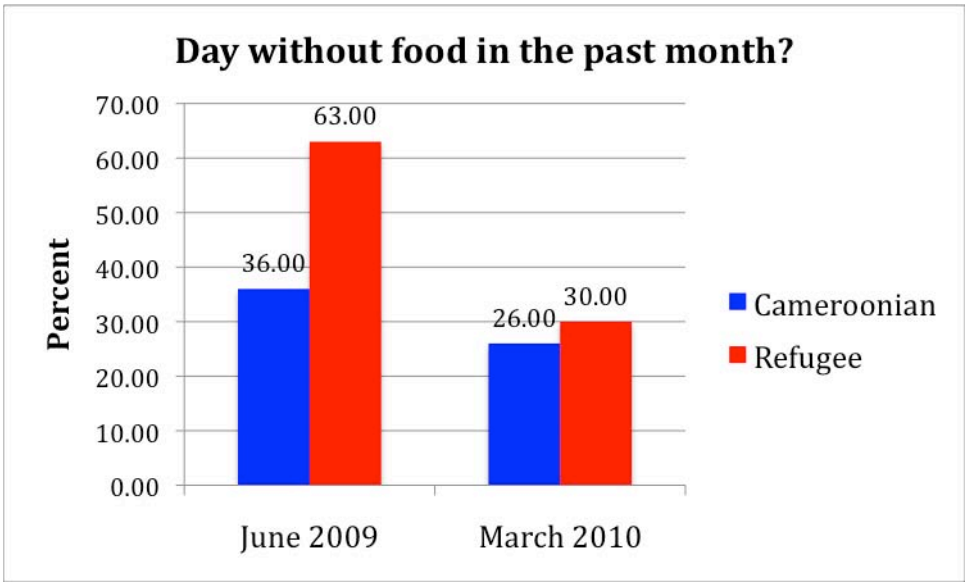
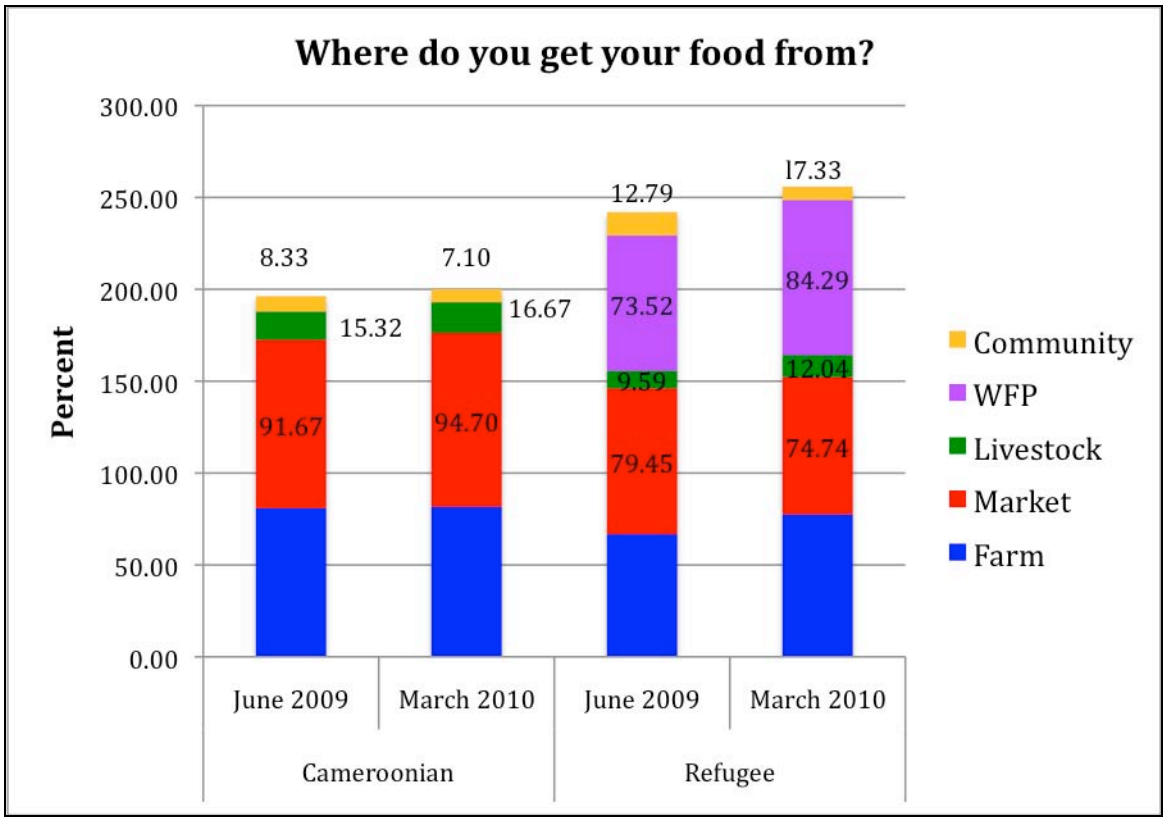


Figure 46. Day without food in the past month

When asked why there wasn't enough food, the majority of Cameroonian women 79% noted a lack of money, while 63% of refugees cited insufficient distributions from the World Food Programme (WFP) and 36% of refugees cited a lack of money. These numbers were not significantly different from the last assessment done 8 months ago.

In order to obtain food, 60% of the population stated that it was not necessary to sell their belongings to get food. If there was a need, 23% of Cameroonians and 22% of refugees resorted to selling their personal belongings, while 6% of Cameroonians and 9% of refugees mentioned that they were forced to work for food. Overall, a higher percentage of refugees had to employ one of these coping strategies to obtain food (39% refugees versus 37% Cameroonian).

Main sources of food include the household's farm, the local market, and to a lesser degree, the household's livestock. As the host population is more likely to own land, they tend to rely more on products of their farm for food than refugees, as was found in June 2009 (82% Cameroonians versus 77% refugees). Similarly, Cameroonians tend to cite the local market as a source of their food more often than refugees (94% versus 77%). Eighty-four percent of refugees rely on WFP for food, and approximately 7% of both host and refugee populations depend on charitable donations from the community for food. None of these numbers are significantly different from the last assessment, except that many more refugees now receive rations from WFP than in June 2009.



(Respondents were able to cite more than one source of food above)

Figure 47. Sources of food

6.2 Water and fuel availability, sources and vulnerability

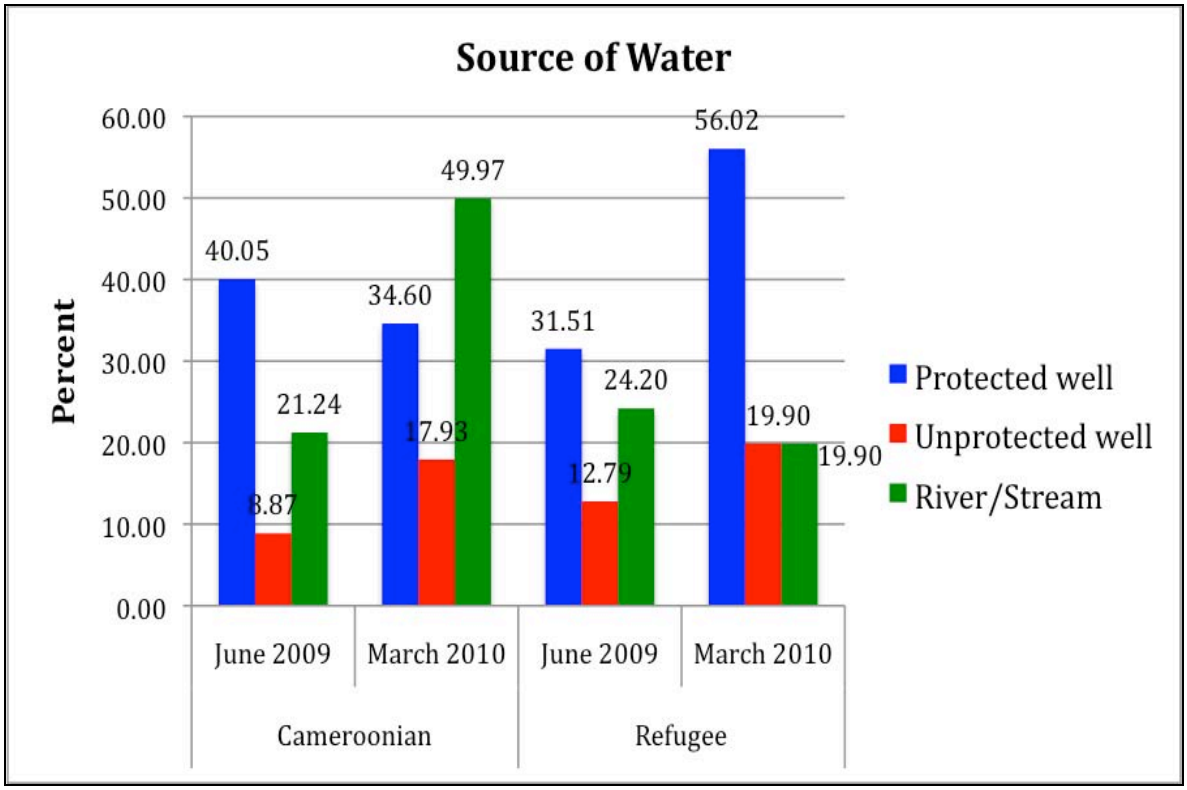


Figure 48. Sources of water

Residents of Djohong District use a variety of water sources. Refugees get water from protected wells 56% of the time, while Cameroonians get water 47% of the time from moving bodies of water, 35% from a protected well and 18% of the time from an unprotected well. This is different from 8 months ago when Cameroonians got water from protected wells 40% of the time, and refugees obtained water from protected wells only 22% of the time. The advantage of a protected well is that they are sealed and therefore not prone to contamination with pathogens that may cause diarrheal diseases. This difference in water source over the past 8 months suggests that agencies tasked with improving living conditions for the population may have focused on refugee populations as opposed to the entire population as a whole. The assessment team recommends that protected wells be placed in both host and refugee communities in order to prevent tensions in the local population.

As in June 2009, the female head of household or female children are primarily responsible for fetching water and do so approximately 2-3 times per day. A small percentage of the time, male children fetch water. The mean time to obtain water is 36 minutes for the host population, and 33 minutes for refugees. The location of the water source has implications for the personal security of the individual tasked with collecting the water.

All households sampled in Djohong District use wood as their primary source of fuel. Ninety-one percent of refugees and 94% of Cameroonians state that they have enough fuel to cook

their meals. Cameroonians spend 110 minutes, on average, to obtain fuel while refugees spend 168 minutes to obtain fuel. This may be due to the larger percentage of relatively wealthier native Cameroonians who are able to buy fuel at the local market or have it delivered. More female refugee head of households collect fuel than their counterparts in the host population (59% versus 53%). A larger proportion of Cameroonians have the resources to buy fuel than refugee women (16% versus 13%).

6.3 Shelter

Though the majority of the population live in mud brick homes (72% Cameroonians, 53% of refugees), a significantly larger proportion of refugees live in beat earth huts (22% of the host population, versus 37% of refugees). Beat earth huts are less stable, structures than mud-brick homes—and also cheaper to build. This not only reflects the lower income of refugees, but also may be a source of vulnerability. However, the proportion of refugees with grass huts has significantly decreased since June 2009—likely reflecting a relative increase in income and resources among this population.

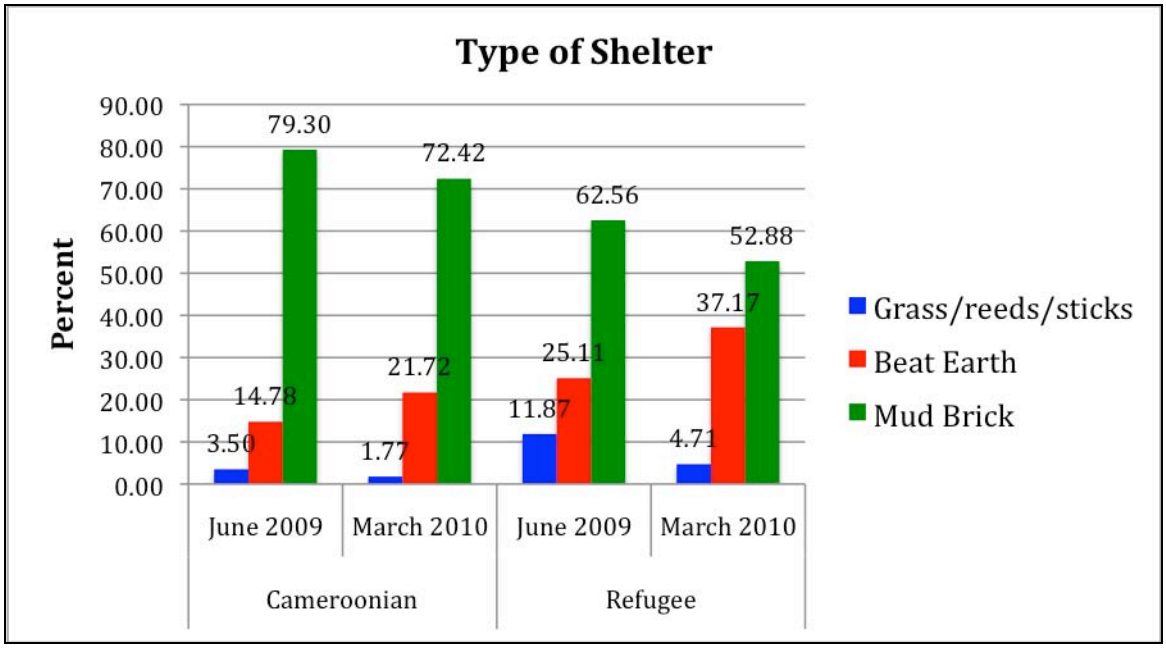


Figure 49. Shelter

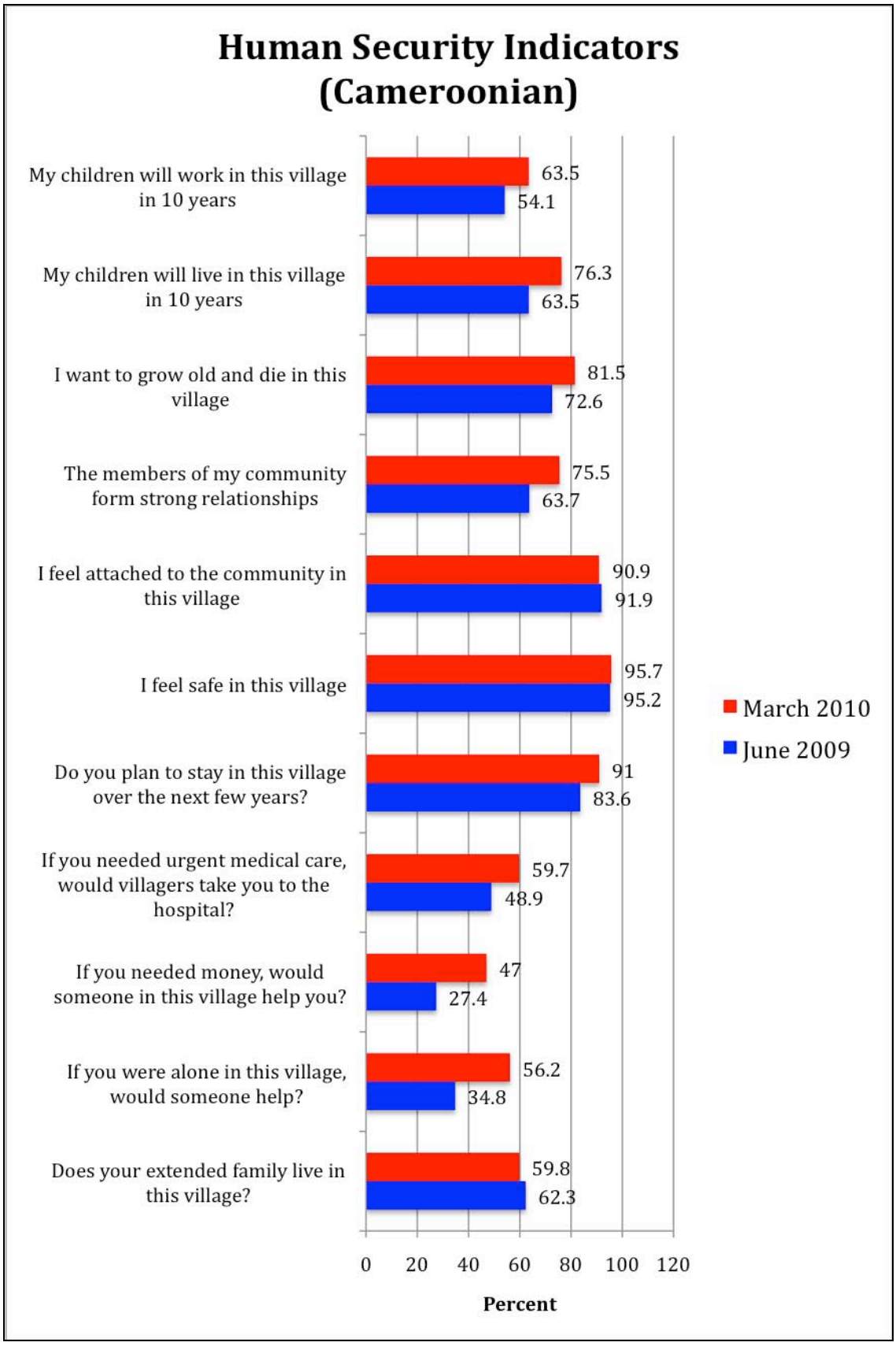
7. Human security

Key informant interviews and focus groups in June 2009 suggested that refugees have been well received in Djohong District, particularly since many from CAR have family in the Cameroonian villages where they reside or are from the same tribe.

The household survey included several questions to assess community integration and support. In general, the responses to these questions indicate that refugees are well integrated into the community, and plan to stay where they have settled. The graphs below show the percentage response "yes" or "I agree" for Cameroonians and refugees to questions about community integration and support over June 2009 and March 2010.

As in June 2009, Cameroonians appear to have more support and resources in the community than refugees. They answer "yes" or "I agree" more often to questions that ask if they could call on other members of the community for help in times of crisis. However, refugees seemed more likely to respond "yes" or "I agree" in March 2010 to these questions than they did in June 2009. This suggests that refugees still feel welcomed in their community, and have become more strongly integrated into their communities since June 2009. This finding is supported by the increase in refugees who responded, "I agree" to the question "The members of my community form strong relationships."

In contrast, refugees were somewhat more likely than Cameroonians to respond "yes" to questions asking if they and their children are likely to settle permanently in their current village. The percentage of refugees who said yes to these questions also increased over the past 8 months, suggesting that refugees in Cameroon still plan to live there permanently.


Human Security Indicators (Cameroonian)
My children will work in this village in 10 years
63.5
54.1
My children will live in this village in 10 years
76.3
63.5
I want to grow old and die in this village
81.5
72.6
The members of my community form strong relationships
75.5
63.7
I feel attached to the community in this village
90.9
91.9
I feel safe in this village
95.7
95.2
Do you plan to stay in this village over the next few years?
91
83.6
If you needed urgent medical care, would villagers take you to the hospital?
59.7
48.9
If you needed money, would someone in this village help you?
47
27.4
If you were alone in this village, would someone help?
56.2
34.8
Does your extended family live in this village?
59.8
62.3
0
20
40
60
80
100
120
Percent
March 2010
June 2009

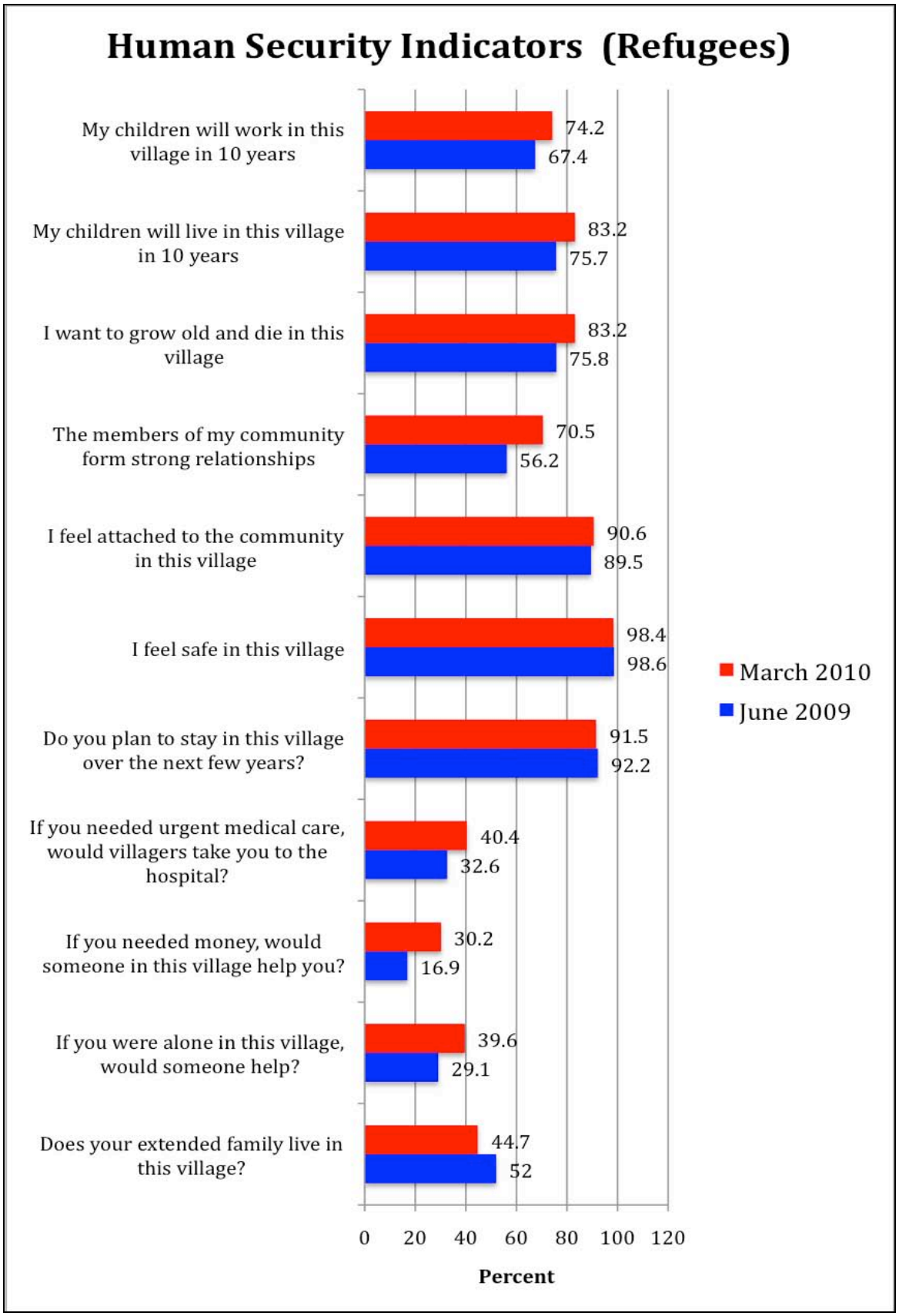

Human Security Indicators (Refugees)
My children will work in this village in 10 years
74.2
67.4
My children will live in this village in 10 years
83.2
75.7
I want to grow old and die in this village
83.2
75.8
The members of my community form strong relationships
70.5
56.2
I feel attached to the community in this village
90.6
89.5
I feel safe in this village
98.4
98.6
Do you plan to stay in this village over the next few years?
91.5
92.2
If you needed urgent medical care, would villagers take you to the hospital?
40.4
32.6
If you needed money, would someone in this village help you?
30.2
16.9
If you were alone in this village, would someone help?
39.6
29.1
Does your extended family live in this village?
44.7
52
0
20
40
60
80
100
120
Percent
March 2010
June 2009

Table 9. Human Security Indicators

Question	Cameroonian % (n)		Refugee % (n)	
	June 2009	March 2010	June 2009	March 2010
Does your extended family live in this village?	62.3 (231)	59.8 (237)	52.0 (114)	44.7 (85)
If you were alone in this village, would someone help?	34.8 (89)	56.2 (222)	29.1 (44)	39.6 (75)
If you needed money, would someone in this village help you, other than family?	27.4 (102)	47.0 (185)	16.9 (37)	30.2 (57)
If you needed urgent medical care, would some non-family villagers take you to the hospital?	48.9 (182)	59.7 (234)	32.6 (71)	40.4 (76)
Do you plan to stay in this village over the next few years?	83.6 (311)	91.0 (354)	92.2 (202)	91.5 (172)
I feel safe in this village	95.2 (354)	95.7 (379)	98.6 (216)	98.4 (188)
I feel attached to the community in this village	91.9 (342)	90.9 (359)	89.5 (196)	90.6 (173)
The members of my community form strong relationships and rely on each other for support	63.7 (237)	75.5 (299)	56.2 (123)	70.5 (134)
I want to grow old and die in this village	72.6 (270)	81.5 (322)	75.8 (166)	83.2 (159)
My children will live in this village in 10 years	63.5 (231)	76.3 (297)	75.7 (165)	83.2 (158)
My children will work in this village in 10 years	54.1 (197)	63.5 (247)	67.4 (147)	74.2 (141)

8. IMC GBV Program

- ***Recommendation:*** **An expansion of the current SGBV program is strongly recommended. The number of women who admit to sexual violence in their lifetimes has doubled since the June 2009 study. This increase is due at least in part to an increased comfort level discussing sexual violence among women in Djohong as a result of the IMC GBV program. According to the March 2010 study, thirty-five percent of women in Djohong District have experienced sexual violence in their lifetimes, and 31% of women in Djohong have been beaten by their husbands in the past 6 months.**

- ***Recommendation:*** **The results of the March 2010 survey show that women who have higher incomes and better education (who are able to do math) have lower rates of sexual and non-sexual violence. Interventions that keep young girls in school and teach women ways to generate income may lead to a decrease in incidence of GBV over the long term. The SGBV program should expand it's focus on livelihood and economic development for the women of Djohong, including expansion of the school reintegration program for school-age victims of violence, vocational training for women in Djohong, and the construction of a shelter for victims of violence to enable women to leave dangerous households.**

- ***Recommendation:*** **Given the high rate of sexual and non-sexual violence perpetrated by men who are members of the community and husbands, the assessment team strongly recommends an education program targeting men and boys in Djohong district on SGBV.**

8.1 Program Description

In June 2009, the program had provided services to 500 victims of violence. As of March 2010, the IMC GBV program has provided services to over 2400 victims of sexual and non-sexual violence (including psychological, economic, physical, and sexual violence). Twenty percent of those treated are survivors of sexual violence. Economic violence is defined as an attack on one's livelihood (stealing cows, destroying crops, etc). Psychological violence is, for example, watching a loved one's murder or rape.

Current staff includes 2 psychologists, one anthropologist, one social worker, one nurse, 4 health promoters, and a lawyer who currently coordinates the social reinsertion program (see **Section 8.2.2**).

The SGBV program continues travels to villages in Djohong District to provide education on sexual health and distribute condoms, and during these visits provides initial counseling and empiric therapy for STIs (when appropriate) to victims of sexual violence. They also test for

HIV and transport HIV positive women and men to Ngaoundere for HIV treatment once per month. According to an interview Dr. Celia Kohn, 50% of women who have been raped and agreed to be tested for HIV are HIV positive. Fifty-four of 99 people have tested HIV positive thus far, and 20 are currently being treated with anti-retroviral therapy. These 20 HIV positive individuals would be unable to access treatment without transportation by the IMC GBV team to Ngaoundere Hospital, which is located several hours away.

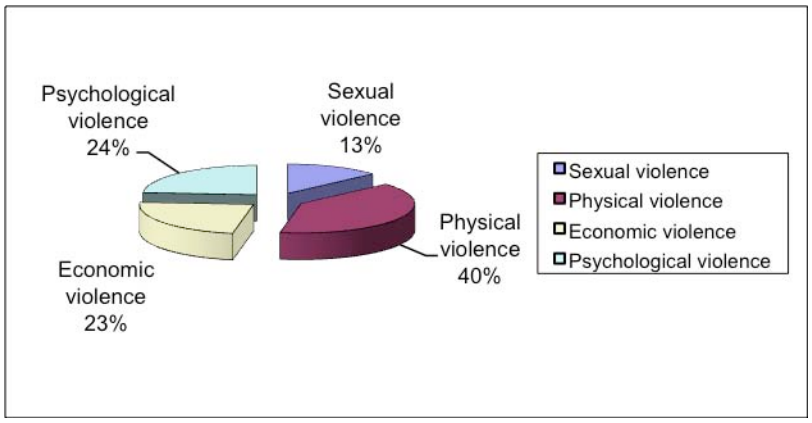


Figure 50. Cases of Violence, IMC Djohong
(Used with permission of Dr. Celia Kohn, March 2010)

Since March 2009, the IMC GBV coordinator has been the only obstetrician in Djohong District. Dr. Kohn has performed 5 fistula repairs and multiple emergency cesarean sections in the past year, often rushing with patients from Djohong District to the nearest surgical facility in Meiganga Hospital 2 hours away.

8.2 Program Expansions

The program has expanded substantially since June 2009, not only in numbers treated but also in services provided.

8.2.1 Psychological Counseling Program

The IMC GBV program has two clinical psychologists on staff. A "counseling room" was recently constructed at Djohong Hospital. This inpatient ward has 3 beds, directly adjacent to 3 antenatal care beds, where women who are suffering from severe depression or PTSD as a result of rape may stay for intensive therapy and observation. Their diagnosis remains unknown to hospital staff, and their confidentiality is assured by the proximity of this room to the obstetric ward. IMC staff psychologists and trained counselors give all women who have suffered sexual and non-sexual violence an average of 3 counseling sessions. According to the outgoing IMC GBV director, 1700 women have been treated since August.

8.2.2 **Social Reinsertion Program**

Women who have been raped are generally rejected by their husbands and family and left without any way to earn an income. In order to help these women cope, the IMC GBV program recently started a program to train victims of violence in dressmaking. IMC Djohong hired a local tailor to train 26 women to learn how to sew. The program has been extremely well received and successful. Additionally, IMC Djohong has provided funds and books to enable 24 girls aged 7-12 who are victims of rape to attend school. In the March 2010 study, women who were able to do math and had higher incomes were far less likely to be victims of sexual and non-sexual violence—thus an expansion of these social reinsertion programs is strongly recommended.

8.2.3 **Community Health Workers**

The IMC GBV program has provided trainings for a network of 53 Community Health Workers (CHWs) and 30 Peer Educators since August of 2009. CHWs primarily work with the local ministry of health, and provide education on HIV, hygiene, STIs and counseling. They assist the IMC program by visiting those who are on treatment for HIV or post-exposure prophylaxis to make sure they are taking their medicines and to monitor side effects. They also provide outreach sessions on sexual health and violence. Peer educators provide sexual health education in villages in Djohong District.

8.2.4 **Traditional Birth Attendants**

IMC Djohong has trained 50 traditional birth attendants (TBAs) in Djohong District in safe motherhood, hygiene, and sexual health. These TBAs are given a kit of basic materials to deliver children safely, and are trained to recognize women who are likely to suffer from complicated labor in order to refer them to Djohong Hospital. TBAs also refer victims of violence to the IMC GBV program.

9. Appendices

Appendix 1: List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
BPRM	United States Bureau of Population, Refugees and Migration
CAR	Central African Republic
CFA	Central African Franc
CHW	Community health worker (French: *relais communautaire*)
DSM IV	Diagnostic and Statistical Manual of Mental Disorders, 4th. Edition
EmOC	Emergency obstetrical care
EPI	Extended Program on Immunization
FGD	Focus group discussion
GBV	Gender-based violence
HHI	Harvard Humanitarian Initiative
HIV	Human Immunodeficiency Virus
HTU	Health Technical Unit
IMC	International Medical Corps
KAP	Knowledge, Attitudes and Practices
KII	Key informant interview
M & E	Monitoring and Evaluation
MoH	Ministry of Health
MMU	Mobile Medical Unit
NGO	Non-governmental organization
OT	Operating Theater
PEP	Post-exposure (HIV) prophylaxis
PRM	Bureau of Refugees, Population and Migration
PTSD	Post Traumatic Stress Disorder
RCA	Central African Republic (French abbreviation)
RH	Reproductive Health
RIB	Rapid Intervention Brigade
SGBV	Sexual and gender-based violence
STI	Sexually transmitted infection
TBA	Traditional birth attendant
TBD	To be determined
TFC	Therapeutic Feeding Center
TOR	Terms of Reference
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNIFEM	United Nations Development Fund for Women
WFP	World Food Program
WHO	World Health Organization

Appendix 2: Scope of Work

SCOPE OF WORK (DRAFT)

Monitoring and Evaluation (M&E) Services in Cameroon

International Medical Corps
February 2009

BACKGROUND

Since early 2006, the Central African Republic (CAR) has been plagued by ongoing internal conflict which has in turn created continuous refugee outflows into Cameroon, Sudan and Chad. The estimated 49,300 CAR refugees that have moved into Eastern Cameroon are largely from the Mbororo ethnic group and most have settled in 50 villages near the border 1. In February 2008, International Medical Corps (IMC) deployed an assessment team to assess the needs of CAR refugees in Djohong District. The assessment showed that the region is by far the most under resourced and impoverished province in Cameroon. Health services, where available, were often distant from the refugee settlements, leaving many refugees with no access to healthcare. Djohong District is incredibly remote, and has received the least amount of humanitarian support, even though it hosts a large number of CAR refugees.

In January 2009, IMC initiated its project entitled "Critical Health Support for Survivors of GBV amongst Central African Republic Refugees in Eastern Cameroon" with funds from the UN Trust Fund in Support of Actions to Eliminate Violence against Women. The **goal** of the project is to reduce SGBV against female refugee and host population members, and provide SGBV survivors with quality health services in Djohong District, Eastern Cameroon. specific objectives are to:

> **Objective 1:** To improve access to quality SGBV and reproductive health services for female refugees and host community victims of violence in Djohong District.
>
> **Objective 2:** Reduce stigma and discrimination around SGBV and ensure community participation in SGBV prevention activities.

The project addresses current needs and existing gaps by providing GBV healthcare and prevention services that are not current being provided by the MoH or UNHCR, UNICEF or WFP. This project has prevention, recognition, and response components. Details on project activities, outcomes and indicators are provided in the project logframe in Annex 1. Two main strategies for reaching these objectives are:

> **Capacity Building:** IMC will train health facility and community health workers on service provision to SGBV survivors. Coaching, supportive (on the job) supervision and regular refreshing training will be provided through monthly visits.
> **Community Awareness and Outreach:** Community capacity building will begin with sensitizing community leaders, including the Imams, teachers, and police. IMC will share awareness raising activities with other agencies, NGOs and concerned communities groups (such as local women groups and human rights groups).
> 1 U.S. Committee for Refugees and Immigrants. World Refugee Survey 2008 – Cameroon. http://www.unhcr.org/refworld/country,,USCRI,,TCD,456d621e2,485f50c66c,0.html

The SGBV project is being implemented in Djohong District of Adamaoua Province over a period of 12 months (January -December 2009) and targets approximately 12,950 women of child-bearing age directly. Another 22,551 CAR refugees and 46,776 Cameroonians are anticipated to benefit indirectly. IMC is currently implementing an emergency primary health care project in the same area with funding from the US Government trough the Bureau of Refugees, Population and Migration (PRM).

While data on SGBV among CAR refugees in the project area are incredibly limited, IMC's rapid assessment conducted in support of proposal development highlighted uncovered stories of women and children being kidnapped for ransom by rebels and bandits, and subsequent murders when families were unable to pay. In addition, due to its proximity to the border, this region is noted for its high level of commercial sex workers. Many women, faced with no income, resort to prostitution for income. This has led to a high prevalence of STIs, HIV/AIDS and overall unsafe sex practices. Interviews with health care providers suggested that little is being done to treat STIs and IMC's assessment found that out o 188 pregnant women, 10% tested positive for HIV.

To fill these gaps, and in support of overall project implementation and evaluation, IMC intends to conduct a comprehensive baseline assessment, establish a rigorous monitoring system, and undertake a final evaluation. A mid-term assessment of project progress will be conducted internally. The final evaluation will be conducted by an external team brought to the field to review what has been achieved during the project period. This evaluation will assess achievement of indicators. The

quantitative and qualitative data collected, analyzed, and compiled in the final report will be disseminated to the following stakeholders: PRM, UNHCR, WFP, provincial health departments, MoH, other NGOs working in the area, and related UN agencies.

DESCRIPTION OF SERVICES REQUIRED AND TIMELINES

IMC has identified three main services areas requiring technical assistance in support of rigorous M&E for the Cameroon SGBV project: 1) Baseline Assessment; 2) M&E System Set-up; and 3) Final Assessment and Evaluation. The consultant(s) would be requested to work in close collaboration with the IMC Country Team in Cameroon and Health Technical Unit (HTU) in Washington to perform the services outlined below.

Timelines are very short and IMC intends to collect baseline data and establish the M&E system by the end of March 2009. The end of project survey and final evaluation are expected to take place in November-December 2009. IMC anticipates that the consultants will travel to Cameroon in early March and stay for 3-4 weeks and return in mid-end November for a similar time period.

1) Baseline Assessment (March 2009)

The consultant(s) will design and implement the baseline assessment in collaboration with the country team, MOH and HTU. The baseline assessment should employ a mix of qualitative and quantitative approaches and generate a comprehensive profile characterizing the extent of SGBV among CAR refugees, community attitudes towards SGBV, and the quality and accessibility of medical and other services to prevent and respond to SGBV.

At a minimum, the following groups should be included in the assessment:

- Male and female refugees and host population (as appropriate) of reproductive age (15-49 years)
- Community leaders and other persons of influence (both refugee and host)
- Health care workers (MoH and NGO)
- GBV survivors who have come forward for services (from IMC or other)
- Local enforcement, legal and administrative officials
- Other TBD during design phase

It is anticipated that data will be collected through focus groups, key informant interviews, and household surveys (population-based representative survey ideally, but to be determined). Review of SGBV related services at the health facilities in the project areas must also be undertaken. The design of the baseline assessment must allow comparisons over time and be able to comment on the ability of the project to meet its objectives.

Specific tasks include:

1. Prepare detailed design and methodology for baseline assessment
2. Develop data collection tools and conduct sampling
3. Train the survey teams on the following:
    - Understanding the objectives of the assessment
    - Explaining the roles and responsibilities of each team member
    - Explaining the sampling method and the importance of adhering to rigor and data collection ethics
    - Interviewing skills
4. Lead the implementation of the survey (2 weeks)
5. Work closely with the IMC country team to develop and oversee the data management, including database design, data entry and cleaning systems
6. Train IMC staff on data analysis and jointly analyze assessment data (analysis plan and basic analysis).
7. Prepare comprehensive assessment report to IMC (no later than 30 April 2009). The report shall:
    - Be at least 15 pages in length not including annexes
    - Include descriptive tables/graphs
    - Include a description of assessment methodology, tools and method of analysis
    - Outline key recommendations

2) M&E Plan Development and System Set-up (March 2009)

The consultant will design and lead IMC Cameroon staff in the initial conceptualization of the monitoring and development plan and development of associated tools and procedures. It is anticipated that this activity will take place over a two-week period in March 2009.

Specific tasks include:

1. Lead IMC program staff in a 3-day workshop to review project strategy and logframe and develop a detailed M&E plan for the Cameroon SGBV project. The detailed M&E plan will include the following:
    - Revised project logframe (incorporating updated activity plans, baseline findings, etc)

- Performance questions, information needs, indicators and related targets, data sources and methods, frequency of data collection, frequency of analysis, persons responsible
- An outline of the information management system
- Detailed responsibilities of program staff in relation to M&E

2. Based on the M&E plan, develop associated data collection, analysis and reporting and communication tools and procedures, including
   - Monthly and quarterly report templates in Excel (basic templates)
   - Simple monitoring tools to assess: community mobilization and education activities; health facility level activities (trainings, clinical care); supportive supervision checklists; client satisfaction interview checklists; clinical record review templates
   - Simple Excel templates to enter, store and analyze data collected through monitoring tools
3. Provide training to IMC staff on how to implement the M&E tools and in data analysis and interpretation for real time program level decision-making.

3) Final Assessment and Evaluation (November 2009)

The consultant will conduct the follow-up assessment in the project areas and conduct a final evaluation comparing baseline data with end of project data. An additional, more detailed evaluation TOR will be developed following the completion of the baseline assessment and shared with the consultant.

Specific tasks include:
1. Prepare detailed design and methodology for follow-up assessment, using baseline as a guide
2. Review and adapt baseline data collection tools for follow-up assessment and conduct sampling
3. Provide refresher training to the assessment teams
4. Lead the implementation of the assessment (2 weeks)
5. Lead IMC staff in the analysis of the follow-up assessment data
6. Prepare a comprehensive final assessment report to IMC (no later than 15 January 2010).

The report shall:
- -Be at least 20 pages in length not including annexes
- -Include descriptive tables/graphs
- -Include a description of assessment methodology, tools and method of analysis
- -Outline key recommendations

7. Conduct a final evaluation of the program, incorporating findings of the baseline and follow-up assessments, program document reviews, site visits and other data sources, as outlined in the evaluation terms of reference (TOR).
8. Prepare final evaluation report (due no later than 30-January 2010)

DESCRIPTION OF DELIVERABLES

The key deliverables are:

1. Baseline assessment report and database (due no later than 30-April 2009)
   a. Complete database (in Access or Excel or other appropriate software) including all data collected during the baseline assessment
   b. Detailed baseline assessment report including: final survey tools

2. Detailed M&E plan and tools (due no later than 30-April 2009)
   a. Detailed M&E plan
   b. Data collection, analysis and reporting tools
   c. IMC-trained staff (At least two IMC staff will be trained in use of tools and M&E management)

3. Follow-up assessment report (due no later than 15-January 2010)
   a. Complete database (in Access or Excel or other appropriate software) including all data collected during the follow-up assessment
   b. Detailed follow-up assessment report including: final survey tools

4. Final evaluation report (due no later than 30-January 2010)
   a. Detailed evaluation report outlining purpose, methods, findings, and recommendations that meets the specifications of the evaluation TOR as developed by IMC.

Outcome 1 To improve access to quality SGBV and reproductive health services for female refugees and host community victims of violence in Djohong District.				
Output 1.1	**Activities**	**Indicators**	**Means of Verification**	**Assumptions and risks**
Improved access to medical service for SGBV survivors	1) Collaborate with MoH partners to establish referral mechanisms from the communities to the hospital for serious SGBV cases. 2) Conduct training courses for health facility staff in the clinical management (prevention and treatment) of SGBV and STI including psychosocial counseling techniques. 3) Conduct supportive supervision for continued reinforcement of the staff capacity every 2 months. 4) Provide and manage appropriate levels of drugs and supplies for Djohong hospital as per national/international guidelines for treatment of SGBV including syndrome management of STIs. 5) Provide diagnostic, prevention and treatment protocol to Djohong hospital for the management of rape survivors, including medical and psychosocial care services and treatment of STI. 6) Develop proper reporting formats to ensure data collection, analysis and interpretation. 7) Supervise the activities monthly 8) Conduct M&E ongoing	1) 25% increase in the number of SGBV cases seen at the Djohong hospital 2) 100% essential medicines (including PEP kit) to prevent and treat the consequences of SGBV are available in Djohong hospital 3) 15 service providers trained in treatment of SGBV survivors including psychosocial counseling techniques 4) 50% increase in KAP test results from pre-training to post-training on SGBV protocols and medical treatment training	IMC program report Drugs management Tools Certificate of drugs donation Data records register IMC program report	Government staff , are not available to provide qualified secondary treatment Local competence is unable to treat all the of SGBV such as fistulae repair Security deteriorates and prevents access to the project sites. Survivors of SGBV are silent about being raped due to cultural barrier. Turn-over of trained staff is high.

CONSULTANT QUALIFICATIONS

Survey design and implementation: The consultant will have experience designing and implementing →→population based surveys, clinic-based assessments, and qualitative research

Data management: The consultant will have experience using Epi-Info, SPSS, STATA, or other appropriate software for database creation and with data entry and cleaning.

Data analysis and report writing: The consultant will have extensive experience in data analysis and possess solid writing and analytical skills. The consultant will be skilled with statistical methods to analyze data collected from surveys with complex sampling designs and be able to analyze qualitative data.

Content knowledge: Solid understanding of SGBV issues and community-based interventions to prevent and respond.

REQUIREMENTS FROM CONSULTANTS

A summary of experience in the above-mentioned areas

Curriculum Vitaes of all staff proposed to work on this project

Estimate budget costs

ANNEX I: LOGICAL FRAMEWORK RESULTS FORMAT

Overall Goal: To reduce SGBV against female refugee and host population members, and provide SGBV survivors with qu

Output 1.2	Activities	Indicators	Means of Verification	Assumptions and risks
Female refugee and host community, victims of SGBV in Djohong District have increased access to appropriate care services through mobile medical units.	1) Identify and recruit the staff of the MMU covering SGBV activities 2) SGBV Program Manager conducts trainings for members of the MMU and MoH staff in the clinical management of SGBV and STI, including psychosocial counseling techniques and others relevant topics such as referral system, activities planning and working with CHW and TBA. 3) Provide logistic and supply support to the MMU to provide effective treatment to SGBV survivors. 4) Provide diagnostic, prevention and treatment protocol to the MMU for the management of rape survivors, including medical and psychosocial care services and treatment of STI at community level. 5) Develop proper reporting formats to ensure data collection, analysis and interpretation. 6) Supervise the activities on monthly basis, and conduct monitoring and evaluation periodically. 7) Conduct monthly meetings with all community stakeholders to get feedback on the project's progress and constraints.	1) MMU conduct at least 20 outreach sessions a month. 2) 90% of identified survivor of SGBV received comprehensive package (psychosocial and HIV/Hepatitis B counseling, STI prevention and /or treatment, tetanus emergency contraception) 3) 100% of individuals attending health services with symptoms of STIs are properly treated	IMC program report	Government staff , included in the MMU are not motivated Security deteriorates and prevents access to the project sites. Survivors of SGBV are silent about being raped.

ality health services in Djohong District, Eastern Cameroon.

Harvard Humanitarian Initiative

International Medical Corps

Outcome 2 Reduce stigma and discrimination around SGBV and ensure community participation in SGBV prevention activities.				
Output 2.1	**Activities**	**Indicators**	**Means of Verification**	**Assumption and risks**
CHWs and TBAs demonstrate increased technical competence in SGBV communication skills	1) Identify at least 25 CHW, 25 TBA and 20 peer educators. 2) Train 50 CHW and TBA in methods of communication on basic concept of SGBV including the causes and consequences 3) TBAs and CHWs demonstrate 50% increase fr om pre-training to post-training in KAP test resu lts.	1) At least 50 CHW and TBA trained in BCC, IEC, mass campaign, and advocacy communication methods. 2) KAP survey shows at least 50% increase in the beneficiaries knowledge of SGBV issues and the importance of seeking treatment/counseling	Training minute IMC program report Training minute IMC program report	Absence of TBA communities
Output 2.2	**Activities**	**Indicators**	**Means of Verification**	**Assumptions and risks**
Communities have increased access to SGBV information through community mobilization and sensitization campaigns through the ue of TBAs and CHWs	1) Design, print and distribute sensitization tool kits. 2) Conduct awareness raising sessions in the community, via CHWs and TBAs. 3) Conduct advocacy sessions with community leaders on the cause and consequences of SGBV and explain methods to combat SGBV. 4) Identify and launch peer educator group among the more skilled women and girls of the community and train them in basic management of SGBV	1)At least 50 outreach sessions are conducted each month, in collaboration with the CHWs and TBAs 2) At least 20 beneficiaries are reached per outreach session	IMC program report	Security deteriorates ar prevents access villages

Appendix 3: Quantitative Assessment Tool

HHI - IMC Enquête d'estimation de santé

1. **CODE DU CAS** _____ (1-5000)

2. Date de l'entrevue _____ _____(JJ) - _____ _____(MM) – 2010

3. Code de l'enquêteur _____ **18 ans+**

4. Code de l'interprète _____

5. Code de village _____

Bonjour, je m'appelle _____ et avec moi c'est _____, mon interprète. Merci d'être avec nous aujourd'hui. Nous somme de Djohong et nous travaillons pour IMC, une ONG international engagée dans la promotion de la santé de la femme. Nous ne sommes pas un groupe religieux ni politique.

Nous menons une enquête pour mieux comprendre les besoins sanitaires des femmes camerounaises et réfugiées vivant dans cette région. Nous ne somme pas là maintenant pour vous procurer une aide humanitaire même si vos réponses vont permettre à IMC de vous pourvoir des meilleurs soins de santé.

Si vous êtes d'accord, j'aimerais vous poser des questions sur votre santé, vos expériences dans cette communauté ; et si vous êtes de la RCA, votre expérience reçue là bas, après la migration au Cameroun et comment ces expériences affectent votre santé. Etant donné que la violence contre les femmes affecte leur santé, je vous demanderais également si vous avez eu à vivre une situation de violence et si l'expérience a affectée votre santé.

Vous avez été choisi au hasard parmi plusieurs femmes pour cet entretien. Aucune de vos réponse ne sera partagée avec quelqu'un, ni reconnue a partir d'une réponse de quelqu'un d'autre. Je vais me rassurer que personne ne sache ce que vous me dites. Je ne demanderai pas votre nom ni celle des membres de votre famille. Personne ne saura ce que vous me dites.

Elle [montre l'interprète] *est ici parce que je ne m'exprime pas dans votre langue. Elle me permettra de vous parlez et vous comprendre. Elle ne dira a personne ce que vous dites ni qui vous êtes. Si vous ne comprenez pas une question, demandez moi de vous expliquer cela plus clairement.*

La santé de la femme est un sujet souvent personnel et sensible à débattre. Veuillez m'avertir si vous ne voulez pas répondre à une question et je vais passer aux questions suivantes. Si vous ne comprenez pas le sens d'une question, veuillez m'arrêter pour plus des précisions. Vous êtes libre d'arrêter l'interview a tout moment. Je ne serai pas fâché. Vous ne serez pas pénalisée pour ne pas avoir répondu aux questions. Vous ne perdez rien si vous ne participez pas.

Cette enquête prendra environ une heure de votre temps

Si vous avez des questions concernant cette étude, vous êtes libre de les poser maintenant. Pour plus de précision, en cas de besoin vous pouvezt contactez les bureau de recherche à l'école de santé publique de Harvard au E.U. sur le numéro +1 866 606 0573. Je vous remercie pour votre participation.

Est-ce que vous avez des questions avant que nous ne commencions?

6. *Vous avez choisi librement de participer à cette enquête?* Oui 1 Non 2

DEMOGRAPHIE

7. Genre: F 1 M 2

8. Quel âge avez-vous? _____Ans Je ne sais pas 99

9. Où habitez-vous actuellement?
Dans ce village 1
Autre (spécifier)_____ 2

10. Depuis combien de temps habitez-vous dans ce village? _____ans _____mois

11. Vous êtes…? Camerounais 1 Réfugié RCA 2 Autre (spécifier)_____3

12. Combien des personnes habitent votre ménage vous inclus? _____

13. Y a-t-il eu un changement dans la grandeur du ménage dans les six derniers mois ?
Oui 1 Non 2

14. Naissances dans votre maison dans les 6 mois passés?
Oui 1 Non 2

15. Des morts dans votre maison dans les 6 mois passés ?
Oui 1 Non 2

16. *Nouvelles arrivées dans votre maison dans les 6 mois passés ?*
Oui 1 Non 2

Veuillez nous donne plus d'information sur les habitants de votre ménage:

	Relation **[Choisir un]**	*Genre*	*Âge*	*Actuellement scolarisé?*	*Type de occupation?* **[Choisir un]**
17.	1 (Vous)	1			
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					
	1=Vous 2=Epoux 3=Autre épouse 4=Fille/Fils 5=Enfant de co-épouse 6=Mère/Père 7=Soeur/Frère 8=Belle soeur/beau frère 9=Belle fille/beau fils 10=Autre relation 11=Non membre de famille	1=F 2=M	En chiffre (ans)	1=Oui 2=Non	1=Cultivateur 2=Eleveur 3=Berger 4=Ménagère 5=Commerçant 6=Marabout 7= Chauffeur 8=Garde chargé de sécurité 9= Retraité 10= Sans emploi - adulte 11= Sans emploi - enfant 12= Étudiant / élève 13= Autorité traditionnelle 14= Autorité religieuse 15= Fonctionnaire d'état 16= Militaire 17= Autres **(spécifier)**

Si quelqu'un est décédé dans votre maison au cours des 6 mois passés, parlez-m'en s'il vous plaît. □ NA

	Genre 1=F, 2=M	Âge de décès	Cause de décès:	1=diarrhée 2=fièvre 3=autre maladie 4=accident 5=vieillesse 6=assassiné 7=décède a la naissance 8=sorcellerie 9=malnutrition 10=accouchement 11=autre **(spécifier)** 88= aucune réponse
27.				
28.				
29.				

30. *Est-ce que tous vos enfants âgés de 5-18 vont à l'école*? Oui 1 **[à 32]** Non 2

31. *Si non (des vos enfants entre 5-18), pourquoi?* **[Encercler UNE]**
Resource financière limitée 1
Les enfants doivent travailler 2
Manque d'établissement scolaire 3
Ecole trop éloignée de village 4
L'insécurité 5
Non applicable 6
Autres (spécifier) _____ 7

32. *Quelle est votre statut matrimonial?* **[Encercler UNE]**
Jamais marié 1
Marié 2
Divorcée 3
Veuve 4
Conjoint perdu 5
Cohabitation 6

33. *Quelle âge aviez-vous quand vous vous êtes mariée pour la première fois?* _____ ans

34. *Quelle est votre groupe ethnique?* **[Encercler UNE]**
Fulbe 1
Mbororo 2
Gbaya 3
Pana 4
Poulo 5
Mboum 6
Mbere 7
Autres (spécifier) _____ 8

35. *Quelle est votre langue maternelle?*
Fulfulde 1

Mbororo 2
Gbaya 3
Sango 4
Français 5
Pana 6
Mboum 7
Autres (spécifier) _____ 8

36. *Quelle est votre religion?* **[Encercler UNE]**
Musulmane 1
Chrétienne 2
Animiste 3
Sans religion 4
Autre (spécifier)_____ 5

SECURITE HUMAINE

37. *Avez-vous un champ ou jardin pour l'utilisation du ménage?*
Oui 1 Non 2

38. *Cultivez-vous pour la subsistance*? Oui 1 Non 2

39. *Cultivez-vous pour le marché locale*? Oui 1 Non 2

40. *Serez-vous capables d'utiliser ce terrain l'année prochaine ou deux ans après ?*
Oui 1 Non 2

41. *Quelle est la largeur du terrain*? _____ hectares

42. *Votre famille élargie vit dans ce village?* Oui 1 Non 2

43. *Si vous étiez seul dans ce village, quelqu'un de ce village vous aiderait -'il?*
Oui 1 Non 2 Je ne sais pas 99

44. *Si vous aviez un besoin financier, trouveriez-vous d'aide hors de votre famille ici au village?*
Oui 1 Non 2 Je ne sais pas 99

45. *Si vous étiez dans une situation d'urgence médicale, quelqu'un du village pourrait-il vous amener à l'hôpital?* Oui 1 Non 2 Je ne sais pas 99

46. *Avez-vous l'intention de rester dans ce village dans les années à venir?*
Oui 1 Non 2 Je ne sais pas 99

S'il vous plaît, exprimer votre degré de satisfaction:

47. *Je suis en sécurité dans ce village.* Pas d'accord 1 Pas d'opinion 2 D'accord 3

48. *Je me sens lié à cette communauté.* Pas d'accord 1 Pas d'opinion 2 D'accord 3

49. *Les membres de ma communauté ont des relations fraternelles et s'entraident.*
Pas d'accord 1 Pas d'opinion 2 D'accord 3

50. *Je veux vieillir et mourir dans ce village.* Pas d'accord 1 Pas d'opinion 2 D'accord 3

51. *Je crois que mes enfants resteront dans ce village dans 10 ans.*
Pas d'accord 1 Pas d'opinion 2 D'accord 3

52. *Je crois que mes enfants travailleront dans ce village dans les 10 ans à venir.*
Pas d'accord 1 Pas d'opinion 2 D'accord 3

REVENUE

53. *Votre famille (votre maison) dispose t'elle d'un terrain?* Oui 1 Non 2

Combien d'animaux domestique votre famille dispose t'elle? **[Spécifier le nombre d'animaux]**

54. Poules_____(no.)
55. Canards_____(no.)
56. Lapins_____(no.)
57. Porcs_____(no.)
58. Chevres_____(no.)
59. Moutons_____(no.)
60. Boeufs_____(no.)
61. Ânes_____(no.)
62. Cheveaux_____(no.)
63. Autres (spécifier)_____(no.)

Quels sont les objets de valeurs que vous possédez?

[NE PAS LIRE – Encercler TOUS ce qui est applicable]

64. Radio	Oui 1	Non 2	71. Machine à coudre	Oui 1	Non 2
65. Téléphone portable	Oui 1	Non 2	72. Moulin	Oui 1	Non 2
66. Assiettes/Plaques	Oui 1	Non 2	73. Lit/matelas	Oui 1	Non 2
67. Vélo/bicyclette	Oui 1	Non 2	74. Voiture	Oui 1	Non 2
68. Moto	Oui 1	Non 2	75. Télé	Oui 1	Non 2
69. Valises	Oui 1	Non 2	76. Autre Oui (spécifier)_____	1	Non 2
70. Groupe électrogène	Oui 1	Non 2			

77. En moyenne, *Quel est le gain journalier de votre famille (votre maison) (en espèce)?*____CFA

EDUCATION

78. *Pouvez-vous lire un journal ou une lettre*?
Oui sans difficulté 1 Oui avec quelque difficulté 2 Non 3

79. *Pouvez-vous faire l'addition et la subtraction des nombres?* Oui 1 Non 2

80. *Quelle est votre niveau scolaire le plus élevé?* **[Encercler UNE]**
Primaire non complet 1
Primaire complet 2
Secondaire non fini 3
Secondaire fini 4
Université non finie 5
Université finie 6
Aucun 7

81. *Avez-vous reçue une formation professionnelle?* Oui 1 Non 2

SECURITE ALIMENTAIRE

82. *Combien de repas avez-vous en moyenne par jour?* _____ repas

83. *Durant le mois passé, vous est-il arrivé un jour de ne pas manger parce que la nourriture était insuffisante et qu'il fallait faire les provisions pour les prochains jours ou il n'y aurait pas de nourriture?* Oui 1 Non 2

84. *Si oui, quelle était la raison pour laquelle la nourriture était insuffisante?* [**Encercler UNE]**
Mauvaise récolte 1
Distribution par le PAM insuffisante 2
Pas de moyen financière pour se procurer la nourriture 3
Pas de nourriture au marché locale 4
Autres (spécifier) _____ 5

85**.** *Quand avez-vous mangé la viande pour la dernière fois?* _____Jours [**Multipliez des mois x 30 pour calculer le nombre de jours**]

86. *Vous est-il arrivé de vendre vos biens (bétails, poules, etc.) ou de rendre un service pour de la nourriture?* **[Encercler UNE]**
Oui, j'ai vendu les bétails 1
Oui, j'ai vendu les produits de bétail (lait, oeufs, viande, etc.) 2
Oui, j'ai vendu mes propres biens 3
Oui, j'ai travaillé pour la nourriture 4
Non, c'est n'était pas nécessaire 5
Non, j'ai troqué plutôt 6
Autres (spécifier) _____ 7

D'où provient votre nourriture? **[Encercler TOUS ce qui est applicable]**
87. Notre propre champs Oui 1 Non 2

88. Du marché local Oui 1 Non 2
89. De notre bétail (lait, oeufs, viande) Oui 1 Non 2
90. Du PAM Oui 1 Non 2
91. Des dons de la communauté Oui 1 Non 2
92. Autres Oui (spécifier) _____ 1 Non 2

EAU

93. *D'où provient votre eau à boire?* **[Encercler UNE]**
Puits protégé 1
Puits non protégés 2
Source/Rivière 3
Lac/mare 4
Robinet communal 5
Robinet à domicile 6
Bassin de récolte d'eau de pluie 7
Autre (spécifier)_____ 8

94. Qui puise habituellement l'eau dans votre ménage? **[Encercler UNE]**
Moi 1
D'autre femme 2
L'époux/autre homme 3
Les filles 4
Les garçons 5
Autres (spécifier)_____ 6

95. *Combien de tours faite-elle par jour pour puiser l'eau?* _____tours

96. *Combien de temps prend-elle pour puiser l'eau* [**départ et retour**]? _____heures
_____minutes

COMBUSTIBLE

97. *Quelle est votre source **principale** de combustible?* **[Encercler UNE]**
Bois 1
Herbes/Feuilles 2
Charbons 3
Pétrole 4
Autre (spécifier) _____ 5

98. *Avez-vous assez de combustible pour préparer vos repas?* Oui 1 Non 2

*99. Quelle est votre moyen **principal** de vous procurer de combustible?* **[Encercler UNE]**
Je collecte moi même 1
D'autre femme collecte 2
Mon époux/d'autres hommes collectent 3

Les filles collectent 4
Les garçons collectent 5
Nous achetons 6
Fourni par une agence humanitaire 7
Aucune source disponible 8
Autres (spécifier)_____ 9

100. *Combien de temps faut-il marcher à pied pour chercher le bois* [**départ et retour**]*?*
_____*heures* _____*minutes*

HABITATION

101. *Quelle type d'abri habiter vous ?* **[Encercler UNE – indiqué le type de murs]**
Bâche 1
Paille 2
Terre battue 3
Brique de terre 4
Brique cuite 5
Ciment 6
Autres (spécifier) _____ 7

ACCES AUX SOINS DE SANTE **[Encercler TOUT ce qui est applicable]**

Avez-vous accès à ces services médicaux?

102. Vaccins pour les enfants	Oui 1	Non 2	Je ne sais pas 99
103. Soins obstétricaux	Oui 1	Non 2	Je ne sais pas 99
104. Pesé et mensuration des enfants	Oui 1	Non 2	Je ne sais pas 99
105. Dépistage du VIH	Oui 1	Non 2	Je ne sais pas 99
106. Soins pour la fièvre ou infections	Oui 1	Non 2	Je ne sais pas 99
107. Soins des lésions post traumatique	Oui 1	Non 2	Je ne sais pas 99
108. Soins des lésions post violence	Oui 1	Non 2	Je ne sais pas 99
109. Conseil pour la tristesse	Oui 1	Non 2	Je ne sais pas 99

Quel service médical utilisez-vous dans votre localité

[NE PAS LIRE – Encercler TOUS ce qui sont applicable]

110. Tradipracticien/marabout	Oui 1	Non 2
111. Sage femme/ accoucheuses traditionnelles	Oui 1	Non 2
112. Centre de nutrition	Oui 1	Non 2
113. Pharmacie	Oui 1	Non 2
114. Poste de santé	Oui 1	Non 2
115. Relais communautaire	Oui 1	Non 2
116. Hôpital	Oui 1	Non 2
117. Clinique mobile	Oui 1	Non 2
118. Autres	Oui (spécifier)_____ 1	Non 2

119. *Si vous étiez dans le besoin des services médicaux mais vous ne les avez pas consulter, quelle à été la principale raison?* **[Encercler UNE]**

Pas d'argent pour payer les soins 1
Insécurité 2
Pas de moyen de transport 3
Service médical éloigné 4
Service médicaux non disponible/NSP où aller 5
Le centre de santé n'a jamais les médicaments 6
Autres (spécifier) _____ 7

120. *Combien de temps de marche à pied faut-il pour arriver au centre de santé?*
Moins d'une heure 1
1-2 heures 2
2-6 heures 3
6-8 heures 4
8-12 heures 5
Plus de 12 heures 6
Je ne sais pas 99

121. *Avez-vous un accès facile au transport (public ou privé) pour arriver au centre de santé?*
Oui 1 Non 2

122. *Avez-vous utilisé les services de IMC ou les cliniques mobile?*
Oui 1 Non 2

123. *Comment appréciez-vous les soins que vous avez reçu des cliniques mobiles de IMC ?*
Médiocre 1 Adéquats 2 Très bon 3 NA ☐

124. *Comment appréciez vous votre niveau de santé maintenant?*
Médiocre 1 Moyen 2 Excellent 3

125. *Les services de counseling ou de santé mentale sont-ils disponibles?*
Oui 1 Non 2 Je ne sais pas 99

126. *Avez-vous eu besoin d'utiliser le service de santé mental ou de counseling?*
Oui 1 Non 2 Pas de réponse 3

127. *Si oui, l'avez-vous reçu ?* Oui 1 Non 2 NA ☐

[Si non à 126: *Si vous étiez dans le besoins de recourir à ce service…*]
128. Si une femme de votre communauté a ressenti le besoin de recourir aux services de Counselling et n'a pas pu y accéder quelles en sont les raisons **[Encercler UNE]**
Non disponible au centre de santé 1
Disponible mais trop cher 2
Disponible mais peur d'exposer les informations personnel au personnels de la santé 3
Disponible mais pas faisable dans votre culture 4
Disponible mais peur d'être découvert par d'autres membres de la famille ou la communauté 5
Autre (spécifier)_____ 6

Enquêteur : Assurez-vous que vous êtes seul,
si quelqu'un d'autre est dans la salle, veillez lui demander de sortir

VIOLENCE SEXUELLE

129. *Quelle âge aviez-vous quand votre premier enfant est né?* _____ans
Je n'ai pas d'enfants 88

130. *Combien de fois êtes vous tomber enceinte?* _____

131. *Combien de fausses couches avez-vous faites?* _____

132. *Combien de naissance vivante avez-vous faites?* _____

Nous allons vous poser les questions sur la sécurité des femmes dans cette communauté. Certaines femmes dans le village ont été victime de violence, y compris le viol qui a des conséquences néfastes sur leur santé et celle de la communauté. Nous aimerions connaître votre expérience sur ce sujet afin de rendre des services appropriés au femmes et filles dans cette communauté avec des pareilles expériences.

Comme je vous l'ai dit déjà, je vais me rassurer que personne n'ai accès aux informations que vous nous communiquez—ni dans la famille ni dans votre communauté. Parlez de la violence peut être difficile, et nous-en somme conscient. Si vous sentez le besoin de parlez avec un conseiller pendant que nous vous entretenons, nous pouvons arranger cela. S'il vous plaît, rappelez-vous que vous êtes au contrôle et que nous pouvons interrompre l'entretien a tout moment.

133. *Est-ce que vous avez jamais été victime d'une violence sexuelle comme des vexations, être déshabillé de force, relation sexuelle forcée ou d'autres actes sexuelle?* Oui 1 Non 2
[Aller à 176]

Veuillez répondre à ces questions en ce qui concerne le dernier épisode de la violence sexuelle.

134. *Y avait-il plus d'un auteur*? Oui 1 Non 2 Je ne sais pas 99

135. *Le dernier épisode est-il arrivé dans les six mois derniers?* Oui 1 Non 2

136. *Qui était l'auteur de la fois dernière ?* **[Encercler TOUS ce qui est applicable]**

a. Conjoint	Oui 1	Non 2
b. Membre de famille	Oui 1	Non 2
c. Ami	Oui 1	Non 2
d. Membre de la communauté	Oui 1	Non 2
e. Soldat/ Rebel	Oui 1	Non 2

f. Coupeurs de route Oui 1 Non 2
g. Un inconnu Oui 1 Non 2
h. Autres Oui (spécifier **la relation**)_____ 1 Non 2

137. *Que faisiez-vous et où étiez vous quand l'événement s'est produit*? **[Encercler UNE]**
Cherchais le bois
Je faisais le ménage 2
Je dormais à la maison 3
Je partais au marché/champ 4
Autre (spécifier)_____ 5

138. Si le répondant est réfugié: *Est-ce que cela s'est produit lorsque vous étiez au Cameroun, lors du voyage pour le Cameroun, ou avant de quitter votre village?*
Lorsque j'étais au Cameroun 1
Lors du voyage pour le Cameroun 2
Avant de quitter mon village 3

139. Si le répondant est réfugié: *Vous sentez vous en sécurité depuis que vous êtes arrivé au Cameroun?*
Moins de sécurité 1 Pas de changement 2 Plus de sécurité 3

Qui est au courant que vous aviez subi une violence sexuelle en plus de l'auteur? **[Encercler TOUS ce qui est applicable]**
140. Personne (avant cette entrevue) Oui 1 Non 2
141. Epoux / conjoint Oui 1 Non 2
142. Autres membres de la famille Oui 1 Non 2
143. Amie Oui 1 Non 2
144. Chef de village Oui 1 Non 2
145. Autorité religieuse Oui 1 Non 2
146. Personnel médical Oui 1 Non 2
147. Relais communautaire Oui 1 Non 2
148. Enseignant Oui 1 Non 2
149. Soldat/gendarmerie Oui 1 Non 2
150. Autres Oui (spécifier) _____ 1 Non 2

Est-ce que la violence a conduit à…? **[Encercler TOUS ce qui est applicable]**
151. La peur de répresaille physique par l'auteur Oui 1 Non 2
152. Le rejet ou l'abandon par l'époux Oui 1 Non 2
153. Violence physique par l'époux ou la famille Oui 1 Non 2
154. Rejet ou abandon par les autres membres de la famille Oui 1 Non 2
155. Rejet par les amies ou la communauté Oui 1 Non 2
156. La grossesse Oui 1 Non 2

157. *Pensez-vous que la personne qui vous a attaqué devrait être puni pour ce qu'il vous a fait?*
Oui 1 Non 2 Je ne sais pas 99

158. *Avez-vous informé l'autorité locale ou la police?* Oui 1 Non 2

Si vous n'avez pas fait part de votre attaque, quelles étaient vos raisons?

□ NA

[<u>NE PAS LIRE</u> – Encercler TOUS ce qui sont applicable]

159. Ne savais pas là ou s'adresser — Oui <u>1</u> Non <u>2</u>
160. Inutile / ça n'allais rien apporté de bien — Oui <u>1</u> Non <u>2</u>
161. La honte / la stigmatisation sociale — Oui <u>1</u> Non <u>2</u>
162. La peur de répresaille physique par l'auteur — Oui <u>1</u> Non <u>2</u>
163. La peur de subi des violences physiques par le conjoint ou la famille — Oui <u>1</u> Non <u>2</u>
164. La peur d'abandon par le conjoint ou la famille — Oui <u>1</u> Non <u>2</u>
165. Ne serais pas cru / pris au sérieux — Oui <u>1</u> Non <u>2</u>
166. La violence sexuelle est normale – aucune raison de se plaindre — Oui <u>1</u> Non <u>2</u>
167. Personne ne me l'a demandé — Oui <u>1</u> Non <u>2</u>
168. Autre Oui (spécifier)_____ <u>1</u> Non <u>2</u>

169. *Est-ce que quelque chose a été faite lorsque vous vous êtes plaint?*

Oui <u>1</u> Non <u>2</u> Je ne sais pas <u>99</u> □ NA

170. *Si quelque chose a été fait, quoi?* □ NA

On a dédommagé la famille <u>1</u>
Il m'a épousé <u>2</u>
On l'a mis en prison <u>3</u>
Autre (spécifier) _____ <u>4</u>

Cette violence sexuelle a-t-elle conduit à des problèmes physiques? **[Encercler TOUS]**

171. Cicatrices physiques / déformations — Oui <u>1</u> Non <u>2</u>
172. Douleurs abdominales chroniques — Oui <u>1</u> Non <u>2</u>
173. Problèmes urinaires — Oui <u>1</u> Non <u>2</u>
174. Difficultés à déféquer — Oui <u>1</u> Non <u>2</u>
175. Infections pelviennes — Oui <u>1</u> Non <u>2</u>

---------- [Tous les répondants recommencent ici] ----------

176. *Avez-vous subi d'autres violences non-sexuelles, à l'exemple de la bastonnade par l'époux dans les six mois passés?* Oui <u>1</u> Non <u>2</u>

177. *Quelle est la fréquence de la violence non-sexuelle à l'égard des femmes dans votre communauté dans les six mois passés?*

Pas du tout <u>1</u> De temps en temps <u>2</u> Très fréquent <u>3</u>

178. *Si une femme est violée ou sexuellement abusée dans votre communauté, est-il probable qu'elle se plaigne auprès de la police ou des autorités locales?*

Oui <u>1</u> Non <u>2</u> Je ne sais pas <u>99</u>

Si non, pourquoi? **[Encercler TOUS ce qui est applicable]**

179. Elle ne saurait pas où se plaindre — Oui <u>1</u> Non <u>2</u>
180. Inutile / ça n'apporterait aucun bien — Oui <u>1</u> Non <u>2</u>

181. Sentiment de honte ou de stigmatisation sociale Oui 1 Non 2
182. La peur de représailles physiques par le(s) auteur(s) Oui 1 Non 2
183. La peur de subir des violences physiques de la part du mari ou de la famille Oui 1 Non 2
184. La peur d'abandon physique par le conjoint ou la famille Oui 1 Non 2
185. La peur de ne pas être cru ou pris au sérieux Oui 1 Non 2
186. La violence sexuelle est normale – aucune raison de se plaindre Oui 1 Non 2
187. Autre Oui (spécifier) _____ 1 Non 2

188. *Si une femme subie des violences non-sexuelles dans votre communauté, est-il probable qu'elle se plaigne auprès de la police ou des autorités locales?* Oui 1 Non 2 Je ne sais pas 99

189. *Si non, pourquoi?* **[Raison principale – Encercler UNE]**
Elle ne saurait pas où se plaindre 1
Inutile / ça n'apporterait aucun bien 2
Sentiment de honte ou de stigmatisation sociale 3
La peur de représailles physiques par le(s) auteur(s) 4
La peur de subir des violences physiques de la part du mari ou de la famille 5
La peur d'abandon physique par le conjoint ou la famille 6
La peur de ne pas être cru ou pris au sérieux 7
La violence non-sexuelle est normale – aucune raison de se plaindre 8
Autre (spécifier)_____ 9

SANTE MENTALE

190. Si le répondant est réfugié: *Quel était votre état d'esprit avant de quitter votre village?*
Mauvais 1 Moyen 2 Excellent 3 Le répondant n'est pas réfugié 4

191. *Quel est votre état d'esprit actuel?*
Mauvais 1 Moyen 2 Excellent 3

Y a-t-il d'autres services que vous pensez être important et que vous n'avez pas?
[NE PAS LIRE – Encercler TOUS ce qui sont applicable]
192. Quelqu'un pour m'écouter Oui 1 Non 2
193. Formation professionnelle Oui 1 Non 2
194. Éducation / alphabétisation Oui 1 Non 2
195. Lieux pour apprendre les petits métiers Oui 1 Non 2
196. Groupes des femmes Oui 1 Non 2
197. Plus d'accès aux terrains et aux marchés Oui 1 Non 2
198. Nourriture Oui 1 Non 2
199. Accès à l'eau potable Oui 1 Non 2
200. Accès aux services de santé plus crédibles Oui 1 Non 2
201. Sécurité Oui 1 Non 2
202. Autre Oui (spécifier) _____ 1 Non 2

203. *Y a-t-il quelque chose d'autre que vous aimeriez me dire et dont je n'ai pas fait part dans ce questionnaire?*

Merci de votre participation à cette enquête. Vos réponses honnêtes vont permettre aux agences humanitaires de mieux prendre en charge les besoins de santé des femmes dans votre communauté.

Si ca ne vous dérange pas, j'aimerais que vous m'accordez cinq minutes pour vérifier mon questionnaire.

[Enquêteurs : relisez le questionnaire et <u>rassurez vous que toutes les questions ont une réponse avant</u> <u>de quitter le domicile ou l'enquête a lieu</u>]

Remerciez la pour son temps qu'elle a bien voulu vous consacrer.

Appendix 4: Schedule of SGBV Assessment

Feb 24-25 Travel from Yaounde to Djohong
Feb 26-28 Trained for Data Collectors on Quantitative Survey, Sampling Methodology
March 1-9 Household Survey (Team A, B led by Dr. Parveen Parmar; Team D, E led by Dr. Pooja Agrawal; Team E shared)

	Team A	Team B	Team C	Team D	Team E
3/1	Ngaoui	Ngaoui	Ngaoui	Ngaoui	Ngaoui
3/2	Tourake	Alhamdou	Ngaoui	Ngaoui	Ngaoui
3/3	Bafouk Koe	Ngam	Mbewe	Mandip Bondo	Yafounou
3/4	Batoua-Godole	Batoua-Godole	Batoua-Godole	Kombo Laka	Kombo Laka
3/5	Djaoro Mone	Yarambang	Yarambang	Mborguene	Mboui
3/6	Garga Pella	Djohong	Djohong	Djohong	Djohong
3/8	Yamba	Yamba	Yamba	Oura Adde	Batoua
3/9	Fada	Nsooh	Fada	Fada	Bafouk

March 10-12 Travel back to Yaounde, and to Boston