International Medical Corps

Needs Assessment Report

South-West Region

Cameroon

July 2018

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Abbreviations and Acronyms

ARV	Antiretroviral drugs
BEmONC	Basic Emergency Obstetric and Newborn Care
BPHS	Basic Package of Health Services
CAR	Central African Republic
CHW	Community Health Worker
CMAM	Community-based Management of Acute Malnutrition
CMR	Clinical Management of Rape
CSB++	Supercereal Plus Plus (corn soya blend)
CSO	Civil Society Organization
EBF	Exclusive Breastfeeding
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Program on Immunization
GBV	Gender-based Violence
HMIS	Health Management Information System
IASC	Inter-Agency Standing Committee
IEC	Information, Education and Communication
IMC	International Medical Corps
IMCI	Integrated Management of Childhood Illnesses
IOM	International Organization for Migration
IYCF	Infant and Young Child Feeding
MAM	Moderate Acute Malnutrition
M.A.SANTE	Meilleur Accès aux Soins de Santé / Better Access to Healthcare
MINAS	Ministry of Social Affairs
MINJUSTICE	Ministry of Justice
MINPROFF	Ministry of Women Empowerment and Family
MISP	Minimum Initial Service Package
MOH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
NFI	Non-Food Items
NGO	Non-Governmental Organization
NSAG	Non-State Armed Group
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
ORS	Oral Rehydration Solution
OTP	Outpatient Therapeutic Program
PCC	Presbyterian Church in Cameroon
PFA	Psychological First Aid
PLW	Pregnant and Lactating Women
PMTCT	Prevention of Mother-to-Child Transmission
SAM	Severe Acute Malnutrition
SC	Stabilization Center
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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Executive Summary

The South-West and North-West regions of Cameroon, which host 16% of the nation's total population, have been experiencing political and social instability since October 2016[1]. Starting in November 2017, the levels of insecurity and violence have progressively increased in these regions. Since then, the escalation of tensions and hostilities between the government's armed forces and non-state armed groups (NSAGs) have led to significant internal displacement, causing a rapid increase in the humanitarian needs of the two regions. The number of households forced to flee their villages in search of safer areas has rapidly and steadily increased since November 2017, with more than 25,000[2] Cameroonians registered as refugees in the Cross River, Benue, and Akwa Ibom States in Nigeria. In early 2018, the epicenter of the crisis moved from Bamenda, the capital of the North-West, to the Meme and Manyu divisions in the South-West. This region, which hosts more than 1.5 million inhabitants[3], is currently registering an internal displacement of 246,000 people[4].

Since the security and political context in these regions have challenged the flow of information, International Medical Corps (IMC) decided to conduct an integrated multi-sector needs assessment on July 12-25, 2018 to evaluate the Health, Nutrition, Water, Hygiene and Sanitation (WASH), Food Security, and Protection needs of the most affected areas in order to inform an adequate and efficient response. IMC partnered with United Action for Children (UAC), a local NGO with extensive experience implementing education and poverty alleviation projects in the region[5], to conduct a multi-sectoral needs assessment in the Fontem, Kumba, and Mamfe health districts of the South-West region.

The methodology used by IMC to conduct this evaluation combined various tools and techniques. First, a desk review of existing needs assessment reports, publications, and secondary data available on the humanitarian situation in the South-West was used to gather relevant background information and to avoid duplication. A health facility assessment and direct observations made it possible to assess the status of each health facility visited and the living conditions of the people affected by the crisis. In addition, the in-depth interviews with heads of households and community leaders, in addition to a Lot Quality Assurance Sampling (LQAS) survey identified the priority needs of displaced people and host communities. Finally, the use of key informant interviews with the main representatives of the various ministries and with the community leaders permitted IMC to identify the humanitarian response gaps in the assessed health districts.

The assessment showed that IDPs and host communities living in the Fontem, Kumba, and Mamfe health districts are facing increasing protection challenges arising from the violence and insecurity as a result of the armed conflict between the government's forces and the NSAGs. The implementation of the "Ghost Town" days (when the population is not allowed to engage in any commercial activities), the daily nighttime curfew, and the closing and burning of schools, health centers, and other public services have severely disrupted the social stability of the region. Many people have lost their identity cards and birth certificates during their displacement or after the burning of their homes, and the replacement of these documents is now even more challenging than ever. Likewise, as many women are now giving birth in the bush, children are being left without proper registration.

The number of children exhibiting distress and/or turning to drug consumption and theft has increased since the beginning of the crisis. Many adolescents are no longer able to attend school (most of the schools

[1] OCHA. Humanitarian Bulletin No. 8. North-West/South-West Crisis. June 2018.
[2] UNHCR. Nigeria Emergency Update: Cameroonian Refugee situation, 16-31. August 2018.
[3] National Institute of Statistics. "Statistical Yearbook". Cameroon. 2016.
[4] OCHA. Humanitarian Bulletin No. 9.Cameroon. August 2018.
[5] More information on UAC can be found at http://uaccameroon.org/about/

are closed due to the crisis) and some have abandoned their previous livelihood activities, leading many of them to join the armed groups actively engaged in the conflict.

The destruction of the infrastructure has increased the levels of insecurity and placed women and children at a greater risk. Access to water has decreased (as explained in the WASH needs section), and there are areas with little to no electricity forcing women and children to cover greater distances to collect firewood and water. People are now reporting being scared of walking alone, especially at night when they are more vulnerable to rape, assault, and abduction. Women, many of whom are widows, are particularly at risk of gender-based violence, especially sexual exploitation and abuse. Girls are particularly at risk of sexual exploitation and forced marriage. The assessment showed very few available services for GBV survivors, and no referral and coordination mechanisms exist.

The evaluation of the health and nutrition needs showed a gap of 122 staff in the 11 health facilities assessed, with the Menji District Hospital being the most affected. Only 1 out of the 11 assessed health facilities has a health protocol in place for the clinical management of rape and treatment of survivors, and only the Mary Health of Africa Hospital in Fontem has a mental health specialist (1 psychologist). Furthermore, all assessed facilities were suffering from shortages of essential medicines and supplies.

Currently, there is no referral pathway between the OTP in Ntam and the stabilization center in Kumba to ensure the proper treatment for children with severe acute malnutrition with medical complications. The degradation of the health system has also severely affected the outpatient therapeutic program (OTP) services in Fotabong, which are no longer able to deliver treatment to severely acutely malnourished children. The gaps in the management and prevention of severe acute malnutrition have been mainly observed in four OTPs: Fotabong, Bukemwe, Ntam and Mamfe urban.

The interviews with community members and officials showed that people are now less able to seek treatment as the insecurity levels make it more difficult to reach the health facilities, and only 3 of the 11 assessed health facilities have an ambulance for the transportation of critical cases to other health facilities. In fact, only 6% of women are now giving birth at a health facility, compared to 93% before the crisis. A second factor affecting people's access to health care is their increased inability to afford the required services, supplies, and other related costs. As transportation becomes more challenging, the availability of medicine and supplies decreases and most people are no longer able to afford the increased prices. As a result, many people have reported an increase in the use of traditional medicine as an alternative.

Outreach activities and disease surveillance have also been severely affected by the conflict. The last Infant and Young Child Feeding sensitization sessions took place more than six months ago, and only 22% of people surveyed have been sensitized on preventable diseases since the beginning of the crisis.

The evaluation of the water, sanitation, and hygiene (WASH) needs showed that only 37% of the assessed households are now collecting water from an improved water source for daily use, compared to 83% before the crisis, and only 35% of people with access to potable water can access it within 30 minutes compared to 78% before the crisis. Most of the improved water sources cannot be used or are damaged, and the lack of personnel impedes their rehabilitation. A number of households have wells, but these are not treated or sufficient to satisfy the demand. As a result, women and children, who traditionally collect firewood and water, are now forced to travel greater distances to reach rivers and other natural sources placing them at a greater risk of assault and abduction. Children are especially at risk of being affected by water-borne diseases such as cholera and diarrhea, as open defecation is becoming more common, and the water from natural springs and most wells are not properly treated and maintained.

Meeting food security needs and restoring livelihoods were among the top priorities for the people (IDPs

and host community) living in the assessed areas. Only 39% of the households interviewed had food in stock, but people are concern these may not be sufficient to provide for their families and increasing numbers of IDPs. Only 29% reported consuming more than one meal per day compared to 99% before the beginning of the crisis. The insecurity levels continue to undermine the livelihoods of vulnerable people. This conflict has reduced the agro-pastoral production, and women engaged in small businesses, like the sale of vegetables and other foods, have been forced to abandon their activities due to the widespread insecurity. The "ghost town" days, nighttime curfews, and the insecurity on the roads have disrupted the movement of goods and supplies including agricultural inputs.

Introduction and Context

The social, economic, and political stability of Cameroon has been challenged by the violence along the borders with Nigeria and the Central African Republic and the large influx of refugees that have settled in the northern and eastern areas of the country over the past ten years. Moreover, the internal conflict that started in late 2016 in the South-West and North-West (Anglophone) regions has further strained the country's resources. According to the Amnesty International report, protests organized people in opposition of what has been viewed as marginalization of Anglophones was met with fierce repression by the Cameroonian government and security forces[6]. Since late 2017 the escalation of tension and upsurge in hostilities between NSAGs and defense and security forces have resulted in over 400 civilian fatalities and over 250,000 displaced people within the country and across the border in Nigeria[7]. The escalation of violence has led to the closing of many social services including schools, hospitals, and markets. The conflict and displacement have disrupted livelihoods, agricultural production, and commercial activity causing food shortages and an increase in prices. The militarization of the two regions, and human rights violations such as unlawful killings, extra-judicial executions, destruction of houses and businesses, arbitrary arrest, and torture[8].

In the South-West specifically, the performance of most public services has diminished, particularly in the domains of education and health. Most parents stopped sending their children to school in October 2016 as part of the protests against the government, and the various attempts to re-start the school programs have failed as teachers and students wishing to attend school continue to be threatened by the NSAGs for failing to support the strike. Likewise, the latest reports from the Ministry of Health (MoH) Regional Delegation show that most health districts are submitting few, if any, monthly data reports to the Regional Delegation due to the lack of personnel and disruptions in the infrastructure[9]. The Akwaya, Bakassi, Konye, and Mbonge health districts reported a vaccination coverage for the Pentavalent vaccine combination below 25% for the first half of 2018 compared to over 90% for the same period in 2017, and all vaccination sessions have been temporarily suspended in the Fontem health district due to insecurity[10]. The overall timeliness of District Vaccination Data Management Tool (DVDMT) reports for the region dropped from 68% in 2017 to 56% in 2018, and the total regional completeness dropped from 94% in 2017 to 71% in 2018[11]. In terms of disease surveillance, 5 out of the 18 health districts in the region were not able to collect any data during the first half of 2018, and 8 health districts were only able to collect data sporadically due to the insecurity[12]. The reports also show that only 3 vaccinating health facilities are functioning in the Fontem health district (out of 16 available facilities), 11 in Kumba (out of 29 available), and 7 in Mamfe (out of 20 available)[13]. As seen in Figure 1 below, the number of curative consultations and hospitalizations reported between January and May of 2018 have dropped considerably in the entire South-West region in comparison to the same period in 2017 due to the lack of personnel and supplies and the population's inability to safely reach these facilities[14]. Government reports show that 151 deliveries were assisted at the

[6] Amnesty International. "*A Turn for the Worse: Violence and human rights violations in Anglophone Cameroon"* 2017.
[7] ACAPS. Cameroon, Risk Report. September 2018.
[8] Amnesty International.
[9] Ministry of Health, Cameroon. *"South West Regional Delegation of Health: Activity report for the administrative regional coordination meeting"*. 14 June 2018
[10] Ministry of Health, Cameroon. "South East RTG-EPI Data Review in the Heart of Socio-political Crisis in the Region". January to June 2018.
[11] Idem.
[12] Idem.
[13] Idem.
[14] Ministry of Health, Cameroon. "South West Regional Delegation of Health: Activity report for the administrative regional coordination meeting". 14 June 2018

health facilities in 2018 compared to 396 in 2017 during the same period (January to June).[15]

Figure 1. Number of consultations and hospitalizations in selected facilities in the South-West during January-May: 2017 vs. 2018[16]

	Facilities out of Fako	2017		2018	
		TOTALS		TOTALS	
		CONS	HOSP	CONS	HOSP
DISTRICT HOSPITALS	District Hospital Muyuka	5466	1002	4870	842
	District Hospital Kumba	14124	3033	11231	2538
	District Hospital Konye	644	64	301	25
	District Hospital Mamfe	5011	925	3294	725
	District Hospital Akwaya	226	36	61	21
	District Hospital Mbonge	1202	322	693	120
	District Hospital Eyujomock	865	179	305	152
	TOTAL	27538	5561	22963	5024

IMC has been present in Cameroon since 2008, responding to the large influx of refugees fleeing violence in the Central African Republic and Nigeria. Currently active in the East, Adamawa, North, Far North and Littoral (through partner M.A.SANTE / BAHCARE Meilleur Accès aux Soins de Santé / Better Access to Healthcare) Regions of Cameroon, IMC is working to keep communities stable by implementing primary health care, gender-based violence prevention and survivor services, child protection, epidemic disease surveillance, and nutrition programs. In the past, IMC carried out activities in response to cholera outbreaks as well as flood relief activities in various communities of the Far North Region, mainly focused on WASH.

The rapid development of the conflict in the South-West and North-West regions during the first half of 2018, and the lack of information regarding the situation of the large displaced population and host communities encouraged IMC to conduct a multi-sectoral needs assessment in July 2018 in the Health, Nutrition, WASH, Food Security, and Protection sectors. This report presents the main findings of this assessment.

[15] Ministry of Health, Cameroon. "Situation des Maladies a Potentiel Epidemique et des Affections Prioritaires a la 26ème Semaine Épidémiologique, 2017", July 2017; Ministry of Health, Cameroon. "Situation des Maladies a Potentiel Epidemique et des Affections Prioritaires a la 27ème Semaine Épidémiologique, 2018", July 2018.
16 Idem.

Objectives of the Assessment

The general objective of this survey was to identify the specific needs of the displaced population (mainly women, children, and older persons) in the Fontem, Kumba, and Mamfe health districts of the South-West region. Specifically, this survey aimed to:

- Identify the specific child protection and GBV needs,
- Identify the gaps in the available health care services in and the needs of selected health facilities,
- Identify the population's general nutrition needs and basic nutrition knowledge,
- Identify gaps in terms of WASH services.

Methodology

Through a cross sectional study design, the needs assessment was conducted by employing both qualitative and quantitative methods. Data collection methods included desk review; a survey using Lot Quality Assurance Sampling (LQAS), individual interviews with key informants such as head of households, government actors, and community leaders; and direct observations.

1. Evaluation Team

IMC's Monitoring and Evaluation Manager designed and reviewed all data collection tools in collaboration with IMC's technical advisors in country, and led the evaluation team throughout the assessment. The M&E Manager conducted the initial training of the evaluation team, remotely supervised the team leaders through daily phone calls in order to provide advice and guide, and to discuss any issues encountered. After the data collection process, the M&E Manager ensured the data quality check and data analysis, as closely participated in the writing of this report.

The evaluation team was made up of 30 people (18 women and 12 men) from the Mamfe, Kumba, and Fontem health districts who had the required academic, technical, and cultural skills, including eight medical officers, ten social workers, and twelve community-based surveyors. The medical officers, who had at least a basic medical background, were in charge of assessing the selected health facilities; the selection process ensured that medical officers did not have a direct personal or professional connection with the assessed health facilities. The social workers, who were required to have at least a bachelor's degree and be familiar with the community to be assessed, led the interviews with key informants. The community surveyors, who were required to have at least a GCE-O level and be familiar with the community to be assessed, collected household-based data. IMC selected women and men from the South-West to be part of the team in consideration of the gender and language sensitivities; male surveyors interviewed male respondents and female surveyors interviewed female respondents, and all surveyors were able to communicate both in English and in the local languages (Kenyang, Mweh, Pidgin, etc.) as appropriate for the assessed areas. The evaluation team was organized into three groups of 10 people each to conduct the assessment in each of the selected health districts. Each group selected a team leader who acted as focal point and remained in contact with the M&E Manager throughout the assessment. These team leaders were briefed on general quality assurance and leadership.

IMC conducted a two-day orientation session on July 12 and July 13, 2018 for the medical officers, social workers, and surveyors. The workshop discussed the objectives of the assessment, the data collection tools, the Lot Quality Assessment Sampling (LQAS) methodology, the humanitarian principles, informed consent, and other ethical considerations, and clarified any issues. During this session, IMC and the participants selected the health areas based on three criteria: existence of IDPs according to reports by people living in the affected areas, safe access for surveyors to proposed areas, and geographical and road

accessibility. IMC and the participants also tested the questionnaires among themselves to anticipate any possible complications in the field.

The assessment took place between July 12 and 25, 2018 with internally displaced persons (IDPs) and host communities. Nine health areas in the three health districts were targeted as follows: Fontem health district (Esso-Attah, Fotabong and Menji areas), Kumba health district (Fiango, Kumba Mbeng and Kumba town areas), and Mamfe health district (Bachuo Akagbe, Mamfe and Tali areas) in the South-West region of Cameroon.

2. Challenges and Limitations

The assessment encountered the following challenges and limitations:

The tense security climate forced the evaluation team to carry out certain activities from a distance such as compilation and analysis of data and supervision of surveyors. The political and security context also influenced the selection of participants. Although the assessment tried to use random selection procedures and various evaluation methods, the evaluation team was not able to conduct any focus group discussions and had to, at times, select interviewees from a very small pool of people. Some people expressed reservations about sharing their full opinions while others completely refused participating, as they feared how each side of the conflict could perceive their words. The limited pool of people and the accessibility constraints posed by the security situation also prevented the evaluation team from carrying out more specific assessments (i.e. rapid mid-upper arm circumference (MUAC) assessment) to determine the nutrition status of the population and other more specific needs.

The responses to the in-depth interviews may have been affected by the language limitations encountered from using questionnaires in English and having to translate the questions to the various local dialects on the spot while conducting the interviews. The evaluation team minimized these limitations by selecting surveyors proficient in both English and the dialects spoken in their assigned sites. IMC also minimized any the impact of the team's personal biases by conducting a training for the entire evaluation team immediately before the assessment where the humanitarian principles (especially impartiality and neutrality), as well as other ethical considerations, were fully explained and clarified.

3. Desk review

Prior to the field assessment, IMC conducted a desk review of existing reports from UN agencies, the government of Cameroon, and humanitarian partners on the crisis in the North West and the South-West regions, as well as other relevant reports on the general humanitarian context in Cameroon. These documents were obtained online from official websites and from documentation shared at the various humanitarian meetings in Cameroon. This exercise helped the assessment team avoid duplicating efforts in the concerned areas, prevent security issues, and focus on the communities experiencing the most need.

4. LQAS survey

Following the LQAS principles, the health districts were considered intervention areas, while the health areas were considered supervision areas. Nine health areas were assessed in the South-West region as shown in Table 1 below.

The evaluation team acquired the official health map from the heads of each health area, which included all the villages in said areas and their population; 19-20 villages were chosen in each area based on the population density, accessibility, and security situation. The surveyors then approached households at an

interval appropriate for the size of each village, and conducted the survey with the adult household member present at the time of the survey; surveyors made a conscious effort to approach an equal amount of women and men.

The findings of the survey should be considered with a margin of error of +/-5%.

Table 1: *Distribution of individuals and households surveyed per location*

Health District	***Health Area***	**Sex of the respondent**		**Number of households surveyed**
		Female	**Female**	
Fontem	Esso-Attah	11	9	20
	Fotabong	10	9	19
	Menji	10	9	19
Total Fontem		31	27	58
Kumba	Fiango	9	10	19
	Kumba Mbeng	11	8	19
	Kumba Town	8	11	19
Total Kumba		28	29	57
Mamfe	Bachuo Akagbe	6	13	19
	Mamfe	10	9	19
	Tali	8	11	19
Total Mamfe		24	33	57
Grand Total		**83**	**89**	**172**

5. In-Depth Interviews with Key Informants

In-depth interviews were conducted with key informants including community leaders, government and civil society actors, and heads of households (Table 2) to have a more complete understanding of the needs of the affected communities. The surveyors selected six households (2 per health area), different from the ones used during the LQAS, to conduct in-depth interviews with the heads of these households. The first household was selected by approaching families at random until the surveyors found a head of household willing to participate in the activity. The surveyors would then go to the other side of the village and replicate this process to find the second head of household to be interviewed who was from the opposite gender (e.g. if the first head of household was a woman, then the second head of household chosen would be a man.) The key informants from the traditional and governmental authorities were chosen based on their availability and willingness to respond. If the head of a certain government office or certain village chief was not available, surveyors would approach their representatives until five people had been interviewed. The surveyors also made a conscious effort to approach authorities from all sectors and to include female representation. Surveyors explained the purpose and format of the interview to the key informants and requested their consent to use the information provided before the beginning of each of the interviews. No remuneration or any other type of compensations was provided to the participants.

Due to the widespread insecurity in the region, it was not possible to conduct focus groups discussions. In fact, for almost a year now, public meetings of more than two people have been prohibited by the security and defense forces in Kumba, Mamfe and Fontem in order to prevent the occurrence of attacks perpetrated by NSAGs.

Table 2: *Number of in-depth interviews conducted per health district*

District	Number of key informants (authorities) interviewed[17]	Number of households leaders interviewed
Fontem	3 Traditional leaders 2 Government representatives	6 (3 men and 3 women)
Kumba	1 Traditional leader 1 Traditional Community leaders 3 Government representatives	6 (3 men and 3 women)
Mamfe	1 Traditional Leader 4 Government representatives	6 (3 men and 3 women)
Total	**15 key informants (10 men and 5 women)**	**18 (9 men and 9 women)**

6. Evaluation of Health Facilities

The IASC multi-sector questionnaire (checklist) for health facilities was used to assess eleven health facilities in the targeted health districts as listed in Table 3. These health facilities were selected by IMC and the evaluation team based on three criteria: existence of IDPs according to reports by people living in the affected areas, safe access to proposed areas, and geographical and road accessibility.

Table 3: *List of assessed health facilities per health district*

Health District	Population[18]	Health Facility	Management
Mamfe	80 128	District Hospital Mamfe	Public (Ministry of Health)
		Mamfe urban health center	Public (Ministry of Health)
		Bachuo Akagbe Integrated Health Center	Public (Ministry of Health)
Kumba	314 353	District Hospital Kumba	Public (Ministry of Health)
		Ntam Sub divisional Hospital	Public (Ministry of Health)
		Kumba Town Sub divisional Hospital	Public (Ministry of Health)
		Bukemwe Integrated Health Center	Public (Ministry of Health)
Fontem	126 248	Menji District Hospital	Public (Ministry of Health)
		Fotabong Integrated Health Center	Public (Ministry of Health)
		Mary Health of Africa Hospital	Private (Catholic)
		Essoh-Attah Integrated Health Center	Public (Ministry of Health)

7. Direct Observations

WASH practices around the general hygiene kept at the household level, such as waste management at home, existence of latrines, latrine hygiene, and condition of drinking water containers, were assessed through direct observations of the living areas of the households that participated in the LQAS survey. Additionally, the medical officers in charge of assessing health facilities conducted direct observations in the 11 health facilities assessed, including 3 district hospitals, 1 private hospital, 2 sub divisional health centers, and 5 integrated health centers. These direct observations allowed the evaluation team to assess the

[17] Due to the security conditions in the region, the assessment teams were not able to meet with all key informants as planned.
[18] Ministry of Health, Regional Delegation of South-West, 2017.

existence of essential medical supplies, the availability of essential drugs and vaccines, as well as the functionality of the WASH infrastructure in these health facilities.

8. Analysis

Statistical analysis was done with the help of the Statistical Package for Social Sciences (SPSS) software, and the qualitative analysis was done with using Atlas.ti. For analysis of LQAS data, estimated value for population were obtained by weighing the results in each of the health areas by population size.

Timeline of the Assessment

The training of the evaluation team and the data collection in the field was completed in sixteen days, and the data entry and data quality check took seven days. The data analysis took three working days, and was conducted by the Medical Coordinator, the M&E Manager, the Protection Coordinator, and the Program Support Officer under the supervision of the Program Director based in the country office. Finally, the global M&E Advisor and relevant Technical Advisors (Health, Mental Health, Nutrition, Protection, WASH, Food Security, and Livelihoods), based at IMC's Head Quarters, conducted the final review of the report before its submission.

Ethical Considerations

IMC sought the approval from the local authorities to conduct the survey prior to the collection of data and employed the necessary measures to ensure the assessment took into account the local ethical considerations. Prior to the administration of the questionnaire and the start of the interviews, the evaluation team explained the overall objective of the assessment to each participant and requested their voluntarily consent, as stated in the questionnaire's introduction (see Annex D). IMC trained surveyors on requesting the parents' consent before interviewing minors and on the methods to ensure the strict confidentiality of the answers provided. No names were collected, and other sensitive information such as the position of certain religious and traditional leaders has been kept confidential. This assessment also followed the WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies.

Quality assurance

In order to maintain standard survey practices throughout the whole exercise, IMC's M&E Manager closely monitored all activities each day, and remotely supported the team leaders to conduct on the spot and random checking of survey tools. All issues were discussed and clarify by the M&E Manager and Team Leaders (focal points) who would then share the information with the entire evaluation team.

Findings of the Assessment

1. Community-identified Needs

a. Household Composition

Table 4 presents the demographic values for households in the assessed area; detailed information on demographics in each of the health areas is presented in Table 14 (Annex B). Out of the 1,710 people living in the 172 households assessed, 863 people were IDPs (for a weighted average of 47% IDPs per household). Bachuo Akagbe, Essoh-Attah, and Kumba town were the health areas hosting the highest number of displaced people among the assessed households. However, as the sample size of each of the health areas is small, the variation in the proportion of IDPs is expected to be due to chance.

The evaluation of the household composition also showed that 29% of households were headed by a widow or a widower as seen in Table 15 (Annex B).

Table 4: . *Estimated demographic values for population, obtained by weighing LQAS values by population size (weighed).*

Assessed demographic	***Estimated value in the population***
% household members that are IDPs	47%
% of heads of households that are widowed	29%

b. Protection Needs Identified

The assessment showed that IDPs and host communities living in the Fontem, Mamfe and Kumba health districts are facing increasing protection challenges arising from the violence and insecurity created by the armed conflict between the government's forces and the NSAGs. The assessment also showed that the conflict has created economic and social instability as a result of the implementation of the "Ghost Town" days (when the population is not allowed to engage in any commercial activities), and the closing and burning of schools, health centers, and other public services. Many people have lost their identity cards and birth certificates during their displacement or after the burning of their homes, and the replacement of these documents is now even more challenging than ever.

"So many children have lost their birth certificates because their houses were burnt, also births are not registered because most of them happen in the bushes. Girls and women need to be protected from sexual assault, physical and emotional violence especially rape; pregnant women need to be given birth care, and sanitary pads. Men and boys should be sensitized in order to help them reduce crime rate, drugs consumption, and abuse of vulnerable women; they also need more jobs opportunities and protection against security forces and Amba boys."

In-Depth interview with traditional leader.

According to the key informants interviewed in the three health districts, the main concern for children is the lack of academic or other activities to engage in, and abandonment. Most children have stopped attending school since the beginning of the crisis in support of the protests against the government, and those willing to ignore this ban are threatened and harassed by the NSGAs. Girls are particularly prone to sexual exploitation and forced marriage, while boys are prone to engaging in drug consumption and forced recruitment by the NSGAs.

The main concern for adults is the lack of shelter and services (electricity and water), the lack of income-generating activities to support their families, and the insecurity created by the conflict. Many houses have been burned down, and the markets, as previously mentioned, have been severely disrupted by the insecurity and curfews (including "ghost town" days). Women, many of whom are widows, are particularly at risk of gender-based violence, especially sexual exploitation and abuse. The assessment showed very few available services for GBV survivors and no referral and coordination mechanisms exist. Both sides are targeting men, and the elderly and other men who are not recruited by the armed groups, are using drugs and violence as coping mechanisms.

"*People are afraid to walk alone and our young boys and girls now have changed behaviors with many of them taking drugs. Most often, the children are frightened with constant nightmares due to excessive gunshots. There is a huge number of displaced people from neighboring villages and many of our people too have left the community. Almost all homes are complaining of lack of food and medicine to cater for their families and the IDPs, especially as our health centers are closed down. Most homes are now experiencing emotional violence especially our adolescents and children are frequently murdered (…) Above all, food and medication have been seized.*"

In-depth interview with a head of quarter

The destruction of the infrastructure has also increased the levels of insecurity and placed women and children at a greater risk. Access to water has decreased (as explained in the WASH needs section), and there are areas with little to no electricity forcing women and children to cover greater distances to collect firewood and water. People are now reporting being scared of walking alone, especially at night when they are more vulnerable to rape, assault, and abduction.

The complex political context has also increased the level of mistrust by both parties to the conflict with the government unable to clearly identify their opponents, and with the NSAGs becoming more aggressive even towards the local population. Civilians are being caught in the crossfire and some areas are becoming more radicalized.

- *Community-Based Indicators: Child Protection and GBV*

The findings of the LQAS survey allowed IMC to set baseline values for indicators for the number of birth certificates lost or needed, the number of early and forced marriages, and the existence of GBV services. **Erreur ! Source du renvoi introuvable.**5 presents estimated percentage values for population, calculated by weighing results for each health district by population size; breakdown of responses by health area is found in Tables 16-18 (Annex B).

Table 5: *Estimated population values for child protection and GBV, obtained by weighing the survey responses by population size (weighed).*

	Estimated value in the population
% of heads of households reporting loss of children's birth certificates	90%
% of respondents aware of cases of early, forced, and arranged marriages	58%
% respondents reporting the existence of care services for GBV survivors	33%

90% of household heads are estimated to have experienced a birth certificate loss; 58% are estimated to have knowledge of cases of early and forced marriages, and 33% are expected to report the existence of care services for GBV survivors in their communities.

c. Health and Nutrition Needs Identified

The in-depth interviews with community members and community leaders showed that people are using the health care facilities less frequently due to insecurity, rising transportation costs, increasing medical costs (for services and medicines), and lack of available services (facilities, personnel, and supplies) in some areas. The levels of insecurity and the fear of reprisal has led the directors of most health facilities to close all services, including the nutritional centers, during "ghost town" days and the daily nighttime curfew. The insecurity level has been a significant impediment to the mobilization of patients, staff, and supplies including nutritional supplements. Only 3 of the 11 assessed health facilities have an ambulance for the transportation of critical cases to other health facilities. Given the fact that the average distance between the remotest villages and the health facilities is more than ten kilometers, people simply avoid taking the risk to travel, even when they are sick. Consequently, some people in need of medical assistance are forced to stay at home (or the bush) or seek the services of traditional healers.

"We are surviving by the grace of God since most of the health centers are closed down. We have no vendors for essentials drugs and we cannot go for medical checkup following the numerous killings by anyone they meet thinking they are informants for the other side. Medicines we used to buy for 150 FCFA are now sold at 1,000 FCFA and are even difficult to find. We have gone back to our traditional medicine. The children and pregnant women don't have vaccination. We keep praying for something to be done."

In-depth interview with a community leader

Another factor affecting people's access to health care is their increased inability to afford the required services and supplies, and the transportation fees to reach the health facilities that are still operating. In the Mamfe health district for example, people in some villages are requested to pay 9,000 FCFA for transport now compared to less than 2,000 FCFA before the beginning of the crisis. In the Kumba health district, the cost of a curative consultation can reach 1,500 FCFA for general practitioners and 5,000 FCFA for a specialist. These financial constraints, coupled with the insecurity levels, have forced many women to give birth either at home or in the bush.
Lastly, the availability of services has been greatly affected by the conflict. Several health facilities have been closed down, especially in the Fontem health district, and some health workers have fled the zone in search of safer areas.

Although the political and security context did not allow a rapid Mid-upper Arm Circumference (MUAC) assessment to be carried out, the in-depth interviews with community members and community leaders showed that the nutrition situation has also been affected by the conflict. Participants reported not being able to have adequate diets .as prices have increased and foods are no longer affordable for them. Food is less available now than before the onset of the crisis, and insecurity has disrupted their farming activities as explained in more detail in the following pages. Several people reported seeing more hungry children now than before the crisis, suffering from weakness, swollen bellies, diarrhea, skin diseases, and weight loss. When asked about coping mechanisms, participants reported asking friends and other people from their community for food donations, using tree bark and wild herbs as food and remedies, and planting more green-leaf vegetables around their homes to supplement tubers (the most available now).

- *Community-based Indicators: health and nutrition*

Three health and nutrition indicators have been assessed at the community level: the proportion of women giving birth in the health facilities, the proportion of respondents reporting that they have been sensitized

on preventable diseases since the beginning of the crisis, and the proportion of respondents reporting that the community has been sensitized on IYCF since the beginning of the crisis.

As seen in Table 6, only 6% of female respondents reported giving birth at a health facility now compared to 93% before the crisis.

Table 6: *Proportion of births by location before the crisis vs. now*[19]

	% Before the crisis	% Now[20]
Birth at health Facilities	93	6
Birth at Home	5	47
Others (Bushes, etc.)	2	47

Figure 2. Proportion of births by location before the crisis vs. now

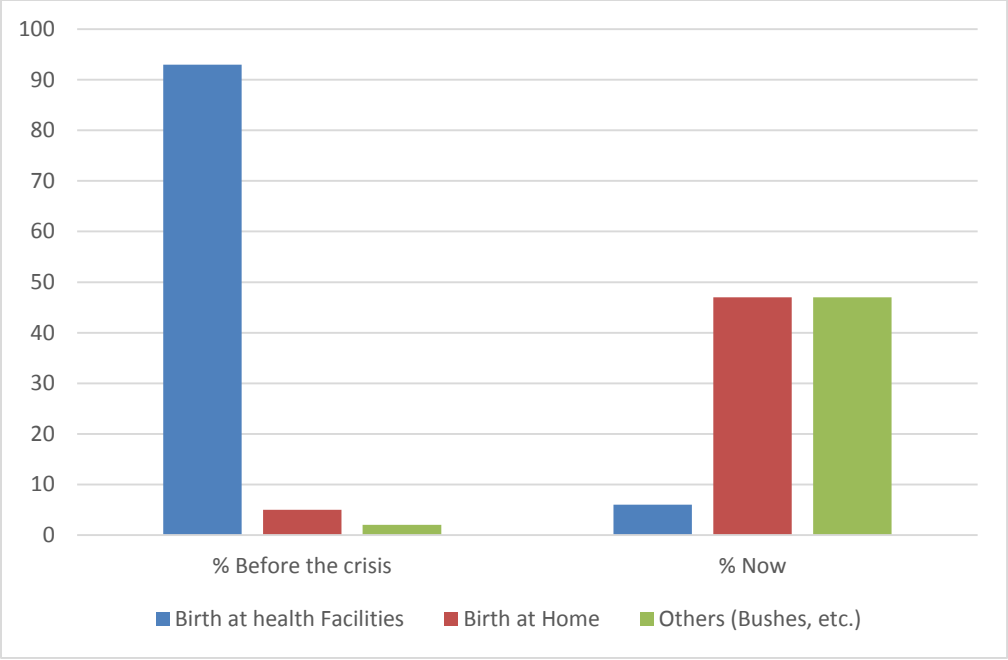


Table 7: *Estimated population values for sensitization on preventable diseases and IYCF, obtained by weighing the survey responses by population size (weighed).*

	Estimated value in the population
% of heads of households having been sensitized on preventable diseases	22%
% of heads of households having been sensitized on IYCF	52%

As seen in Table 7, the LQAS survey findings revealed that an estimated 22% of people surveyed have been sensitized on preventable diseases since the beginning of the crisis. This low coverage is due to the

[19] Weighted proportions based on the population size of Fontem, Kumba and Mamfe.

[20] This is the value of the indicator at the time of the survey (July 2018).

fact that health community-based activities are no longer conducted in most of the assessed health districts. 52 % of respondents have been sensitized on IYCF since the beginning of the crisis, although the last sensitization sessions took place more than six months ago in the assessed areas. The breakdown by health area can be found in Tables 19 and 20 (Annex B).

d. WASH Needs Identified

According to respondents, most of the water, sanitation, and hygiene services have become less available since the beginning of the crisis.

Most of the water sources are either damaged or non-functioning; in some areas, taps are not working or maintained because of insecurity and lack of personnel. Some households have wells (many uncovered and without lining), but these are not treated or sufficient to provide water for the population. People are now covering even greater distances (over 30 minutes) to get water from rivers and other natural unprotected sources placing women and children, the ones who are traditionally in charge of collecting firewood and water, are at a greater risk of assault and abduction.

"We get our drinking water from the spring or an open well. But the road to get to the spring is very poor as it is hilly, stony and sometimes muddy and watery. The water itself is not of good quality. Sometimes we carry rain water, children put containers outside when it rains or to the neighboring villages to carry water from their stream"

In-depth interview with a female household leader in Essoh-Attah

People reported storing their water in containers (plastic, clay, aluminum) at home and letting it sit for a day before drinking as their prefer method to "treat" water, although some people are still boil their water. When asked about waste management, most people reported throwing their garbage behind their homes or abandoned areas. Others reported burning the piles of garbage from time to time. Children are especially at risk of being affected by water-borne diseases such as cholera, diarrhea, as open defecation is becoming more common. As previously mentioned, water from natural springs and most wells are not properly treated and maintained.

"The taps are no longer flowing due to the dangers on the catchment and bad leaking pipes all over the place. Many homes lack good pit latrines so feces is seen everywhere along the bushes and abandoned homes. The schools toilets are abandoned and damaged especially in schools which are not functioning."

In-depth interview with representative of a Municipal Council

Lastly, the health facilities evaluated reported burning their medical waste as the most common waste management method. Authorities reported having difficulties in maintaining catchment areas, septic tanks, and other water and sanitation structures due to the lack of supplies (mostly chemicals) and personnel as many people have fled the area.

- *Community-based Indicators: WASH*

As seen in Table 8, only 37% of the assessed households are now collecting water from an improved water source for daily use, compared to 83% before the crisis. Among the people that have access to potable water, only 35% can access water within 30 minutes including queuing time and walk time compared to 78% before the crisis. A breakdown by health area can be found in Tables 21 and 22 (Annex B).

Table 8: *Estimated population values for WASH indicators, obtained by weighing the survey responses by population size (weighed).*

	Estimated value in the population
% of households collecting water from an improved water source	37%
% of households having access to potable water in 30 minutes	35%

e. Food Security and Livelihoods

Food security and restored livelihoods were among the top priorities for the people (IDPs and host community) living in the areas affected by the crisis. Respondents reported having diminishing food stocks and most of the households with food stocks did experience food shortages because of lack of electricity and fridges to ensure proper conservation of perishable foods. Moreover, since the beginning of the crisis very few households can afford more than one meal per day, and most of the heads of households interviewed have not yet received any food assistance.

Before the crisis, the main income generating activities for most people were based on the production and sale of food crops (including cassava, maize, cocoyam, yam, vegetables and plantain), smoked fish, cow's skins and palm oil. However, the increasing levels of insecurity and the limitations caused by the curfews (including "ghost town" days) have disrupted the movement of goods and supplies including agricultural inputs. Women engaged in small businesses like the sale of vegetables and other foods have been forced to abandon their activities due to the widespread insecurity. Commercial vehicles carrying goods are constantly attacked on the road leading to a decrease in the number of available items and an increase in the prices.

"Before the crisis, we used to trade in food items like rice, beans and other things. The crisis came and crumbled my trading because the road to town is blocked and I cannot go and buy items. Income has dropped and revenue cannot sustain us. We used to eat five times before the crisis started. The food hardly gets us full but we share to avoid having an empty stomach. Before I was able to buy enough food but now there is no money. Even when there is little money, things are insufficient and we do not see the food to buy. We have not received any assistance whatsoever since the crisis started."

In-depth interview with a traditional leader

- *Community-based Indicators: Food Security and Livelihoods*

The assessment evaluated the proportion of households with food in stock, the proportion of households consuming more than one meal a day, and proportion of households that have not received food assistance. A breakdown by health area of these values can be found in Tables 23-25 (Annex B).

Table 9: *Estimated population values for food security and livelihoods indicators, obtained by weighing the survey responses by population size (weighed).*

	Estimated value in the population
% of households with food in stock	39%
% of households having more than one meal per day	29%
% of households that have not received any food assistance since beginning of the crisis	87%

As seen in Table 9, only 39% of the households have food in stock. Among the surveyed households, the situation is especially critical in the Kumba Health District where only 4 out of 57 households surveyed

reported having food in stock, although there is not enough evidence to state whether this is the case for the entire Kumba Health District given the small sample size. Only 29% of the households are estimated to consume more than one meal per day, compared to 99% before the beginning of the crisis.

Finally, 87% of the households in the assessed areas have not received any food assistance since the beginning of the crisis.

2. Needs of Health Facilities

a. Community Health Care Services

As presented in Annex C, it can be observed that globally four of the eleven (36%) assessed health facilities did not provide child health activities at the community level. The community components of the Integrated Management of Childhood Illness (IMCI), including health promotion activities through Information Education and Communication (IEC) sessions for child caretakers and active-case finding, were not ensured in Fotabong, Bachuo Akagbe, Kumba town, or in the Mamfe urban health areas. It was observed that the Kumba town, Mamfe urban, and Fotabong health areas had not conducted community-based maternal and newborn health activities. Indeed, the distribution of clean delivery kits to pregnant women, the IEC, and behavioral change communication sessions on reproductive health have not been conducted in these three health areas for almost two years.

The Mamfe urban and Fotabong health areas have not conduct any Sexually Transmitted Infections (STI) and HIV/AIDS prevention activities at the community level for almost a year. Additionally, the collection of vital statistics at the community level, including community births and deaths, and registry of pregnant women, was not ensured in three of the eleven (27%) health facilities assessed.

b. Primary Health Care Services

As shown in Tables 26-28 (Annex C), the primary health care services facing the most difficulties are the management of acute malnutrition, the provision of mental health care, and services for GBV survivors.

The assessment of the nutrition needs showed that in 10 of the 11 health facilities assessed the nutrition registers were either unavailable or not filled in the last twelve months. Nonetheless, the directors of these nutritional centers indicated they had limited or completely stopped the provision of services such as community-based screening, routine screening, treatment of severely acutely malnourished children in OTPs, and referral of severe acute malnutrition cases with medical complications to stabilization centers, since January 2017 due to the lack of materials and supplies, and the lack of personnel who has fled the area as a result of insecurity. The stabilization center of Kumba Town, the only one still collecting data, reported ten cases of moderate acute malnutrition and 1 case of severe acute malnutrition in the month of June 2018 alone.

The gaps in the management and prevention of severe acute malnutrition were mainly observed in 4 OTPs: Fotabong, Bukemwe, Ntam and Mamfe urban. The referral for treatment of acute malnutrition with medical complications to stabilization centers is not ensured in Fotabong, Bukemwe, and Ntam OTPs given the insufficient number of community health workers and the lack of transportation of patients due to insecurity. Likewise, the treatment of Vitamin A deficiency is not ensured for pregnant and lactating women (PLW) and children aged 6-59 months in any of these four OTPs.
Finally, 3 of the 11 health facilities assessed were partially conducting nutrition activities at the community level, and four health facilities were conducting no activities at all. These activities normally include children discharged from outpatient care (OTP), follow-up of Infant and Young Child Feeding (IYFC)

sessions, prevention of acute and chronic malnutrition and micronutrient deficiencies through nutrition education, community screening of children aged 6-59 months, and detection of micronutrient deficiencies among children, pregnant and lactating women. In addition, the Ntam, Mamfe, Bachuo Akagbe, and Fotabong health areas did not implement community-based management of acute malnutrition (CMAM) programs.

In terms of mental health, only 2 of the 11 assessed health facilities reported having psychotropic essential medication available and reported providing support to patients suffering from acute distress and anxiety, as well as neurological, and substance-abuse disorders. Only the Mary Health of Africa Hospital in the Fontem health district has a mental health specialist (one psychologist) available to provide some specialized mental health services. The Fotabong health center and the Mary Health of Africa Hospital are providing identification and treatment for epilepsy only; in the health center of Fotabong (the only one where statistics were available) 15 cases of epilepsy (including 10 men and 5 women) were recorded in June 2018. However, other mental health disorders such as psychotic disorders, depression, anxiety, and developmental disorders were not part of their response due to unavailability of qualified staff. Availability and accessibility to quality mental health services is low as most facilities do not have staff who have been trained to support people with mental health problems, and while two facilities had some staff their ability to support a range of mental health problems is limited, and the quality of care not assessed at this stage.

Regarding the available services for GBV survivors, 10 of the 11 assessed health did not have a health protocol in place for the clinical management of rape and treatment of survivors. None of the assessed eleven health facilities had a coding system in place for rape survivors to ensure confidentiality, and only 7 health facilities kept patients' files in a secured manner. Moreover, there is no established referral pathway for survivors of sexual violence in the Menji District hospital, or the Essoh Attah, Bukemwe, Kumba Town, Bachuo Akagbe and Mamfe urban health centers. PEP Kits (for treatment of STI & HIV infections, plus Hepatitis B and Tetanus vaccination) were only available in 3 out of 11 assessed health facilities, and only 5 of the 11 health facilities are providing basic assistance to GBV survivors.

c. Secondary and Tertiary Health Care Services

Secondary health care is lacking in the three assessed health districts, while tertiary care is only available in Buea, the regional capital, and in Limbe. The provision of general clinical services, which include blood bank services, emergency and elective surgery, inpatients services, laboratories and pharmacies, is very challenging.

The Ntam Sub Divisional Hospital and the Menji District Hospital lack blood banks and are unable to adequately respond to emergencies. Emergency and elective surgery are only partially ensured in these health facilities due to the lack of sufficient staff and medical supplies. In-patient services at these facilities also lacked adequate equipment and supplies, and are no longer able to offer surgical services.

The laboratories and pharmacies of all the evaluated health facilities did not have enough, if any, materials and essential medicines to serve the displaced and vulnerable host populations. The escalation of insecurity has affected the supply chain especially for the procurement of essential medicines and medical supplies, and although most of the health facilities have a cold chain in place, the unreliable flow of electricity prevents them from working normally.

d. Health Care Staff

As seen in Table 10, the evaluation highlighted a total shortage of 122 staff in the 11 health facilities assessed.

Table 10: *Number of health care staff in the assessed health facilities*

Health Facility name	# of staff needed (N)	# of staff available (A)	Gap (N-A)
Mamfe District Hospital	90	36	54
Menji District Hospital	90	9	81
Kumba District Hospital	90	25	65
CMA Ntam	12	14	-2
CMA Kumba Town	12	53	-41
Mamfe Urban health center	6	5	1
Bachuo-Akagbe Integrated Health Center	6	6	0
Bukemwe Integrated Health Center	6	20	-14
Fotabong Integrated Health Center	6	2	4
Essoh-Attah Integrated Health Center	6	6	0
Mary Health of Africa Hospital	12	38	-26
TOTAL	**336**	**214**	**122**

Table 11 below shows the gaps by type of health staff in the three districts hospitals, which are the facilities most in need of staff. The Menji District Hospital (in Fontem health district) has the greatest gap in health personnel. For over 6 months this health facility has been practically closed since the health personnel has also fled the area because of the widespread insecurity in the Lebialem division. There is no midwife to provide reproductive health care, and the 9 remaining staff cannot adequately deliver services to the displaced population and vulnerable host communities. The Kumba District Hospital has a gap of 65 staff, while Mamfe District Hospital has a gap of 54 staff.

Table 11: *Situation of health staff in district hospitals*

Health staff position	Kumba District Hospital			Menji District Hospital			Mamfe District Hospital		
	# available	National standard	Gap	# available	National standard	Gap	# available	National standard	Gap
Nurse	4	28	24	5	28	23	15	28	13
General Practitioner	3	1	-2	1	1	0	1	1	0
Surgeon-Dentist	1	1	0	0	1	1	0	1	1
Medical assistant	0	28	28	0	28	28	0	28	28
Vaccinator	2	0	-2	0	0	0	0	0	0
Midwife	12	19	7	0	19	19	8	19	11
Lab technician	2	5	3	2	5	3	10	5	-5
Other (*adjoint technician medico-sanitaire [fr.]*)	0	7	7	0	7	7	0	7	7
TOTAL	**25**	**90**	**65**	**9**	**90**	**81**	**36**	**90**	**54**

In the sub-divisional hospitals (public and private), as seen in Table 12 below, there is a sufficient number of staff, but some specific gaps need to be filled. More precisely, in the Ntam Hospital four positions need to be filled including one medical doctor, one nurse assistant, one midwife and one pharmacist. The private hospital (Mary Health of Africa) is lacking a pharmacist.

Table 12: *Situation of health staff in sub divisional and private hospital*

Health staff position	CMA Ntam			CMA Kumba Town			Mary Health of Africa Hospital		
	# available	National standard	Gap	# available	National standard	Gap	# available	National standard	Gap
Doctor	1	2	1	3	2	-1	9	2	-7
Nurse	6	2	-4	5	2	-3	23	2	-21
Medical assistant	4	5	1	28	5	-23	0	5	5
Midwife	0	1	1	3	1	-2	2	1	-1
Lab technician	3	1	-2	11	1	-10	3	1	-2
Pharmacist/ Tech	0	1	1	3	1	-2	0	1	1
Psychologist	0	0	0	0	0	0	1	0	-1
TOTAL	**14**	**12**	**-2**	**53**	**12**	**-41**	**38**	**12**	**-26**

Concerning the health centers, Table 13 below shows that the Fotabong integrated health center is the most affected by the gaps in health personnel with a shortage of one nurse assistant, one midwife, one lab technician, and one pharmacist. The Mamfe urban health center is lacking one nurse assistant, and the Essoh-Attah integrated health center is lacking one nurse and one pharmacist. Bachuo Akagbe is lacking the nurse assistant and the pharmacist, and Bukemwe is lacking one pharmacist as well.

Table 13: *Situation of health staff in integrated health centers*

Health staff position	Mamfe Urban health center			Bachuo-Akagbe Integrated Health Center			Bukemwe Integrated Health Center			Fotabong Integrated Health Center			Essoh-Attah Integrated Health Center		
	Actual *	Needed **	Gap	Actual	Needed	Gap	Actual	Needed	Gap	Actual	Needed	Gap	Actual	Needed	Gap
Nurse	1	1	0	1	1	0	6	1	-5	1	1	0	0	1	1
Vaccinator	0	0	0	2	0	-2	5	0	-5	0	0	0	0	0	0
Midwife	1	1	0	1	1	0	2	1	-1	0	1	1	1	1	0
Lab technician	1	1	0	1	1	0	3	1	-2	0	1	1	1	1	0
Pharmacist/ Tech	1	1	0	0	1	1	0	1	1	0	1	1	0	1	1
TOTAL	**5**	**6**	**1**	**6**	**6**	**0**	**20**	**6**	**-14**	**2**	**6**	**4**	**6**	**6**	**0**

*Actual = Number of staff currently available

** Needed = Number of staff needed according to the National Protocol

3. Recommendations

Protection prevention and response (Child protection, GBV)

- Establish a Protection referral pathway for children and survivors that includes protection stakeholders and community-based organizations.
- Improve the Protection capacities of through targeted trainings.
- Facilitate the identification and support of separated and unaccompanied children through case management and reunification services.
- Facilitate the development and reconstitution of birth certificates for children at risk of statelessness.
- Facilitate the establishment of essential GBV services including clinical management of rape and basic psychosocial support for survivors.
- Facilitate the creation of Protection Committees, and support their advocacy and outreach activities.
- Advocate for and support a more in-depth assessment of the needs of children and women and men.

Access to Primary Health Care and Management of Acute Malnutrition

- Improve access to primary health care services for IDPs and vulnerable populations in the targeted health district by providing financial and material support to patients.
- Improve access to primary health care and nutrition services through mobile units for hard-to-reach areas. Improve access to reproductive health services by supporting health facilities (through supplies and capacity building) in providing Basic emergency obstetric and Neonatal care (BEmONC) and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC).
- Improve and facilitate the supply of essential medicines (antibiotics, antifungals, anti-malarial, antipyretic, antigens, and psychotropic drugs) in health centers and district hospitals.
- Facilitate improvements to infrastructure and the provision of essential medical equipment.
- Improve availability of services by advocating for increased number of health staff, and/or by temporarily filling the gaps in personnel.
- Train and support health staff on the identification and management of acute malnutrition. Design and implement a prevention strategy (through BSFP and IYCF) for malnutrition in the health areas of Fotabong, Bukemwe, Ntam, and Mamfe urban.
- Facilitate the referral system of severely malnourished children from the community to OTPs, and from OTPs to stabilization centers for children with SAM and medical complications.
- Support outreach and referral services for IDPs and vulnerable people.
- Advocate for and support nutrition screenings and monitoring in all conflict-affected areas.

Access to Water, Sanitation, and Hygiene

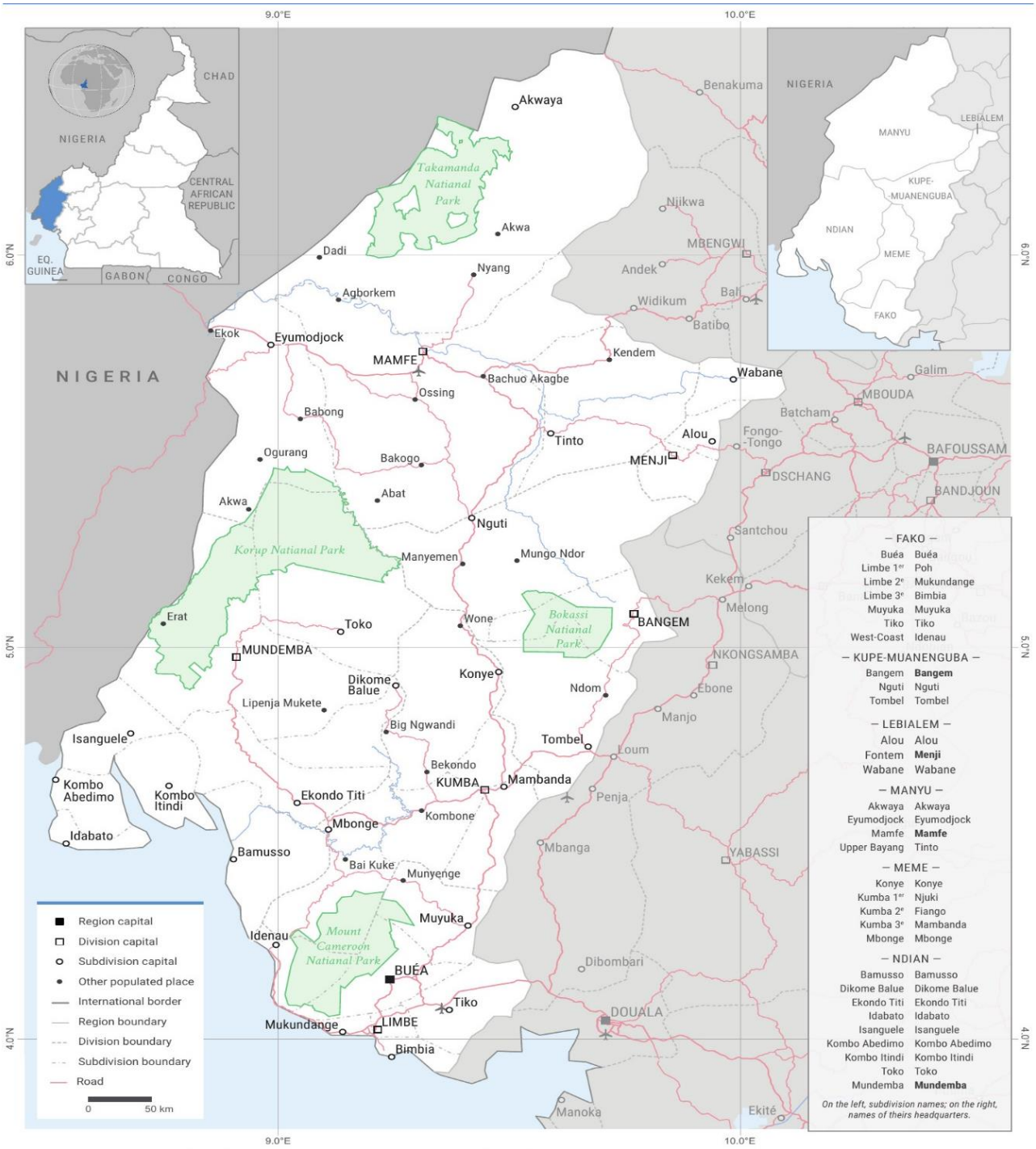
- Conduct a rapid nutrition assessment as soon as this is possible; to get a clear picture of the nutrition situation, and in order to decide if a nutrition intervention is needed, and what type of intervention this should be.
- Improve availability of WASH services by providing materials, equipment, and training to local partners. Provide appropriate water storage containers and water treatment supplies to IDPs and vulnerable people within the host communities.
- Advocate for improved waste management and sanitation measures in markets, schools, health facilities, and other public places.
- Support outreach activities by identifying and training community volunteers on hygiene promotion, waste management, and water treatment methods at home.

Food Security and Livelihoods

- Support vulnerable people through the distribution of food (general and supplementary), other household items, and agricultural inputs.
- Advocate for and support the rehabilitation of markets.

4. Annexes

a. Map of the South-West region, Cameroon



Source: OCHA. June 2018

b. Unweighted LQAS survey results, disaggregated by health area

Table 14: *Number of people and IDPs living in the assessed households per health districts and health areas*

Health District	***Health Area***	**Number of people living in the household**	**Number of IDPs living in the household**	**Average Number of IDPs per household**	**% of IDPs per households**
Fontem	Esso-Attah	240	153	8	64%
	Fotabong	170	87	5	51%
	Menji	160	74	4	46%
Total Fontem		570	314	5	55%
Kumba	Fiango	144	41	2	28%
	Kumba Mbeng	230	101	5	44%
	Kumba Town	175	92	5	53%
Total Kumba		549	234	4	43%
Mamfe	Bachuo Akagbe	269	179	9	67%
	Mamfe	162	70	4	43%
	Tali	160	66	3	41%
Total Mamfe		591	315	6	53%
Grand Total		**1710**	**863**	**5**	**50%**

Table 15: *Proportion of widows and widowers headed households*

Health District	***Health Area***	**Number of widows and widowers headed households**	**Number of households surveyed**	**% of widows and widowers headed households**
Fontem	Esso-Attah	6	20	30%
	Fotabong	9	19	47%
	Menji	7	19	37%
Total Fontem		22	58	38%
Kumba	Fiango	2	19	11%
	Kumba Mbeng	5	19	26%
	Kumba Town	8	19	42%
Total Kumba		15	57	26%
Mamfe	Bachuo Akagbe	4	19	21%
	Mamfe	4	19	21%
	Tali	5	19	26%
Total Mamfe		13	57	23%
Grand total		**50**	**172**	**29%**

Table 16: *Proportion of respondents reporting children birth certificates loss*

Health District	***Health Area***	**# of respondents reporting birth certificates loss**	**# of people surveyed**	**% of respondents reporting birth certificates loss**
Fontem	Esso-Attah	20	20	100%
	Fotabong	19	19	100%
	Menji	17	19	89%
Total Fontem		56	58	97%
Kumba	Fiango	19	19	100%
	Kumba Mbeng	16	19	84%
	Kumba Town	16	19	84%
Total Kumba		51	57	89%
Mamfe	Bachuo Akagbe	13	19	68%
	Mamfe	17	19	89%
	Tali	18	19	95%
Total Mamfe		48	57	84%
Grand Total		**155**	**172**	**90%**

Table 17: *Proportion of respondents reporting cases of early, forced and arranged marriages*

Health District	***Health Area***	**# of respondents reporting cases of early, forced and arranged marriages**	**# of people surveyed**	**% of respondents reporting cases of early, forced and arranged marriages**
Fontem	Esso-Attah	17	20	85%
	Fotabong	18	19	95%
	Menji	16	19	84%
Total Fontem		51	58	88%
Kumba	Fiango	11	19	58%
	Kumba Mbeng	14	19	74%
	Kumba Town	5	19	26%
Total Kumba		30	57	53%
Mamfe	Bachuo Akagbe	6	19	32%
	Mamfe	13	19	68%
	Tali	0	19	0,00%
Total Mamfe		19	57	33%
Grand Total		**100**	**172**	**58%**

Table 18: *Proportion of respondents reporting the existence of care services for GBV survivors*

Health District	***Health Area***	**# of respondents reporting the existence of care services for GBV survivors**	**# of people surveyed**	**% of respondents reporting the existence of care services for GBV survivors**
Fontem	Esso-Attah	2	20	10,00%
	Fotabong	9	19	47,37%
	Menji	7	19	36,84%
Total Fontem		18	58	31,03%
Kumba	Fiango	9	19	47.37%
	Kumba Mbeng	2	19	10.53%
	Kumba Town	3	19	15.79%
Total Kumba		14	57	24,56%
Mamfe	Bachuo Akagbe	12	19	63.16%
	Mamfe	12	19	63.16%
	Tali	17	19	89.47%
Total Mamfe		41	57	71.93%
Grand Total		**73**	**172**	**42.44%**

Table 19: *Proportion of people sensitized on preventable diseases since the beginning of the crisis*

Health District	***Health Area***	**# of respondents reporting that they have been sensitized on preventable diseases since the beginning of the crisis**	**# of people surveyed**	**% of respondents reporting that they have been sensitized on preventable diseases since the beginning of the crisis**
Fontem	Esso-Attah	2	20	10,00%
	Fotabong	1	19	5,26%
	Menji	5	19	26,32%
Total Fontem		8	58	13,79%
Kumba	Fiango	7	19	36,84%
	Kumba Mbeng	3	19	15,79%
	Kumba Town	3	19	15,79%
Total Kumba		13	57	22,81%
Mamfe	Bachuo Akagbe	8	19	42,11%
	Mamfe	6	19	31,58%
	Tali	4	19	21,05%
Total Mamfe		18	57	31,58%
Grand Total		**39**	**172**	**22,67%**

Table 20: *Proportion of respondents reporting that community have been sensitized on IYCF since the beginning of the crisis*

Health District	***Health Area***	**# of respondents reporting that community have been sensitized on IYCF since the beginning of the crisis**	**# of people surveyed**	**% of respondents reporting that community have been sensitized on IYCF since the beginning of the crisis**
Fontem	Esso-Attah	7	20	35%
	Fotabong	9	19	47%
	Menji	10	19	53%
Total Fontem		26	58	45%
Kumba	Fiango	16	19	84%
	Kumba Mbeng	13	19	68%
	Kumba Town	8	19	42%
Total Kumba		37	57	65%
Mamfe	Bachuo Akagbe	3	19	16%
	Mamfe	2	19	11%
	Tali	1	19	5%
Total Mamfe		6	57	11%
Grand Total		**69**	**172**	**40%**

Table 21: *Proportion of households collection their water from an improved water source*

Health District	*Health Area*	**% of households collecting their water from an improved water source before the onset of the crisis**	**% of households collecting their water from an improved water source now[21]**
Fontem	Esso-Attah	95%	15%
	Fotabong	100%	5%
	Menji	89%	5%
Total Fontem		95%	9%
Kumba	Fiango	74%	42%
	Kumba Mbeng	84%	58%
	Kumba Town	79%	37%
Total Kumba		79%	46%
Mamfe	Bachuo Akagbe	79%	47%
	Mamfe	74%	53%
	Tali	84%	37%
Total Mamfe		79%	46%
Grand Total		**84%**	**33%**

[21] This is the value of the indicator at the time of the survey (July 2018).

Table 22: *Proportion of households having access to potable water in 30 minutes*

Health District	*Health Area*	**% of households having access to potable water in 30 minutes before the onset of the crisis**	**% of households having access to potable water in 30 minutes now**
Fontem	Esso-Attah	55%	25%
	Fotabong	21%	5%
	Menji	68%	26%
Total Fontem		48%	19%
Kumba	Fiango	100%	5%
	Kumba Mbeng	95%	58%
	Kumba Town	89%	53%
Total Kumba		95%	39%
Mamfe	Bachuo Akagbe	79%	74%
	Mamfe	32%	26%
	Tali	63%	42%
Total Mamfe		58%	47%
Grand Total		**67%**	**35%**

Table 23: *Proportion of households with Food in stocks*

Health District	***Health Area***	**# of households with food stocks**	**# of households surveyed**	**% of households with food stocks**
Fontem	Esso-Attah	19	20	95%
	Fotabong	19	19	100%
	Menji	16	19	84%
Total Fontem		54	58	93%
Kumba	Fiango	1	19	5%
	Kumba Mbeng	0	19	0%
	Kumba Town	3	19	16%
Total Kumba		4	57	7%
Mamfe	Bachuo Akagbe	4	19	21%
	Mamfe	2	19	11%
	Tali	3	19	16%
Total Mamfe		9	57	16%
Grand Total		**67**	**172**	**39%**

Table 24: *Proportion of households having more than one meal per day*

Health District	*Health Area*	**% of households having more than one meal per day before the onset of the crisis**	**% of households having more than one meal per day now**
Fontem	Esso-Attah	100%	30%
	Fotabong	100%	0%
	Menji	100%	26%
Total Fontem		100%	19%
Kumba	Fiango	100%	5%
	Kumba Mbeng	95%	21%
	Kumba Town	100%	42%
Total Kumba		98%	23%
Mamfe	Bachuo Akagbe	100%	68%
	Mamfe	100%	74%
	Tali	95%	58%
Total Mamfe		98%	67%
Grand Total		**99%**	**36%**

Table 25: *Proportion of households not receiving any type of food assistance since the beginning of the crisis*

Health District	***Health Area***	**# of households not receiving any type of food assistance since the beginning of the crisis**	**# of people surveyed**	**% of households not receiving any type of food assistance since the beginning of the crisis**
Fontem	Esso-Attah	19	20	95%
	Fotabong	18	19	95%
	Menji	19	19	100%
Total Fontem		56	58	97%
Kumba	Fiango	17	19	89%
	Kumba Mbeng	17	19	89%
	Kumba Town	15	19	79%
Total Kumba		49	57	86%
Mamfe	Bachuo Akagbe	15	19	79%
	Mamfe	13	19	68%
	Tali	17	19	89%
Total Mamfe		45	57	79%
Grand Total		**150**	**172**	**87%**