

An Assessment of Humanitarian Response to Internally Displaced Persons: The Case of South West Region of Cameroon

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Abstract

The magnitude of the Anglophone crisis and its impact on the population requires a multi-sectorial and multi-dimensional response that includes humanitarian, resilience and development components. Only coordinated and harmonized actions can mitigate human suffering and address the root causes of this crisis. However, the response has been minimal, while the precarious situation on the ground has worsened. The study carried out an assessment of the different challenges of internally displaced persons (IDPs) in the South West region, with a survey which was administered to 155 households and the health record of 1930 IDPs. This study identifies the major challenges faced at hand through an assessment with percentages and with the support of Middle Upper-Arm Circumference (MUAC) as well as informant interviews of internally displaced persons (IDPs). The study results show that there is a significant deterioration of the situation of IDPs in the domain of healthcare, nutrition, WASH and food security. On the other hand, the results also indicate that they are leaving deplorable situations even with the creation of the centre for humanitarian assistance plan in SW region. The assessment has also identified several levels of household hunger, reaching severe levels among some households. They lack a diversity of food intake and difficulty of households to a balanced diet. In combination with delayed supplementary feeding for infants and unreliable quality of water further aggravates the already precarious situation.

Keywords: *Assessment, humanitarian response, internally displaced persons, healthcare, nutrition, food security, South West region, Cameroon.*

Acronyms

FCS	-	Food Consumption Score
GAM	-	Global Acute Malnutrition
HFIS	-	Household Food Insecurity Score
HHS	-	Household Hunger Score
IHC	-	Integrated Health Centre
MAM	-	Moderate Acute Malnutrition
MUAC	-	Middle Upper-Arm Circumference
NSAG	-	Non-State Armed Groups
OCHA	-	United Nations Office for the Coordination of Humanitarian Affairs
RNA	-	Rapid Needs Assessment
SAM	-	Severe Acute Malnutrition
SW/NW	-	South-West/North West regions
WASH	-	Water, Sanitation and Hygiene
WFP	-	World Food Program

Introduction

Internal displacement in Cameroon was already in the headlines five years ago, when one thousand five hundred people died and several thousand became internally displaced during the Boko Haram attacks in the Far North in 2014. Cameroon has over the past two years seen a dramatic increase in social and political violence. The country has experienced a combination of humanitarian crisis due to the instability in the South West and North West. The Anglophone crisis at the crossroads since October 2016, protests and strikes related to sectorial demands have escalated into a crisis over the economic

and political marginalisation of Cameroon's Anglophone minority. The crisis in the two English speaking regions of Cameroon has been on-going and has seen several episodes of deterioration, the most recent following the elections in October 2018. Given the political situation, security aspects and access issues, the humanitarian response has thus far been limited. These have resulted in the loss of lives and sustained injuries, with many affected communities displaced from their homes and thus prone to starvation and destitution, burning of homes, schools and hospitals. The UN agencies only activated the clusters in October 2018, declaring a level two emergency due to the worsening situation in the regions a few months after. Only few international NGO are intervening most of which respond through a local partner which are already on the ground.

Military operations have been recorded in more than one hundred villages in the Southwest and Northwest regions since October 2017. Most if not all of the inhabitants of the villages targeted have fled, and around 80 per cent are thought to have sought refuge in the forest, where they have no access to shelter, water and sanitation. Education has been severely disrupted as many schools have been shut down as part of the initial protests, and armed groups have banned them from reopening. They have also burned some schools down, and threatened others who did not comply with the ban. Around 42,500 children are thought to be out of school as a result, and the figure is expected to rise to 311,000 at end of 2019.

The South West region is saturated with a plurality of active non-state armed groups, and on-going operations by the armed forces bring about violence and insecurity. The armed conflict has affected an estimated 1.3 million people, of which roughly 437,500 people forced to flee their homes (246,000 in South-West region). With the first assessments completed, the image arises of a steadily worsening humanitarian situation though data is sparse. Violence has resulted in the interruption or complete disappearance of many basic services including health care, education and access to functioning markets. Livelihoods have been disrupted and agricultural production been reduced. The first victims of violence are children and vulnerable populations that see their protective environments crumble, exposing them to risks and violations. The recently activated clusters indicate that priority areas for intervention are Protection, Food Security, WASH, Shelter and Healthcare, addressing the needs of vulnerable individuals and IDPs in the bus, improvised settlements, with host families or new rental accommodation. This study therefore carries out an assessment on the needs and to understand the challenges of IDPs in the SW region.

Background of the study

Violence erupted in 2016 in the North-West (NW) and South-West (SW) regions, prompting security clampdowns. The crisis shifted into armed conflict with the proliferation of non-state armed groups (NSAG) and deployment of military forces to the regions. In late 2017, and in response to the violence and loss of life, humanitarian organizations were reporting that families were fleeing the two affected regions. Displacement was further compounded by limited access to education for children due to a ban and attacks on schools by the non-state armed groups.

The crisis has worsened considerably in the past six months due to several factors including: anticipation of periods of high insecurity (the start of the school year, the 1 October anniversary and the 2018 presidential elections) movement restriction in the two regions (curfew extended in the North-West, "No Movement" declaration by non-state actors, and increase of both official and informal checkpoints).

The socio-political situation remains tense. There has been a proliferation of non-state armed groups and intensification of confrontations between NSAG and the armed forces. Punitive actions are also reported to have taken place on civilians perceived as associated with parties to the conflict. Since 8 November 2017, the date of the first clash between NSAG and the State armed forces, confrontations between the two parties have displaced around 350,000 people (246,000 in SW and 104,000 in NW), triggering an unprecedented crisis in the two regions.

The humanitarian crisis has a growing impact in the bordering West and Littoral regions. Clashes have hit neighbouring areas, particularly in Menoua division in the West region. In the run up to the elections, Littoral and the West regions saw the number of internally displaced persons rise (85,000 as of October 2018). While some have returned, many remain displaced. The population of NW and SW

regions regularly face protection issues such as threats from armed elements, being caught in crossfire, restriction on freedom of movement due to multiple official and unofficial check points, arbitrary arrests and confiscation of personal documents, etc. Teachers, students and Government workers who do not adhere to the armed groups' education boycott have been threatened. The Government has tightened security, limiting the movement of people and goods through curfews.

Even though efforts are being made to distribute humanitarian assistance to IDPs in the SW and NW regions, the people are still suffering. They lack basic necessities and live under deplorable conditions. This motivated the researcher to carry out an assessment on healthcare, nutrition, food security and WASH to IDPs in the SW region.

With the creation of the centre for the humanitarian assistance plan in the SW and NW region, the government urged the coordinators to guarantee the aid gets to targeted groups of IDPs. Since the creation of these emergency humanitarian plan centres, national and international response has been massive but the condition of IDPs has not changed. The distribution of this aid to the victims of the socio-political unrest in the two Anglophone regions is a series of efforts deployed by the government to reduce the pains of the thousands of people affected by the crisis but they still live under deplorable conditions.

The aim and objective of the study

Aim

The aim is to identify the challenges faced by IDPs through a multi sectorial assessment, with the support of Middle Upper-Arm Circumference (MUAC) and on food security, nutrition, Water, sanitation and hygiene (WASH).

Objectives

1. To assess the needs and priorities of IDPs in the South West Region.
2. To understand the nutritional status of the affected population in the area. The data collected also serves to provide information to other actors for the general support of the humanitarian response, which is struggling with sparse data.
3. To provide information on the wellbeing of IDPs to government and humanitarian organisations.

Statement of problem

The humanitarian assistance is usually in urgent need by the IDPs anywhere they are located in the world and this was the case in the SW region, but they are hardly delivered on time, due largely to a very weak and non-agile supply chain and poorly coordinated logistics and supply chain management system.

IDPs visited in the SW region in the course of this research, live under deplorable conditions due to none or late arrival of humanitarian assistance that is in most cases insufficient. The problem is so serious that some IDPs especially the children and the elderly were looking severely unkempt, malnourished, and ill and in some cases appeared to be dying gradually. It is however necessary to know under which conditions IDPs are living? Do they have access to nutrition, healthcare, WASH and food security? What are the challenges they faced?

Literature review

Humanitarian supply chains consist of a network of interaction between donor governments, international and locally based agencies, suppliers and numerous other stakeholders that co-ordinate the flow of supplies, services, finances and information for the purposes of responding to beneficiary needs (Howden, 2009: 5).

The movement of supplies and materials should be cost effective and therefore proper planning and control is essential (Hermann, 2007: 20). Humanitarian logistics involves a set of supply chain activities carried out during disaster operations with the aim of attaining co-ordinated logistics excellence. It is necessary that all the humanitarian events occurring before and after a disaster are appropriately conducted in order to meet the needs of the affected communities.

This can be achieved when the factors influencing relief operations are taken into account during such operations (Minnich & Maier, 2005: 34).

Factors to be considered in designing humanitarian supply chain frameworks

Humanitarian organisations and the state face various challenges during relief operations. The movement of supplies and materials should be cost effective and therefore proper planning and control is essential (Hermann, 2007: 20). Humanitarian logistics involve a set of supply chain activities carried out during disaster operations with the aim of attaining co-ordinated logistics excellence. These activities involve the task of transporting large volumes of supplies and materials that are essential during relief operations (Tatham & Pettit 2010: 611; Thomas & Kopczak 2005: 226; Tomasini & Wassenhove 2004: 438).

It is necessary that all the humanitarian events occurring before and after a disaster are appropriately conducted in order to meet the needs of the affected communities. This can be achieved when the factors influencing relief operations are taken into account during such operations.

Two key issues have been identified to impact on the success of any supply chain which is closely linked. Those are the flow of accurate information on the needs of IDPs and effective and accurate demand management.

The flow of accurate information within any supply chain is a critical factor and influences response efficiency (Pettit & Beresford, 2009: 458) as accurate demand chain management, which governs the success of the operation, and covers a set of practices with the goal of managing the entire demand chain from the end customer and working backwards to the suppliers of raw materials (Heizer & Render, 2014: 339).

The initial period after a natural disaster occurrence is characterised by a sense of panic with the communities usually having inadequate resources available to initiate appropriate and correct response operations. As they usually occur without prior warning, there is no time to conduct needs assessments (Tatham & Spens, 2011: 17) which leads to difficulties in accurately determining the number of affected people, their geographic location, and type of and number of relief supplies required. With the affected governments and relief organisations not being in a position to appropriately assess the damages (Balcik, Beamon, Krejci, Muramatsu, & Ramirez, 2010: 28) and with little or no demand information available, the respondents usually transfer supplies to the affected areas within the hope that such supplies will be adequate to meet the needs of those affected by the disaster (Kovacs & Spens, 2007: 104).

This often leads to a congestion of the supply chain with unwanted and inappropriate supplies, as donors and relief organisations respond by transferring supplies into the supply chain, without having accurately determined the actual beneficiary needs (Murray, 2005: 3).

Humanitarian operations are often conducted in areas with destabilised infrastructure, including improper transportation channels, such as airports, road networks and railway lines (Kovacs & Spens, 2007: 100). These conditions affect the success of disaster operations exacerbating the accessibility of the affected areas.

The majority of humanitarian disaster operations are usually under-funded, which results in most organisations not prioritising the adoption of key supply chain concepts. This affects and compromises the success of their disaster operation efforts (Moe & Pathranarakul, 2006: 400).

Another key variable in disaster relief operations is the availability of supplies. This includes supplies of sanitary medical products, foodstuffs and water plus clothing and shelter equipment, all of which need to be procured and distributed during operations (Pateman et al. 2013: 93). Lead time is commonly used as a measure of efficiency with most customers preferring that the period between placing an order and receiving it is kept at an absolute minimum.

Due to the unexpected and extraordinary nature of the disaster event relief organisations require supplies, to be delivered from either their donors or suppliers within the least possible time (Chopra & Meindl, 2013: 328) in order to alleviate the hardship of the people affected by the disaster. A key expectation from relief organisations is to source their supplies on a shorter lead time basis (Sheu, 2006: 687).

Humanitarian organisations can draw practical lessons from prior research on how the concept of agility in relation to how it has been implemented in different organisational operations. As a result, an explanation of how agility has been implemented through postponement, virtualisation and co-ordination is appropriate.

Humanitarian response

In the 1990s conflict and drought in Somalia caused an influx of Somali nationals seeking refuge in Kenya. Similarly, political instability and the victimization of political opponents by the Mugabe regime in Zimbabwe since 2007 and a cholera outbreak in 2008, triggered a massive exodus of Zimbabwean nationals into South Africa to seek a place of safety. Article 14 of the 1948 Universal Declaration of Human Rights recognizes the right to seek asylum in another country, a gesture that the Organisation of African Unity Convention of 1969 qualifies as a “peaceful and humanitarian act”. A refugee-receiving country, particularly one that has ratified the refugee conventions, is bound by the obligation to provide humanitarian assistance to persons who seek refuge in the country. In the event that such a country is unwilling or incapable of providing such assistance, humanitarian agencies are mandated to intervene to provide the necessary response.

Owing to the humanitarian imperative, the Humanitarian Charter recommends three rights-based core values by which humanitarian response must be guided: “the right to life with dignity, the right to receive humanitarian assistance and the right to protection and security. The fact that victims of emergency situations are guaranteed these rights means that they are ipso jure recognised as right-holders. By implication, legal and moral obligations are imposed on the state and humanitarian agencies respectively to ensure that these rights are respected, protected and fulfilled.

Implication for the future of humanitarian response

When human rights are contravened in humanitarian emergencies, it negatively impacts the well-being of the persons whose precarious situation of the humanitarian response is intended to ameliorate. This lays a risky precedent for the future of humanitarian work as humanitarian assistance may lose its significance and therefore defeat the purpose of trying to serve humanity. Transgressing human rights in emergency situations implies that the core values of humanitarian response, which are principally human rights-based, have also been contravened.

The researcher argued elsewhere that no intervention on the pretext of protecting the human rights of IDPs or of serving humanity is justified if it renders the situation worse than it would be without the intervention.

Essentially humanitarian response is intended among other things to alleviate human suffering, which means every humanitarian action is supposed to improve conditions for persons affected by humanitarian emergencies.

Humanitarian aid would serve no purpose if victims, who in the context of this paper include IDPs and the local population, are subjected to almost the same circumstances that caused them to flee from the community of origin.

The situation of the IDPs in the Far North region illustrates the manner in which the human rights of victims of humanitarian emergencies have been dealt with. Humanitarian emergencies are not only becoming increasingly frequent but more severe, resulting in increased human casualties, damage to property, and displacement of people.

As indicated earlier on, humanitarian action imposes the **rights-based duty to protect and the needs-based duty to assist**, which ultimately need to converge in order to advance the humanitarian imperative to alleviate human suffering.

In this regard, unless humanitarian planning is properly conceptualized, victims will continue to suffer contravention of their inalienable human rights. By humanitarian planning, the researcher refers to the process of policy-making, program-designing and on-the-field operations in response to a humanitarian emergency. This process needs to take an integrated approach to combining the needs-based and rights-based approaches as we have endeavoured to illustrate in the table 1 below.

Table 1. An integrated approach to humanitarian response, combing the needs-based and right-based approaches.

Integrated Approach to Humanitarian Response		
Needs-Based Approach	Rights-Based Approach	Humanitarian Response
Beneficiaries deserve humanitarian assistance as an act of charity	Persons affected by a humanitarian crisis are entitle to assistance, protection, and security as a matter of human rights	Core values: - Right to life with dignity, - Right to humanitarian assistance - Right to protection and security
The state ought to respond in humanitarian crises but no one has definite obligations	The state has a binding legal obligation towards affected persons to ensure the respect, protection and fulfillment of their human rights	Guiding Principles: Humanity: Affected persons are treated humanely and as right holders in every humanitarian emergency
Beneficiaries are seen as lacking the agency to take action and therefore need to be helped	Affected persons are by right active participants in humanitarian response programs	Neutrality: May not take sides or engage in controversies of a political, racial, religious or ideological nature
When resources are scarce some beneficiaries may to be left out in the distribution of humanitarian aid	Every affected person has the equal rights to life with dignity, to receive assistance and to protection and livelihood security	Impartiality: Non-discrimination in the provision of assistance based on most urgent need alone.
Certain groups have the technical expertise to meet beneficiaries' needs	Every person has the responsibility to play a role in ensuring the realization of the human rights of victims of humanitarian emergencies	Universality: Humanitarian response entails equal responsibility towards persons in emergencies
Relief aid is provided to address specific immediate situations	Legislative and other measures are taken to ensure long term prevention of rights abuse	Independence: Autonomy from political interference in the provision of assistance
Ownership of programs and projects usually belong to the implementing agency	Ownership of programs and projects belongs to the affected populations	Do no harm: Avoid exploiting the vulnerability of affected persons to achieve other purposes

Indicators of vulnerability verified during the rapid assessment

Highlighted here are the key vulnerability indicators assessed and reported against in the current assessment. At times, reference can be made to additional questions included in the questionnaire.

Nutrition and health

Nutrition vulnerabilities we verified primarily through the following indicators

1. Prevalence of acute malnutrition among children under five (5) years in the accessed communities through proactive MUAC screening.
2. Morbidity analysis and measles vaccinations
3. Primary Health vulnerability criteria assessed during the RNAs include:
4. Household access to a health centre / service
5. Coping mechanism in case a household member falls sick

Wash

Indicators for vulnerabilities related to WASH, pertaining mainly to access to water and basic hygiene practices included

1. The primary source of drinking and cooking water
2. Water treatment before drinking
3. Hand washing practices observed
4. Morbidity of Water borne diseases in children under 5 years

Food security

Food Security vulnerabilities were only partially measured during the assessment. Vulnerabilities related to access and diversity in basic food needs was assessed through

1. Household Hunger Score (HHS)
2. Food Consumption Score (FCS)

Quantity and supply of food items were not directly address in the RNAs. Questions were included about priority needs and difficulties in access primary needs, not providing concrete data but rather indications of possibly influencing factors to the food security levels of the assessed communities.

Methodology

In order to collect primary data for this research, Structured Questionnaire and Direct Observations were used. In addition, the internet, Professional Journals, articles and text books on humanitarian assessment were referred to as secondary data from hospital sources to support primary data generated in this study.

Population and sample

The study population is made up of 155 household assessment and 1934 hospital cases of IDPs were consulted in the different communities.

Time of study

This study was conducted from August to September 2019

Technique of data collection

Data was collected only in the areas where access was obtained and security of the researcher could be reasonably assumed. The concrete collection of data took several forms, including informal interviews, household level Rapid Needs Assessments (RNAs) with IDP families, health facility assessments and MUAC.

The combination of several means of data collection needed to be flexible and adaptable to the volatile context. The majority of data was collected through direct interactions with the communities visited and from hospitals.

Procedure for data analysis

In this study questionnaires were designed in such a way that they will elicit unbiased responses from the study population. The data collected were analysed using percentages as a statistical tool to provide answers for the research questions.

Further observations were made of the households and hospitals while the questionnaires were administered. The whole process was designed to help in drawing definite conclusions from the data analysis

Presentation of study area

The southwest region of Cameroon is one of the ten regions in the country, with Buea as the regional capital. The region is divided into six divisions or departments: Fako, Koupe-Manengouba, Lebialem, Manyu, Meme, and Ndian.

These are in turn broken down into sub divisions. The region of southwest shares an international boundary to the west with Nigeria and three national and administrative boundaries with North West, West and Littoral regions as shown in the map 1 below

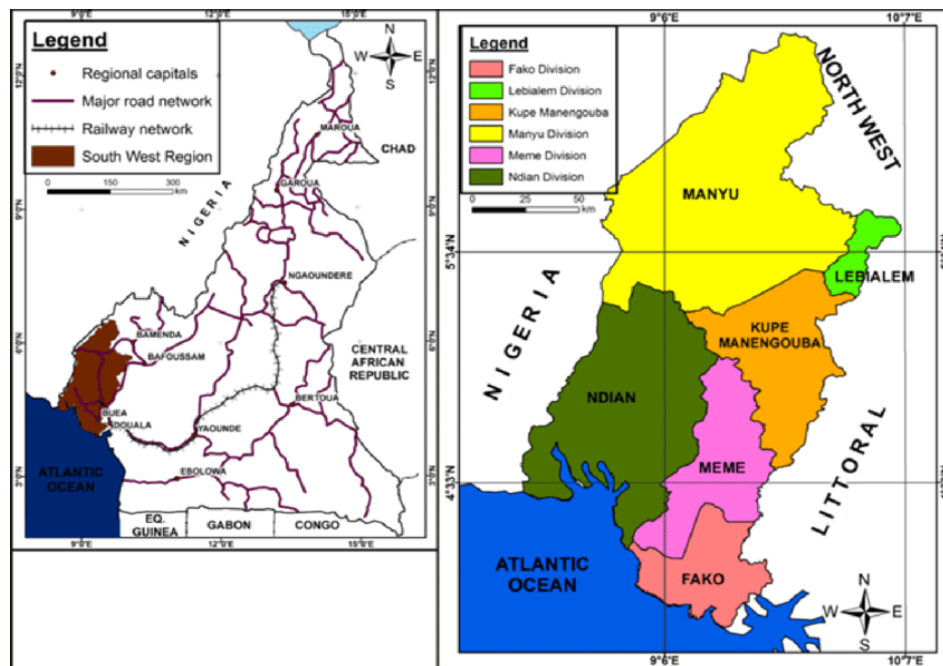


Figure 1. Map of Cameroon, SW region and its divisions.

Source: https://www.researchgate.net/figure/Map-of-Cameroon-showing-the-South-West-Region_fig1_271187139.

Data analysis and findings

Each locality clearly seems to be having their particular difficulties, with food insecurity being a larger issue in the Kumba than in Limbe or Tiko, and access to clean water being a priority in Mamfe rather than Kumba II.

On the other hand, we also observe some over-arching challenges including limited access to healthcare and high levels of morbidity among the assessed populations. When asked point-blank what their primary needs were; households systematically returned the same answers: Food, Health, Shelter, Water, Protection and Education. These self-identified needs were flowingly assessed through the RNA surveys, revealing similar areas of priority needs.

Nutrition and health

The prevalence of acute malnutrition among children U5 in the accessed communities through proactive MUAC

Malnutrition screening took place from 22 November 2018 to 24 September 2019. Out of the 1930 children 6-59 months screened for acute malnutrition, 1903 returned normal readings and 31 suffered wasting: 1.4% suffered from moderate acute malnutrition (MAM), and 0.26% suffered from severe acute malnutrition (SAM). SAM and MAM readings used the following cut-off points

SAM [$\leq 115\text{mm}$] = MUAC of below 115mm;

MAM [$\geq 115\text{mm}$; $< 125\text{mm}$] = MUAC of greater than 115mm but below 125mm;

The results show GAM below emergency thresholds ($>15\%$). The screenings only took place in the localities where access was granted. Nonetheless, at least one malnourished case was found in each locality, except for Mutengene and Bonadikumbo, areas where very limited screening was done as summarised in the table below. MUAC.

Table 2. Areas screened and MUAC results

Region	Division	Sub division	Village /town	No. of children MUAC screened	Children with "normal" nutritional status	% GAM (n)	% MAM (n)	% SAM (n)
South West	Fako	Tiko	Mutengene	12	12	0% (n=0)	0.00% (n=0)	0.00% (n=0)
South West	Fako	Tiko	Upper Costain, Camp Center, Motombolombo-Ekanje 1 & 2	236	232	2% (n=4)	1.27% (n=3)	0.42% (n=1)
South West	Fako	Limbe	Bonadikumbo / Mile 4	31	31	0% (n=0)	0.00% (n=0)	0.00% (n=0)
South West	Manyu	Mamfe	Mile1/ Egbekaw	38	36	5.30% (n=2)	5.30% (n=2)	0.00% (n=0)
South West	Manyu	Mamfe	Main street /Okoyong	211	205	3% (n=6)	2.37% (n=5)	0.47% (n=1)
South West	Meme	Kumba I	Kumba I - Cassava Farm, Mbonge road	204	201	1% (n=3)	1.47% (n=3)	0.00% (n=0)
South West	Meme	Kumba I	Mile 1 - Mbonge road - Kumba to Mbonge axis	654	647	1% (n=7)	0.92% (n=6)	0.15% (n=1)
South West	Meme	Kumba II	Kumba II – Fiango area - Akale, Bao, Paradise, Confidence, Farm.	169	164	3% (n=5)	2.96% (n=5)	0.00% (n=0)
South West	Meme	Kumba III	Kumba III -Apollone/ Cemetery Street, Ntam, Mambanda	375	375	1% (n=4)	0.79% (n=3)	0.26%(n=1)
			Accumulative Total	1930	1903	1.66% (n=31)	1.40% (n=27)	0.26% (n=4)

Source: Research findings from field survey, 2019

Since the researcher could only manage to screen where access was possible, and during distributions only, rather than door-to-door, only a very small sample (2%) of the 6-59 months population in the South-West region was touched by the screening exercise as can be seen in the table 3 below

Table 3. Population screened

	Girls	Boys	Total screened	Population	Estimated population 6-59 months	Percentage sampled/population 6-59 months
TIKO	126	122	248	128,176	23,072	1.1%
KUMB	366	492	858	54,864	9,876	8.7%
MAMFE	124	125	249	10,371	1,867	13.3%
KUMBA II	51	118	169	54,864	9,876	1.7%
KUMBA III	237	138	375	54,864	9,876	3.8%
LIMBE	11	20	31	199,045	35,828	0.1%
TOTAL	917	1,017	1,930	502,184	90,393	2.1%

Source: Research findings from field survey, 2019

The Global Acute Malnutrition (GAM) rates measured as per the screening data collected are thus distributed as such following administrative partitioning as shown in figure 1 below

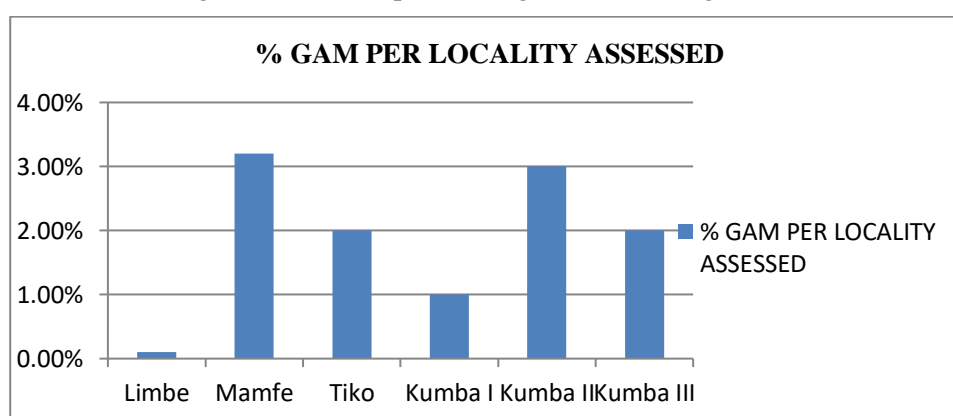


Figure 2: Percentage of GAM per locality assessed

The figure 1 above simply identifies the division where the highest percentages of malnourished cases were identified among the children screened. Limbe for example shows 0% GAM, yet only 31 children were screened, therefore limiting the validity of this percentage.

Among the identified malnourished cases, were four (04) cases with Severe Acute Malnutrition (SAM). One case was identified in each of the following localities

1. 1 case in Mamfe
2. 1 case in Kumba III
3. 1 case in Kumba I
4. 1 case in Tiko (with complications)

Each of the cases received treatment from the assessment team, which had left with a contingency stock supplied by UNICEF in the case where SAM children would be found. Each case was provided with one months' worth of Plumpy nut rations, as continued monitoring is not possible within the given context. The case identified in Tiko showed complications and was thus referred to the MSF hospital in Buea for further consultation and treatment.

Morbidity analysis and measles vaccinations

MUAC screening was accompanied by simple questions on illnesses observed in the last 15 days, feeding methods and vaccination status of the child. Based on these questions, the researcher tried to gain a primary understanding of the main morbidity challenges faced by the affected population. As can be seen represented on the figure 2 below, in the report's of 1930 children screened, 59% of them have been ill in pass 15 days.

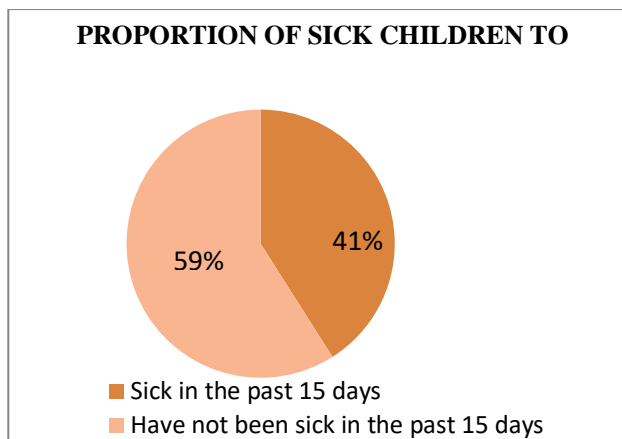


Figure 3

The following figure 2 below represents the proportion of sick children found in each health area during MUAC screening. Kumba 1 had the highest proportion of sick children registered with Kumba II, Kumba III, Mamfe and Tiko still being considerably high. With the compromised security, most health facilities in these health areas are non-functional and in the nearest future these values are likely to keep increasing as shown in figure 3 below.

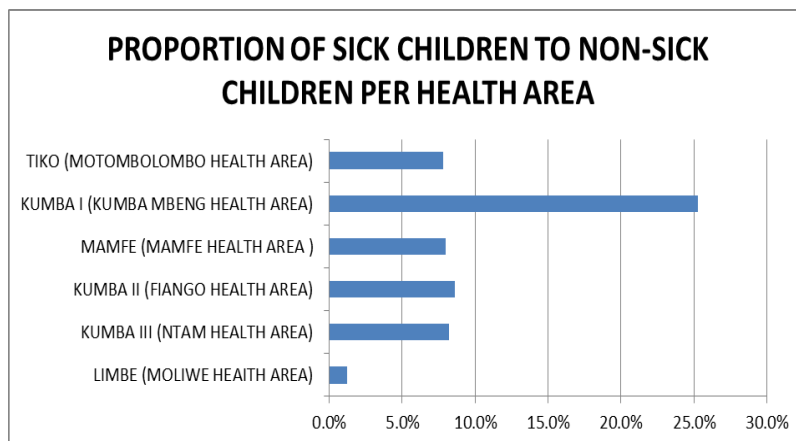


Figure 4

Children 6-59 months who had fallen sick in the last 15 days before screening in the areas assessed primarily suffered from respiratory tract infections, Malaria, diarrhoea and skin infections. The main causes of morbidity among the 59% ill children 6-59 months of age represented in the first figure are disaggregated here below. As also presented in figure 4 below, all the health areas showed a considerably high proportion of respiratory, malaria, skin and diarrhoea related diseases

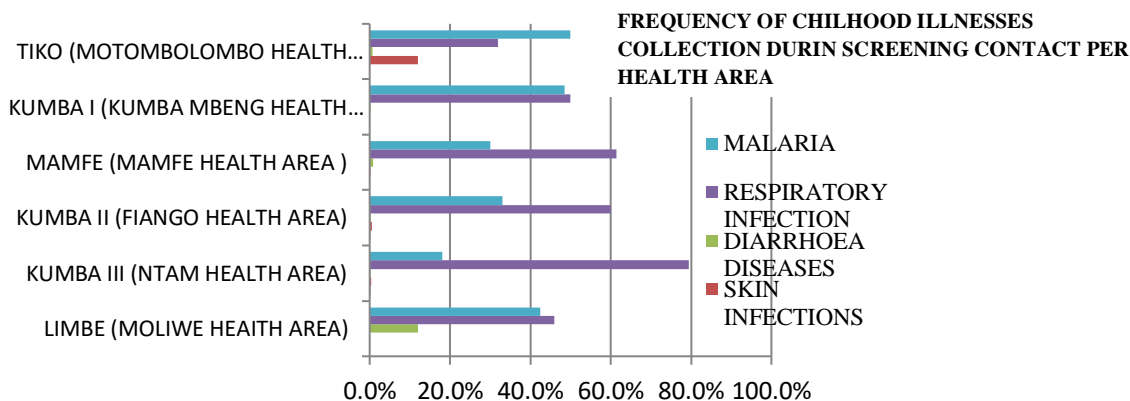


Figure 5

Interviews conducted with the District Medical officers and nurses, highlighted an increasing incidence of these diseases due to the cold period now in the SW region (for respiratory infections) as surveys were conducted during raining season where temperatures drop and rain is frequent. Other possible reasons towards illness could be the lack of adequate shelter, lack of long-lasting treated mosquito nets for most displaced homes (for malaria) and equally lack of potable water for the diarrhoea diseases and skin infections.

The figure 5 below shows the percentage of children from 9 months who received measles vaccine. MUAC screening questionnaires showed an overall coverage of measles vaccinations across the assessed areas at 73.1% coverage. While it falls short of the acceptable coverage rate of 80% as per the recommended health standards in the SW region, it is still within expectations. The majority of parents of children whom had not received their measles vaccine mentioned this to be due to their displacement. Compounded with the lack of operational health facilities, addressed here below, it could indicate that those not yet vaccinated will not receive their coverage in the near future either. All three health areas around Kumba I, II and III show low coverage in measles vaccination, as these areas are found at the core of highly compromised security that has led to the slowed primary health care services. Limbe and Tiko on the contrary have good vaccination coverage against measles of the children screened from the age of 9 months. This could be because public and para-public health facilities still have some control of their activities as shown in figure 5 below.

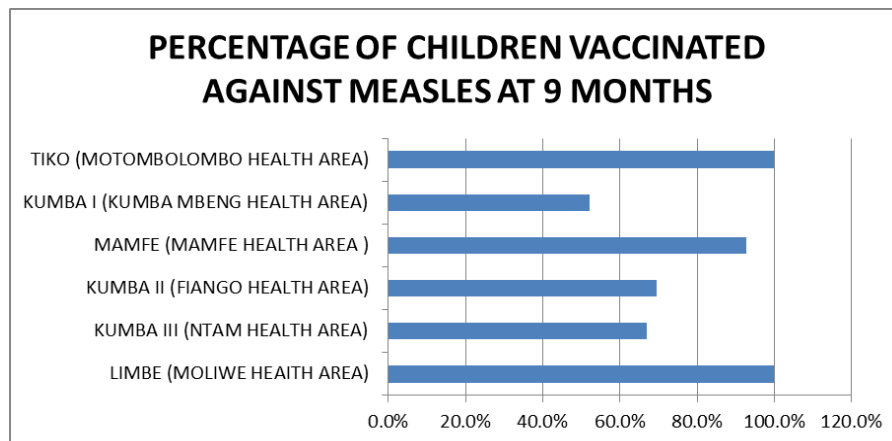


Figure 6

Access to a health centre / service

Secondary information initially indicated a weak health care infrastructure in the SW region, with the Health cluster reporting more than 40% of the 257 facilities in SW no longer providing vaccinations and disease surveillance being nearly non-existent. In their assessment conducted in July 2018, IMC also found that a significant gap in staffing at health facilities. RNA responses, as well as interviews conducted with health workers confirm these initial indications. The RNAs included questions on the access to health centres, on coping mechanisms for treatment of diseases and on general morbidity observed within households.

While some health facilities remain functional, access to said facilities is not always guaranteed. From the households surveyed, only 20 of 155 (13%) households mentioned having access to health facilities, inversely close to 90% does not have access to health facilities. The only locality where more than 20% had access to a facility was Kumba II, which probably without coincidence is where St. Johns clinic is operational. This clinic was ran by Caritas, a faith-based organization which had thus far ensured free consultations up until 2018. The main reasons for not having access to clinics include: (1) not being able to afford the costs of transport, treatment or drugs, (2) the distance to the clinics, (3) lack of supplies available at the clinic and (4) fear of using state facilities. As exemplified in the small survey above: many facilities are no longer functional since the communities are displaced, they have lost access to their livelihoods, possibly explaining the difficulties in affording transport, treatment and drugs. With displacement, also the distance to clinics becomes greater, especially since many clinics are closed. The few facilities that are open often struggle with supplies, with the government struggling

to maintain supply chains of medicines. Facilities in more urban areas, such as Tiko often struggle less in their supplies than those in more remote areas, although none of the assessed facilities had a functioning ambulance service. During the interview with the general manager of St. John clinic, it became clear that ambulance services in the current context are extremely hard to ensure, with even MSF not being able to provide this service in Kumba at the time of assessment. Lastly, with serious threats by armed groups against all those who take help from the government, families have become hesitant to seek and/or accept state support.

Wash

The primary source of drinking and cooking water

The WASH cluster by the end of December 2018 estimated that over 700,000 affected people are in need of WASH assistance. Highlighted were needs of access to safe water and knowledge on treatment of unsafe water. However, as of yet no priority areas have been clarified. As of February 2019, an assessment reported shared by REACH Initiative, covering South West region indicated that access to water is a key challenge across the area, both in terms of quality and quantity. It further indicated that access to hygiene is very limited and that the overall sanitation situation is poor; with only few households have access to soaps or latrines. The RNA conducted by the researcher indicates open and unprotected wells to be the most frequent (35 HH) source of water at household level among the 147 responses recorded on water sources. This is closely followed by community taps (34 HH) and boreholes (32 HH). Unsurprisingly, boreholes and community taps seem to be the main sources of water for drinking and home use in the urban areas of Tiko and Limbe, whereas open unprotected wells and boreholes are used more in rural and semi-urban areas such as Mamfe and around Kumba

While the assessment team was not within the capacity to evaluate the water for quality, experience and field observations cast serious doubt over the quality of the water accessed, with prevalence of reported and observed diarrhoea as well as skin infections, as they were acutely aware of the bad quality of the water they were using.

Water treatment before drinking

With water sources varying in quality significantly, households were also asked to indicate whether they habitually treated their water before drinking. Among the surveyed, only 33/86 did indeed treat their water, whereas the majority 53 (or 61%) did not treat their water. In the cases where water was treated, this was done almost exclusively with liquid bleach. Only one household indicated boiling the water before drinking. Treatment was proportionally more frequent in areas where access to the local market was easier, such as in Tiko, than in areas with less direct access to markets such as in Kumba III. In Mamfe and Kumba III, only 28% and 22% of the assessed households treated their water as compared to 79% in Tiko.

Hand washing practices observed

To understand knowledge of basic hygiene practices, such as hand washing, households were asked five simple questions about the crucial moments during the day to wash hands. This question was only added after surveys in Mutengene and Limbe had already been completed, thus no data is available there limiting the responses to 86 respondents. Most homes in the semi-urban areas (Kumba III and Tiko) reported washing their hands after using the toilets (34 HH), but this practice is less observed in rural areas (such as Mamfe). Most households confirmed washing their hands before eating, be it in semi-urban, urban or rural areas.

The most two prevalent forms of morbidity among children under 5 are malaria and respiratory tract infections. It further indicates that the highest proportions of water borne diseases are found in Tiko and Kumba II, as compared to other localities. Morbidity of diarrhoea is most present in Tiko (6.7%). In Kumba II we observe 6% of skin infections, as in Tiko 11.3%, higher than in other areas. These are both areas where springs and open unprotected wells are the main source of water. Unclean water, and especially the lack of water treatment in places such as Mamfe, could significantly affect the prevalence of such illnesses, as compared to for example Kumba I, where water treatment is proportionally more practiced. Similarly, in Kumba II, where springs and open unprotected wells together make up the

majority of primary water sources, 6% of cases of morbidity are reported to be skin infection, which could indicate lack of access or quality water.

Food security

Household hunger scale (HHS)

As part of the questionnaire presented to IDP households during the distribution, the assessment aimed at identifying Household Hunger Scales (HHS). While not all participating households were able to complete the HHS questions, 143 out of 155 responded. The percentage share of households as categorized in three levels: from severe hunger experienced in the household (a score from 4-6) to little or no hunger experienced in the household (a score from 0-1). From the assessed, 87 out of 143 IDP households affirmed having experienced on of these three scenarios as least once in the last four weeks. 15% were facing severe food insecurity, and 36% were moderately insecure as shown in figure 6 below

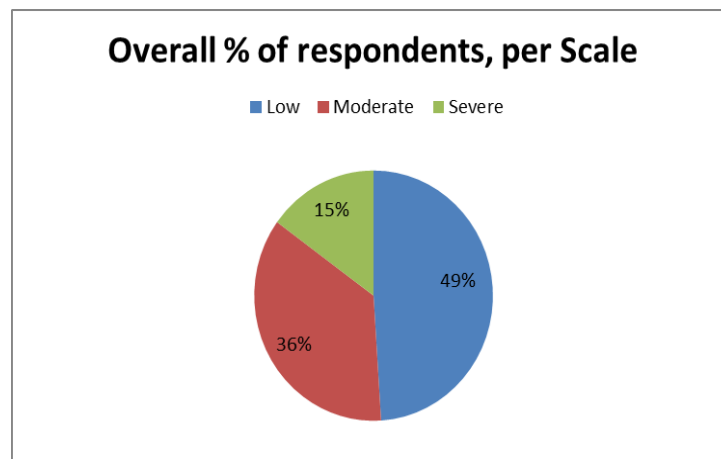


Figure 7.

The figure below details further the hunger scale per locality, with percentage shares of respondents per category. It is clear that household hunger, or food insecurity, is experienced relatively more in Kumba I, Kumba II and Mutengene, than for example in Tiko or Limbe. Kumba I, Kumba II and Mutengene clearly show the highest proportion of IDP households facing food insecurity, with each community having 78% of the assessed population either moderately or severely affected. Kumba II seems to host the largest proportion of IDP households with severe scores, at 33%.

While the data cannot be considered conclusive due to the limited number of participating households, it is clear that food insecurity is present among IDPs residing in each of the seven assessed localities, in some to a larger extent than others. Interesting to note also is that the three areas with the highest scores are all semi-urban settings, not too far from larger towns, but not urbanized as much as Tiko or Limbe.

Food consumption score (FCS)

Given the time it takes to conduct an FCS, and taking into account the security situation and assessment fatigue already witnessed, the researcher only conducts a limited number of FCS questionnaires among IDP families per locality. In total, 71 out of 155 conducted RNAs returned completed FCS forms, which are represented. The completed forms received provide indicative scores, which may not be exhaustive in their representation of food consumption of the locality as a whole, nor of the entire region.

The FCS questionnaires presented 9 food groups, asking each household which of the nine groups they had consumed in the last 24 hours. The majority of IDP households, regardless of the locality, reported consuming five or less food groups in the last 24 hours. In some localities, such as Kumba III and Kumba I, Mile 1, not one IDP household reported consuming more than 4 groups, possibly indicating a rather low diversity in food consumption.

If we consider the diversity in food consumption, we can say that the more food groups consumed, the higher the diversity of consumption and thus diet will be. From the data collected, keeping in mind all the previously mentioned limitations, it can be considered that overall the diversity of food consumption is quite low.

The figure below illustrates the number of responses per category. Main food groups consumed included Cereals and tuber (starchy items) and fat groups. Following were protein and vegetable groups. Note, over 25% of households reported having consumed spices and condiments, such as tea and coffee; however, these should not be taken too much into consideration for they should be considered supplementary to, and not substitution for other core food groups.

Conclusions, recommendations and limitations

Conclusions

While malnutrition prevalence did not reach the emergency thresholds levels (>15% GAM prevalence) four out of seven localities assessed did reveal cases of Severe Acute Malnutrition. Nevertheless, given difficulty to access children, nothing can yet be concluded regarding nutrition situation. Compounded with the aggravating factors identified, such as food insecurity among a significant number of households, the lack of access to clean water, and clear gaps in access to primary health care facilities, limited access to the markets, and eroded livelihoods, it can be considered that the overall situation is at high risk for increased malnutrition.

Notably, the large number of illnesses recorded among IDPs households across all localities is worrisome, including diarrhoea, malaria, respiratory tract infections and skin rashes. The absence of trained health personnel and units to manage acute malnutrition at the primary, secondary and even tertiary levels within the South West region is cause for concern. In the occasion where the situation further deteriorates and malnutrition prevalence increases, current capacities are not able to provide the necessary coverage.

WASH indicators reveal limited access to clean and safe water in most localities assessed. In combination with limited practice in water treatment and hand washing, the use of unreliable water could result in higher occurrences of illness and possibly malnutrition. In terms of access to food and the diversity of food intake, localities score low across the board with 4/5 households reporting a dietary diversity of 61% of households experiencing severe food insecurity, according to WFP standards. Lastly, but certainly not least, with 87% of households not having access to health facilities, and a significant prevalence of morbidity among the assessed population, the lack in health care coverage is bleakly apparent. The Do No harm approach needs to be included as well (initial feedback from communities).

WASH kits received showed suspicion from parties in conflict, and led to beneficiaries being questioned. Given these risks, protection should be mainstreamed (staff training, referral, strong monitoring of action) in any short-term intervention. Nevertheless, some health facilities could still be supported (i.e.: St John clinic) and Mobile Health and Nutrition teams (implemented through CARITAS who has access to communities) would allow to provide services to populations without health access. Through improved understanding of context, initiate MHCP activities, which will allow continuing gain access and understanding of nutrition situation and care practices

Recommendations

The short-term calls for firstly, continued multi-sectorial (including MHCP aspects) assessments, screening of children (door to door as far as possible), needs mapping and more thorough analysis of the areas already covered as well as those not yet reached. Initial data clearly indicates that there is a wide range of needs, but the best possible response can only be oriented more suitably with more information available on IDPs in Cameroon and SW in particular.

In the middle term, the government and international organisations should support IDPs on food and livelihoods, providing the required means to vulnerable households to provide for their families and ensure an adequate and varied diet for themselves and their children. The central government in Yaounde also should approve cash-based interventions, which in the current context could provide quick and efficient relief. The creation of local centres for humanitarian assistance in every community

to take care of IDPs in the SW region and good logistics for quality food distributions, which should be based on the preliminary information and needs on the ground.

This crisis is expected to continue, given its complexity and the unwillingness of main actors to negotiate / discuss, for an extended period of time. Therefore, longer term multi-sectorial positioning could be considered, providing an integrated Health, Nutrition, WASH and food security approach. Such an intervention would probably focus on strengthening the healthcare system (based on accessibility of course) through Health Facility support in technical capacity and WASH, as well as working on areas such as MHCP, and Protection/GBV referral systems with more dialogue and bring peace and security in the SW and NW regions.

Limitations

Data was collected only in the areas where access was obtained and security of the researcher could be reasonably assumed due to high insecurity in the SW region. All data collected was limited to the localities where the researcher obtained access.

The concrete collection of data took several forms, including informal interviews, household level Rapid Needs Assessments (RNAs) with IDP families, health facility assessments and MUAC screening of children under the age of 5-years-old. As a result, not all types of assessments were conducted in each location or in each community to the same extent. The majority of the presented data was collected through direct interactions in the communities visited and from hospital statistics. The coverage of the screening at the sub divisional levels was very low that is 2.1 % due to accessibility issues as highlighted above.

The consistency of data is another limitation of the assessment conducted. The assessment was carried out by the researcher with limited experience in humanitarian assessment and time. It is suggested therefore that a further study be conducted and that other key stakeholders such as the beneficiaries are included, so as to have a plurality of perspectives. This could further evaluate the impact of humanitarian assistance to IDPs or supply chain management of humanitarian aids in Cameroon.

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