Rapid Needs Assessment Report

Cameroon / Far North / Logone & Chari

International Medical Corps | October 2016 | Monitoring & Evaluation Division

Contents

I. List of abbreviations and acronyms

ARV	Antiretroviral drugs
BEmONC	Basic Emergency Maternal Obstetric and Newborn Care
BPHS	Basic Package of Health Services
CHW	Community Health Worker
CMAM	Community-based Management of Acute Malnutrition
CMR	Clinical Management of Rape
CNAS/M	Centre Nutritionnel Aigue Sévère/Modéré
SC	Centre Nutritionnel Therapeutique Intensif
CSB++	Supercereal Plus (corn soya blend)
EBF	Exclusive Breastfeeding
EmONC	Emergency Obstetric and Newborn Care
EPI/PEV	Expanded Program on Immunization
EWASA	Energy, Water and Sanitation Authority
F100 and F75	Formula 100 and Formula 75 therapeutic milk products
GBV/VBG	Gender-based Violence
HMIS	Health Management Information System
IASC	Inter-Agency Standing Committee
IEC	Information, Education and Communication
IHC	Integrated Health Center
IMCI	Integrated Management of Childhood Illnesses
IRA	Initial Rapid Assessment
IYCF/ANJE	Infant and Young Child Feeding
L/p/d	Litres per person per day
M2M	Mother to Mother
MAM	Moderate Acute Malnutrition
MISP	Minimum Initial Service Package
MOH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
NCDs	Non communicable diseases
NFI	Non-Food Items
NGOs/ONG	Non-Governmental Organizations
ORS	Oral Rehydration Salt
OTP	Outpatient therapeutic program
PFA	Psychological First Aid
PLWHAs	People Living with HIV/AIDS
PMTCT/PTME	Prevention of Mother-to-Child Transmission
SAM/MAS	Severe Acute Malnutrition
SRH	Sexual and Reproductive Health
STI	Sexually transmitted infections
UNHCR	UN Agency of High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary counselling and testing
WASH/EHA	Water, Sanitation and Hygiene
WHO/OMS	World Health Organization
WHO mhGAP	WHO Mental Health Gap Action Programme

II. Acknowledgments

We are deeply grateful to all people who would have contributed to this needs assessment. We sincerely wish to thank each of the humanitarian actors in Logone & Chari, the District Medical Officers of the health districts of Kousséri, Goulfey, Makary and Mada, the Divisional officer of Logone & Chari, and the sub-Divisional officer of Makary, Goulfey and Kousséri and Mada. We also thank all the coordinating agencies of the United Nations system represented in Maroua for their support. Finally, we would like to extend a special thanks to the NGO Solidarité d'Afrique for the ongoing support it has provided us throughout the field data collection operations.

III. Summary

Recent assessments in the Logone & Chari Division have reported a significant humanitarian demand. This request concerns all sectors of the traditional humanitarian response: health, nutrition, food security, water hygiene and sanitation, protection, shelter and non-food kits. Despite the interventions of the various humanitarian actors present in Cameroon, the situation of the displaced communities of Logone & Chari is still deeply worrying. In October 2016, International Medical Corps (IMC) conducted a targeted assessment in the areas of health, WASH, nutrition and protection.

The methodology used by IMC to conduct this evaluation combined various tools and techniques. The literature review was used to make the most of existing assessments and data in relation to Logone & Chari. Direct observation made it possible to assess the status of each health structure visited and the living conditions of the populations. The focus groups identified the priority needs of each target population group. Finally, the mapping of the actors made it possible to identify gaps in terms of humanitarian response in the Division.

The results of the evaluation show that food security and nutrition remain the main concerns of the internally displaced populations and of the host populations staying in the Division. The prevalence of severe acute malnutrition exceeds the 2% threshold in almost all the health areas visited and that of the MAG is 10.8%. In the area of health, responses in terms of primary health care and reproductive health are still insufficient. Indeed, geographical, financial barriers and lack of health resources (medical personnel, medicines, and equipment) make it impossible to access health services for displaced communities, especially for boys, girls and women. The gap in terms of drinking water infrastructure is estimated at 471 structures. Interviews with municipal authorities revealed the proliferation of poor hygiene practices, thus leading to major public health risks. Fifty percent of the districts of Logone & Chari do not yet have protection programs, yet women, boys, girls, and community leaders expressed their wishes to have basic protection services in the communities for the most vulnerable.

Given the density of unmet needs in the Logone & Chari Division, there is an urgent need for multi sectoral responses to save the lives of displaced communities and host communities that are increasingly in distress because of the aftermath by Boko Haram, because of the famine, or because of the recurrent floods in the area. Emergency interventions are required in the areas of primary health, reproductive health, hygiene promotion, latrine construction, rehabilitation / construction of boreholes, creation of a more secure environment for girls, women and boys, prevention and management of acute malnutrition, epidemiological surveillance of vaccine-preventable diseases and rehabilitation of health structures. To achieve this, IMC would like to position itself in the areas of health, nutrition, WASH, child protection and gender-based violence to provide these services within four health districts as follows:

Mada Health District (Mada Health Areas, Blangoua and Hile Alifa)
Goulfey Health District (Goulfey, Gana, Afade, and Mara Health Areas)
Kousséri Health District (Dabanga Health Areas, Madiako, Zimado, Ngodeni, Zina, Pagui)
Makary Health District (Makary Health Areas, Fotokol, Biamo and Woulky).

IV. Context and rationale

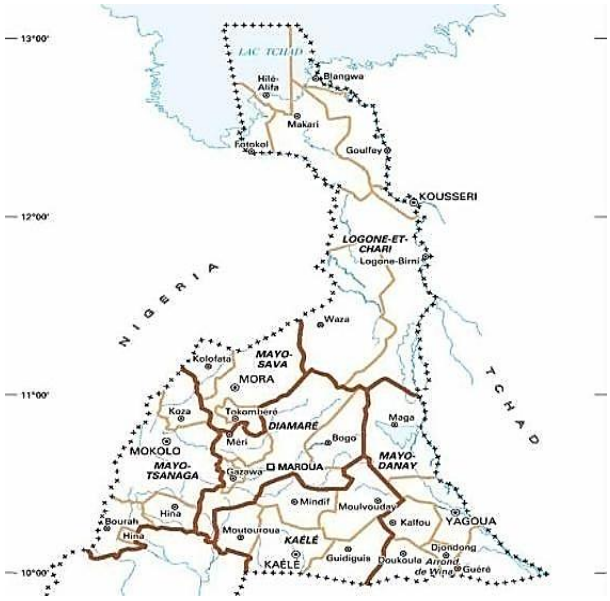
Cameroon since 2010

Since the beginning of the second decade of 2000, Cameroon has faced one of the most important humanitarian crises in its history. The post-electoral conflict of 2012 following the disputed election of President Francois Bozizé plunged the Central African Republic into a civil war, mainly opposing two fractions of the army, the Seleka and the Anti-Balaka. The violent clashes between these two groups have tipped 50% of the population of the Central African Republic (2.3 million) into a humanitarian crisis according to the United Nations. The vulnerability of these populations led them to seek refuge in Cameroon in its southeastern part, to such an extent that the country had received the recorded number of two hundred and fifty thousand Central African refugees for the year 2015, according to UNHCR. Moreover, the rise of Boko Haram in 2015, which pledged allegiance to the Islamic State in March of the same year, contributed to further weakening the humanitarian context of Cameroon, so that in October 2016, the country had about 33,253 Nigerian and Central African refugees, as well as 192,912 internally displaced persons according to UNHCR. This unprecedented humanitarian situation in Cameroon's modern history poses major challenges in terms of security of people and goods in the country, and by extension in the Central Africa sub-region, especially the Logone & Chari Division in the Far North Region that is most affected.

The Logone & Chari Division in present day

While it is true that at the south-eastern borders of Cameroon the security situation is relatively stable, the fact remains that security in the north-west part of the country remains fragile, mainly due to the change in the mode of operation of the jihadist movement Boko Haram, following the entry into operation of the mixed multinational military force in November 2015. Over the past twelve months, multiple incursions of Boko Haram in the form of suicide bomber attacks have occurred several times in the Divisions of Mayo Sava, Mayo Tsanaga and Logone & Chari; The consequences being more serious in Logone & Chari where 58% of the population is currently in a humanitarian crisis according to the Office for the Coordination of Humanitarian Affairs (OCHA). This situation coupled with the appalling statistics of the State of Borno in neighboring Nigeria - 3.7 million people require medical assistance, 53% of health facilities are non-functional, and only 13% of sanitary facilities were financed in 2016 - make Logone & Chari the zone of Cameroon where humanitarian needs are the most pressing. This combination of exogenous factors has resulted in the destructuring of the socio-economic fabric which, coupled with the desert advance in the Sahel strip, has completely destroyed the chances of host and internally displaced populations. According to the OCHA inter-agency evaluation, two out of five (2/5) households are food insecure, six hundred and thirty-five (635) schools have been closed generating idleness among girls and boys, one-third (1/3) of people get their supplies from a source unfit for consumption, twenty-five percent (25%) of people in the Division practice open defecation, resulting in a proliferation of major public health risks. Moreover, the outbreak of the polio epidemic in the State of Borno in August 2016 makes it more vulnerable, the Logone & Chari Division which share a long border with this state of the Federal Republic of Nigeria. It is on the basis of these arguments that IMC has set itself the objective of conducting a more targeted needs assessment of the Logone & Chari Division.

International Medical Corps in the Far North of Cameroon



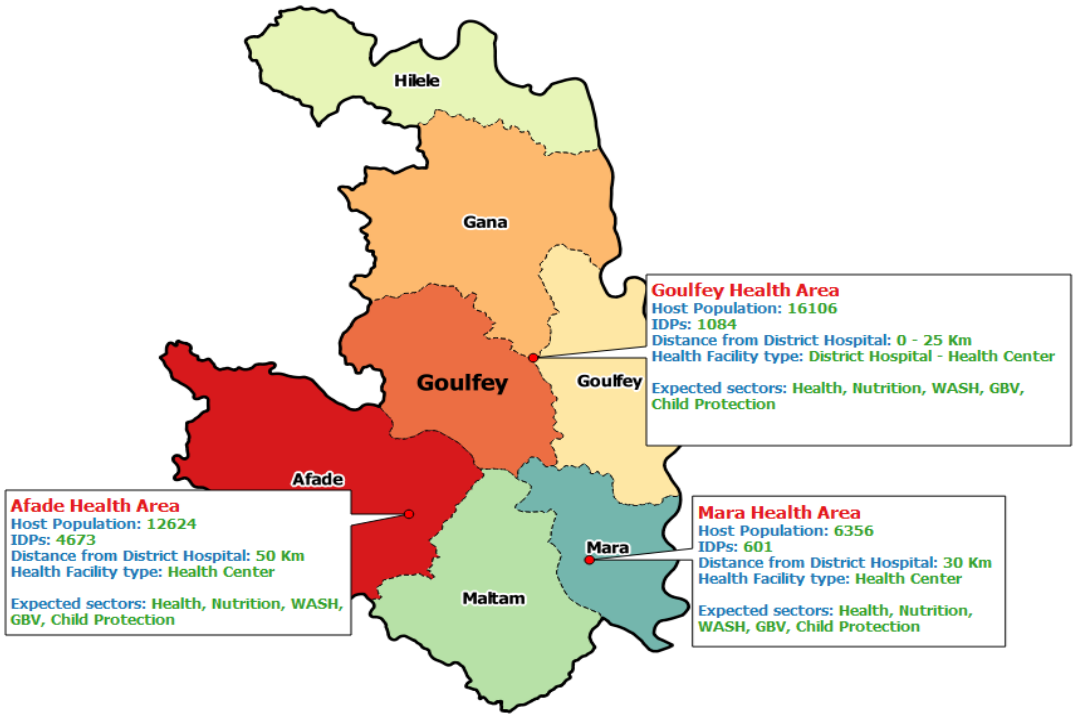
International Medical Corps (IMC) began its mission in the Far North region in 2010 in Mokolo to respond to cholera epidemics and providing first aid to the flood victims of Maga floods in Mayo Danay Division. Later in 2013, IMC was deployed in the Division of Mayo Kani with a program to combat malnutrition in the health districts of Kaélé, Mindif, Moulvoudaye and Guidiguis. Since July 2014, IMC has intervened without interruption in the Division of Mayo Tsanaga, in four (04) Health districts: Mokolo, Bourha, Roua and Mogode. In turn, IMC has provided answers in the fight against cholera, primary health and reproductive health, nutrition, WASH, child protection and the fight against gender-based violence. This permanent presence of IMC in the extreme north of Cameroon has allowed it to strengthen its experience in the region, so that today IMC has 183 employees in the region. Moreover, the fact that sixty-five percent (65%) of these employees are from the region, gives IMC good integration and acceptance at all community scales. Thanks to its rich experience in Mayo-Tsanaga Division, IMC is prepared to extend favorably its activities in the Division of Logone & Chari from the year 2017. This expansion requires a good command of the environment.

Mapping of assessed health districts [1]

- **Goulfey Health District**

The health district of Goulfey has 60,729 inhabitants (host population) and about 7,850 internally displaced persons. It is bordered to the north by the Health District of Makary, to the South by the Health District of Kousséri, to the East by the Logone River leading to Chad and to the West by Nigeria. It is composed of seven (07) health areas located at an average distance of 35 km from the district hospital and accessible by an unpaved road. The needs assessment team looked at three (03) of the seven (07) health areas available. These are the health areas of Goulfey, Mara and Goulfey Gana. The cumulative total of the population of these three health areas is 23,785 inhabitants, including 1,323 internally displaced persons and 22,462 persons forming the host population.

As shown in the Goulfey Health district map below, the presence of IMC in the health areas selected for this assessment would enable the organization to reach 6,358 IDPs and 35,086 host people in the Goulfey health district if the security situation does not deteriorate. Indeed, IMC, by positioning itself in Goulfey, Goulfey Gana and Mara, could easily intervene in the locality of Afade, which concentrates most of the identified internally displaced persons in the health district of Goulfey. As illustrated in the map below, health, nutrition, WASH, child protection and GBV programs could be implemented for displaced populations and host communities.

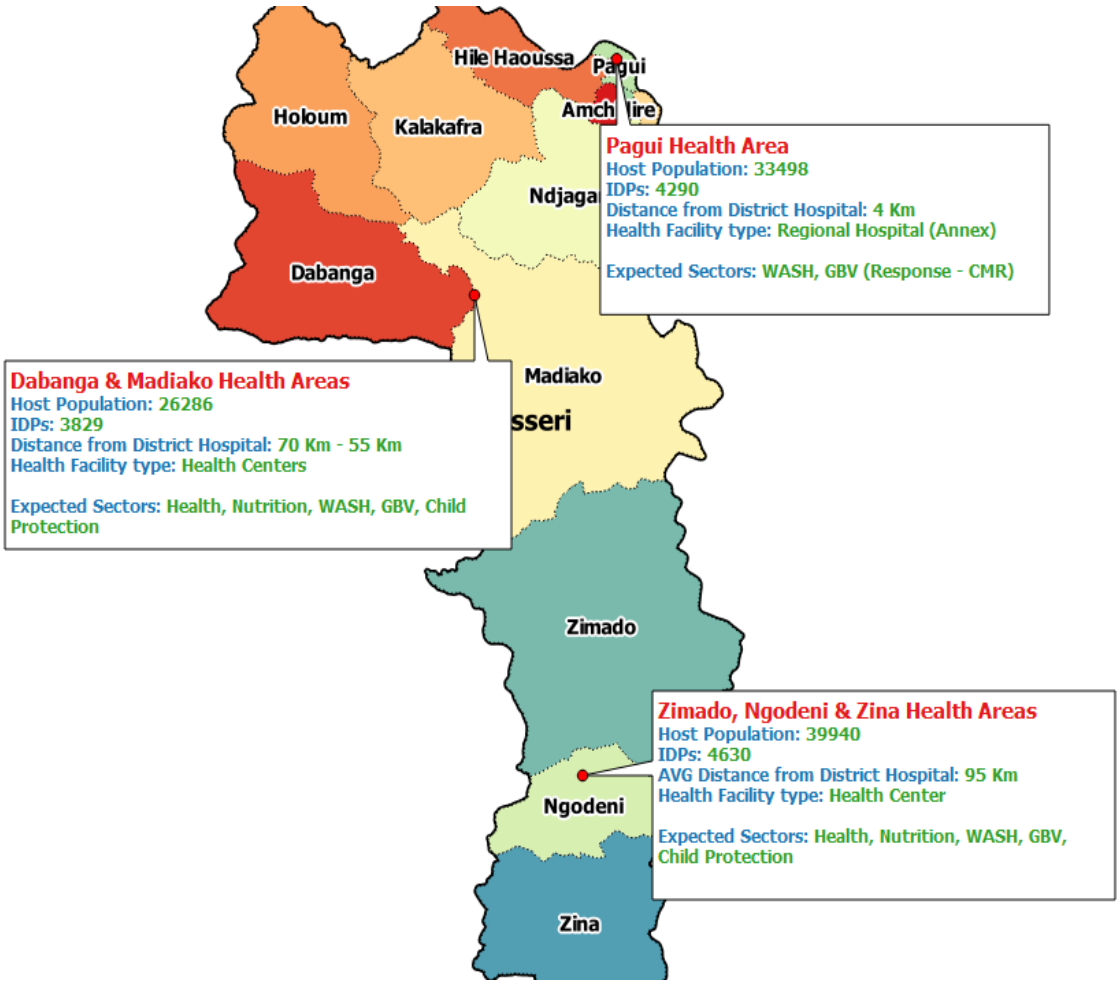


[1] The demographic statistics of the internally displaced persons presented in this section are taken from the reports of the IOM for the month of August 2016. The statistics of the host populations are taken from the databases of the National Institute of Statistics according to the rate of Annual demographic growth of Cameroon estimated at 4.1%.

- **Kousséri Health District**

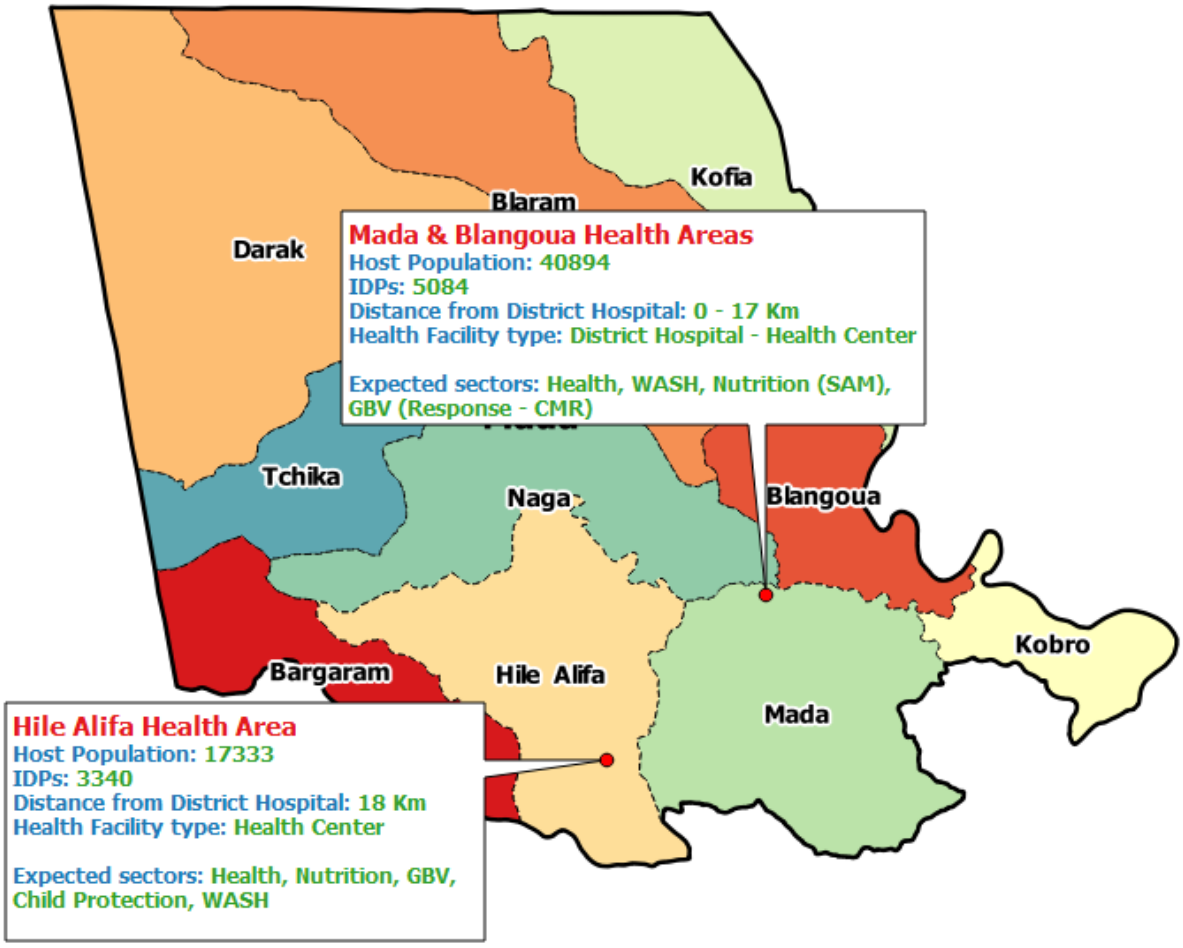
The Kousséri health district has twelve (12) health areas, each located at an average of 40km from the Kousséri district hospital. The host population of the district of Kousséri has 209,951 inhabitants, including approximately 4,000 internally displaced persons. The eastern and western borders of the Kousséri district are occupied respectively by the Republic of Chad and the Mora health district. To the north is the Goulfey health district and to the south is the Mada health district. The evaluation in Kousséri was carried out in the health areas of Pagui, Dabanga and Zimado. The Pagui Health Area is home to the Kousséri Regional Hospital and the District Health Unit. As MSF is currently managing the Kousséri district hospital for Logone & Chari, IMC looked at the Zimado and Dabanga health centers due to their geographic locations. Zimado is located at the crossroads of the health areas of Madiako, Ngodeni and Zina, 53km from the Kousséri district hospital. By supporting the Zimado Integrated Health Center, IMC would relieve the health needs of 32% of the population of the Kousséri district.

The presence of IMC in the Dabanga health area would provide services to the populations of Holoum and Kalakafra to increase coverage of the Kousséri health district to about 70%, adding to the presence of MSF in the Amchidire and Madana. In a medium- and long-term vision, IMC would be able to establish itself in the health areas of Madiako, Ngodeni and Zina with the prospect of reaching 12,749 IDPs in the health district of Kousséri. As the health district of Kousséri is the most secure for humanitarian staff, IMC may even consider the deployment of mobile clinics in the most remote villages to improve coverage of health services throughout the district.



- **Mada Health District**

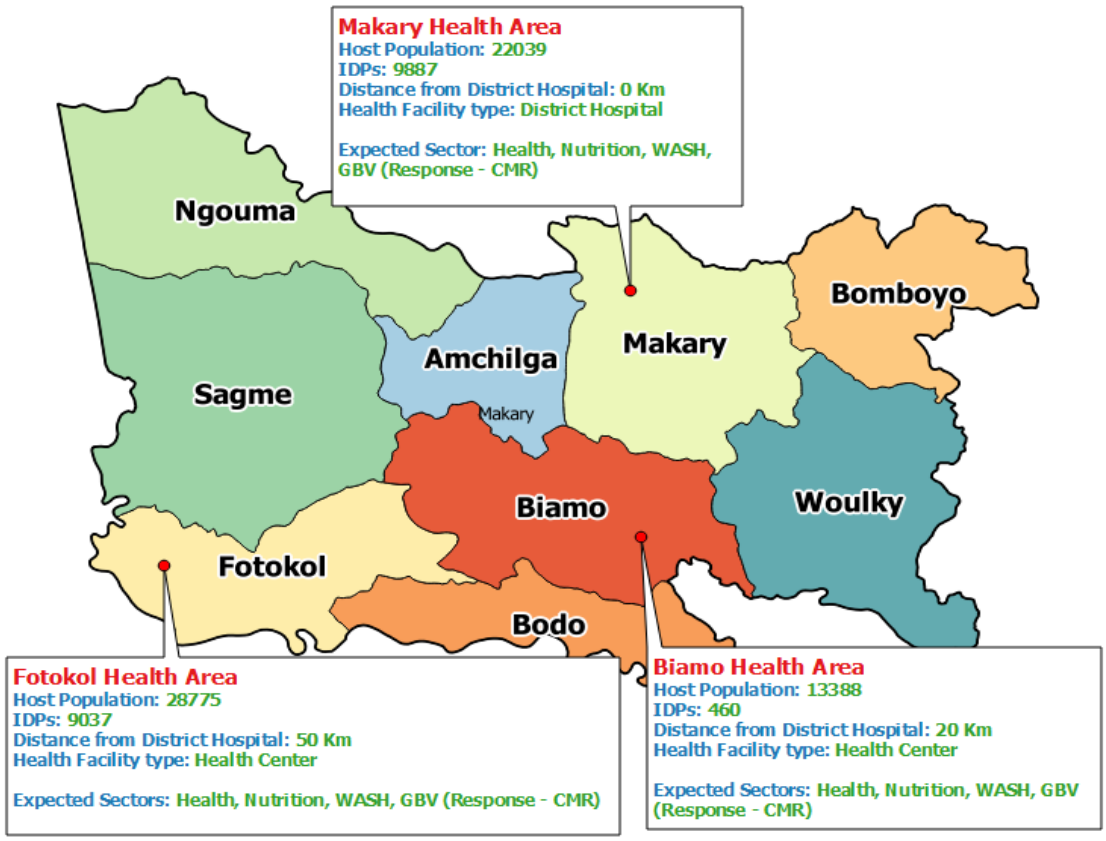
The Mada Health District has ten (10) health areas. After Makary, it is the most vulnerable health district of Logone & Chari due to its close proximity to Northeastern Nigeria, and its isolated geography. This proximity is so dangerous that two health facilities in the district are currently non-functional and inaccessible. These are the integrated health centers of Tchika and Bargaram which are completely stopped because they were attacked and looted by Boko Haram. Since then, no health workforce has dared to venture there, so that the nearby health area of Hile Alifa, which has a well-equipped medical center, is currently saturated by a massive influx of internally displaced persons. According to the IOM's August 2016 census, Hile Alifa is home to about 3,340 IDPs. In this high-risk health district of Mada, IMC was limited to evaluating two health areas: Mada and Hile Alifa.



IMC's presence in these two health areas would make it possible to offer health services to the rest of the health districts via mobile clinics and to establish a referral system based on the training of community volunteers. 58,227 people from the host community and 8,424 internally displaced persons could then receive medical assistance from IMC, representing 49% of the total population of the Mada health district. In the long term, and if appropriate, an extension of responses in WASH, child protection, GBV prevention and health could be carried out by IMC to the health areas of Blangoua, Blaram, Kofia and Darak.

- **Makary Health District**

The South and West parts of the health district of Makary are open to Nigeria, precisely on the State of Borno. In the east, Makary borders the health district of Goulfey and north of the district of Mada. The health district of Makary has 9 health areas serving a host community of 144,512 inhabitants and a displaced community of more than 25,000 people. With four (04) health areas on the border with Nigeria (Ngouma, Sagme, Fotokol and Bodo), the health district of Makary is most affected by the aftermath of the Boko Haram crisis. The health services are currently delivered in accordance with strict security measures and under the watchful eye of the Cameroonian defense forces. The best strategy for IMC in this district would be the Biamo and Makary health areas as a basis for optimizing the quality of future interventions.



The health area of Biamo which is located at the crossroads of five health areas: Sagme, Amchilga, Fotokol, Bodo and Woulky was assessed and identified as the most solicited of the districts during the intensity of the clashes between the Cameroonian army and Boko Haram. This can be explained by its geographical location, which gives it some security compared to other health areas in the district. The Makary health area is home to the most internally displaced people throughout Logone & Chari, and there are about 9,887 internally displaced persons. The presence of IMC in the Makary and Biamo health areas would improve access to health services for 45,774 people in the district, or about 31% of the district's host population.

Depending on the security situation, IMC would be positioned to extend its healthcare services in Fotokol, Sagme, Ngouma, Bodo and Woulky with the aim of serving 19,384 IDPs (78% of the district's internally displaced persons) and 64,202 people (or 44%) of the host population.

Perspectives for this Needs Assessment

As stated earlier, International Medical Corps is currently present in the Mayo Tsanaga Division in the Far North region. This rapid assessment of needs is justified by its concern to help save lives in distress by responding to the most pressing needs of the population with their full participation since the identification phase of these needs, project design, implementation, monitoring and impact assessment. As such, this document is meant to be an informative tool to guide decision-makers in the choice of areas of intervention. The results presented and the recommendations formulated could be exploited by various humanitarian actors: NGOs, UN agencies, State services and development partners in Cameroon.

As regards International Medical Corps, this evaluation will provide the strategic guidelines for a possible intervention in the Logone & Chari Division in order to contribute to the overall effort of other humanitarian and state actors already present in this area; thus avoiding duplication of effort and overlapping of interventions through objective and coordinated targeting of response sites and adequate responses.

V. Methodology

Objectives

Overall, this evaluation will enable us to highlight the needs of the most vulnerable areas of the Logone & Chari Divisions. The results will be shared with the entire humanitarian community in Cameroon and will help IMC to refine its strategy of presence in the Far North region in 2017 in order to contribute significantly to improving the living conditions of communities Affected by the conflict in the region.

More specifically, this evaluation will aid in the:

- Identification of the priority needs of the most vulnerable communities living in the health districts of Goulfey, Kousséri, Mada and Makary;
- Identification of the most disadvantaged health centers;
- Analysis of gaps in terms of the humanitarian response currently being provided in the area;
- Orientation of the decision-making with a view to adopting a strategy of efficient intervention in Logone & Chari.

Selection of assessment areas.

The choice of assessment areas is based on five criteria:

- The presence of IDPs,
- Secure access to the area for humanitarian personnel,
- The distance from the reference hospital,
- The low presence or absence of other humanitarian actors,
- The size of the host population.

Thus, in each health district, we selected the most vulnerable health area and the most vulnerable village in this health area, taking into account the criteria mentioned above. The table below shows the areas in which the evaluation was conducted.

***Table 1** : Presentation of Evaluation Areas*

Districts	Health Area	Distance from District Hospital[2]	Host Population[3]	IDPs[4]	Humanitarian personnel security [5]	Type of health facility
Makary	Makary	0 Km	22039	9887	YES	District Hospital
	Biamo	20 Km	13388	460	YES	Health Center
Kousséri	Zimado	53 Km	15465	869	YES	Health Center

[2] All roads leading to different health districts are unpaved. In the dry season 3 hours are needed to cover 80 km, and in the rainy season, roads are virtually impassable. An entire day may be necessary during a period of high flooding of the Logone to cover 50 km in some places.

[3] The host population data comes from the NSI projections (product of the 2015 population and the average population growth rate 4.1%)

[4] Data on IDPs (internally displaced) are from the last IOM published in August 2016.

[5] A security audit was recently carried out in the area by IMC with the support of the UNDSS and the Cameroon security forces to ensure that humanitarian personnel can intervene in the selected localities.

Districts	Health Area	Distance from District Hospital[2]	Host Population[3]	IDPs[4]	Humanitarian personnel security [5]	Type of health facility
	Dabanga	70 Km	5850	759	ESCORT[6]	Health Center
	Pagui	4 Km	33498	240	YES	Subdivisional Hospital
Goulfey	Goulfey	0 Km	9173	968	YES	District Hospital
	Mara	30 Km	6356	239	YES	Health Center
	Goulfey Gana	25 Km	6933	116	YES	Health Center
Mada	Mada	0 Km	18445	420	YES	District Hospital
	Hile Alifa	18 Km	17333	3340	YES	Health Center

***Source**: IOM Database September 2016 and Makary, Mada, Kousséri and Goulfey Health districts databases.*

Method of data collection

Desk review

Over the past two years, various reports have been published on the humanitarian situation in the Far North region of Cameroon in general and more specifically in the Division of Logone & Chari. In the context of this needs assessment, it was essential to review all the related documents in order to define the scope of the evaluation, to avoid asking the same questions to the beneficiaries, authorities and stakeholders and to avoid redundancies in the formulation of recommendations. To this end, the following documents were read and referenced:

- *Epidemiological surveillance databases of the health districts of Kousséri, Makary, Goulfey, Mada*
- *Database on Displaced Populations and Refugees in Cameroon, IOM, August 2016*
- *Northeast Nigeria Response, Borno State Health Sector Bulletin # 01, September 2016*
- *Cameroon Factsheet, UNHCR, September 2016*
- *Multiple Indicator Cluster Survey (MICS5) Report, Unicef - MINSANTE - NIS, July 2015*
- *Nutrition Survey Report SMART, UNICEF - MINSANTE, October 2015*
- *Report of the Rapid Assessment Mission to Logone & Chari, AHA, April 2016*
- *Inter-agency rapid cross-sector evaluation of Logone & Chari, OCHA, June 2016*

[6] Every morning around 9 am, a military convoy accompanies the vehicles that make the Kousséri - Waza route in order to ensure their safety on this high - risk section. The town of Dabanga is on this route.

- *Inter-agency inter sectoral report on the situation in the Far North, August 2016*
- *Revised requirements and response priorities Lake Chad Basin, OCHA, September 2016*
- *Monthly Epidemiological Record No. 4, WHO, September 2016*
- *Report of the rapid assessment mission to Logone & Chari, SDA, September 2016*

Data collection at national, regional and Divisional level

- ***Mapping of actors at the national level***
  At the national level, IMC regularly participates in inter-agency and intersectoral meetings organized by agencies of the United Nations system. The presence at these meetings allowed us to inquire about the distribution of other humanitarian actors in Logone & Chari.

- ***Cartography of actors at the regional level***
  The International Medical Corps evaluation team met and interviewed various stakeholders at the regional level in order to have a fairly precise idea of the humanitarian services already offered in the Logone & Chari Division. Thus, the various sector leaders of the UN agencies such as UNHCR, UNICEF, WHO were met.

Table 2: Directory of key informants met at regional level

Title of informant	Institution	Contact (Cell + email)
Regional Delegate	Regional Health Authority for the Far North	djaor@yahoo.fr
Focal Point H6 / Field Coordinator Maroua	WHO	(00237)698227962 fmahamat@who.int
Protection Associate	UNHCR	EBENEZOB@unhcr.org +237)695073993
WASH Administrator	UNHCR	(+237)691141327 KADESSOU@unhcr.org
Nutrition Specialist	UNICEF	(+237)699046500 Jmgoman@unicef.org

In addition, meetings were held with various government partners such as the Ministry of Public Health and the Ministry of Water and Energy Mines. Representatives of the main international NGOs based in Maroua such as the ICRC, Intersos, MSF, and Plan, have been contacted by email and / or by telephone to collect information on their areas of intervention in Logone & Chari.

- ***Cartography of the actors at the Divisional level***
  The information gathered at the national and regional levels was confronted with the reality on the ground once the IMC monitoring and evaluation team visited the town of Kousséri, capital of the Logone & Chari Division. The Divisional representations of the national and international NGOs established in the city were visited for this purpose. Interviews with heads of organizations with an office in the Division has allowed us to better map the services available.

Table 3 *: Directory of key informants met at the Divisional level*

Title of informant	Institution	Contact (Cell + email)
Divisional officer for Kousséri	Divisional Authority	*Confidential*
Goulfey Sub-Divisional officer	Goulfey SubDivisional Authority	*Confidential*
Hile Alifa Sub-Divisional officer	Hilé Alifa SubDivisional Authority	*Confidential*
Makary Sub-Divisional officer	Makary SubDivisional Authority	*Confidential*
District Medical Officer	Kousséri Health District	695176744 Simo.foaka@gmail.com
District Medical Officer	Goulfey Health District	696185000/664090315 Mosesjo2000@yahoo.fr
District Medical Officer	Mada Health District	699217916 jonongalexis@yahoo.fr
District Hospital Director	Makary Health District	694666782
District Hospital Director	Mada Health District	677821473
Supervisor	Annexe Regional Hospital of Kousséri	699044186/696068722
Chief of Health Bureau	Goulfey Health District	694246947/694246937 malakoaetienne@gmail.com
Chief of Health Bureau	Mada Health District	694535037/673129876
Chief of Health Bureau	Makary Health District	694139483/672293334 Passale_robert@yahoo.fr
Nurse superintendent Hilé Alifa	Hilé Alifa SubDivision Medical Center	654190014
Nurse superintendent of center	Goulfey Integrated Health Center	697431475/672623217
Nurse-Head of intergrated health center	Goulfey-Gana Integrated Health Center	694555676
Nurses superintendent	Mara Integrated Health Center	697468199
Nurses superintendent	Dabanga Integrated Health Center	696074736/675940894/666252543
Nurses superintendent	Zimado Integrated Health Center	694384756/666724802
Nurses superintendent	Biamo Integrated Health Center	676367986/699662040
Focal Point PMTCT/RH	Kousséri Health District	694839989
Supervisor SC/Maternity	Mada District Hospital	694157479
Laboratory	Goulfey District Hospital	697934127/675473227

Data collection in health facilities

- ***Collecting activity reports from health districts***
  Health districts surveillance reports were collected and analyzed to compare the different health areas existing in each district. The analysis of these databases allowed us to establish a ranking of the health zones by level of vulnerability.

- ***Administration of the IASC[7] evaluation questionnaire for health facilities***
  The health centers selected according to the previously defined criteria of vulnerability were subjected to a detailed evaluation according to the standardized evaluation guide of the health facilities designed by the IASC.

- ***Direct observation***
  The visit of the different health structures selected for this evaluation and the taking pictures of the premises and equipment was one of the complementary stages of the data collection in the health facilities. This phase of our evaluation allowed us to visit and appreciate in particular reception services, maternity services, pharmacies, observation rooms, laboratories, places for the destruction of medical waste, water supply, etc.

Data collection at community level

- ***Focus group discussion***
  Thirty-two (32) focus groups were conducted by IMC in the four selected villages. The composition of the focus groups was based on the gender, localities and type of target population. In each village selected, 8 focus groups were conducted; four (04) focus groups for IDPs and four (04) focus groups of 10 people per average for host populations. For each type of population, we formed a boys' discussion group, a group of girls, a group of women and a group of men. Interviewees were randomly selected by health authority officials and health authorities. Six interviewers were required for the data collection in the focus groups. Male interviewers conducted male focus groups, and female interviewers facilitated female groups to facilitate the free expression of needs and difficulties. In the health district of Makary, we interviewed the inhabitants of Biamo. In the health district of Kousséri, we interviewed the inhabitanst of Dabanga. In the health district of Mada, we interviwed the population of Hile Alifa. Lastly, in the health district of Goulfey, we interviewed the inhabitants of GouldfeyGana.

- ***Interview with key informants***
  Mainly, the traditional authorities and those responsible for the health facilities serving the selected health areas were interviewed. In addition, the administrative authorities of the boroughs of Kousséri, Goulfey, Makary and Mada were met and open discussions were held with them to give us an overview of the security situation and the presence of humanitarian actors from each of the boroughs visited .In addition, we also interviewed the head of the hygiene Division of the town hall of Kousséri, the Divisional delegate of social affairs and a member of the Divisional delegation of the

[7] IASC (Inter-Agency Standing Committee). The IASC provides an in-depth assessment of the needs of a health facility based on key public health indicators. To learn more about IASC, please follow the link below. https://interagencystandingcommittee.org/resources/iasc-products

Ministry of Water and Energy; In order to have a brief overview of the major challenges in terms of WASH and social assistance.

Evaluation Team

Nine (09) people participated in this needs assessment:

- One (01) doctor, Dr Jean Mukenga, Male, Expert in public health. National Program Coordinator at International Medical Corps Cameroon. He has been involved in the preparation of the evaluation, review and validation of the final report.
- One (01) doctor, Dr Isaac Bayoro, Male, Medical Coordinator of Epidemiological Surveillance Programs at IMC Cameroon. He intervenes in Mayo Tsanaga and has extensive experience in the management of district hospitals. He took care of the data collection in the health structures and their analysis.
- One (01) Monitoring & Evaluation Specialist, Benjamin Tsala, Male, National Monitoring and Evaluation Coordinator at IMC Cameroon. He has been involved in the desk review, stakeholder mapping and data collection at the community level.
- Three (03) women interviewers. They took care of data collection in the focus groups of girls and women.
- Three (03) male interviewers. They took care of data collection in the focus groups of boys and men.

The interviewers were selected locally on the basis of their proficiency in local languages, Arabic and the French language. We also ensured that they had an academic background equivalent to BEPC (Brevet d'Etudes du Premier Cycle), or 6th grade, in order to enable them to rapidly take ownership of the questionnaires.

Data analysis techniques

Various methods were required for the analysis of the data. Data from the focus groups and interviews with key informants were uploaded to a text analysis platform. The data were then cross-tabulated by target population group and by location to highlight the needs of each group, each community.

Data from health facilities were analyzed using Microsoft Excel spreadsheets to calculate and analyze key public health indicators. The geographic information was imported to a geographic information system in order to provide a better spatial view of the localities and health facilities visited.

Photos were taken, such as: hospital buildings, water points and displaced persons' camps were used to support analysis derived from direct observation.

Limits and Challenges

- ***Evaluation duration***

One of the main limitations of this evaluation is the deadline for data collection. Following the various security and financial constraints, the duration of the evaluation was 16 days in the field. More time would have allowed deepening of certain questions raised by the

beneficiaries in order to understand their worries. However, the collection of qualitative and quantitative data could be conducted within acceptable limits, as required by good engineering practice.

- ***Training time for surveyors***

The training of the interviewers lasted on average one day whereas in principle two days are necessary to ensure that they have integrated very well the techniques of animation of the discussion groups. Indeed, security constraints have limited the time spent by the evaluation team in the field. However, we were constantly with the investigators on the ground to give them substantial support when it became necessary.

- ***Barriers to reach certain areas***

Our survey strategy focused on covering the most vulnerable and neglected areas. However, the security conditions did not allow us to access some areas that were considered very vulnerable. The distance also between these zones and the city of Kousséri were a barrier, as the team was required to travel back and forth every day.

- ***The pre-test of the questionnaires***

The questionnaires used for the collection of community data and for the collection of data in the health facilities could not be pre-tested in light of the small material time available and the security constraints.

The results of this evaluation are therefore admissible taking into account these limits.

Presentation of results

VI. Mapping the actors

During this needs assessment, we identified 25 institutions involved in the humanitarian responses currently being carried out in Logone & Chari. These institutions include United Nations agencies, international NGOs, national NGOs and Cameroonian state institutions. In order to have a more complete reading of the answers, we proposed to make a mapping of the activities of the institutions present in the Division. This mapping was developed taking into account the classical sectoral organization of humanitarian responses: food security, nutrition, health, protection, WASH and provision of shelter and non-food kits.

Actors involved in food security

The area of food security is the one with the most stakeholders in the Division. Six organizations at the operational level have been identified by our evaluation team as providing a response in this area. The overall strategy used by the operational teams in this area is based on community volunteers who serve as transmission lines between NGOs and beneficiaries.

***Table 4** : Actors involved in the field of food security*

Organizations	Services delivered[8]	Intervention Zones	Contacts
IEDA Relief	Food distribution to the internally displaced population (partenership with WFP)	Makary, Biamo, Fotokol, Amchiga, Blangoua, Darak, Dabanga, Zimado, Logone Birni, Goulfey, Waza	Head of Office IEDA Kousséri 669801510
Plan Cameroon	Cash-Based Transfer[9] in partnership WFP	Centre urbain de Kousséri	Head of Office Plan Kousséri 697441601
	Needs assessment is on-going in the domains of (WASH, Education and Protection)		M&E Coordinator CBT 675464957 – 696852210
ONG Saheli	Distribution of food to internally displasced populations (partnership with WFP)	Ibou, Malak, Nkombola, Massi-al Kanam, Ndjagare	Coordinator 696380738 – 699696978 – 670312120 Saheli_maroua@yahoo.com

[8] Services delivered include activities in progress and possibly activities planned for 2017.

[9] Cash-Based Transfer: Project enabling households to purchase food on the local market from electronic money. The project teaches the community how to use the benefits of technology to address the food security challenge. Currently the project benefits almost 1242 households of internally displaced persons and is only implemented in the town of Kousséri.

CICR – Geneva	Distribution of food to the internally displaced population.	Maltam, Tilde, Kousséri	690557177 radjei@icrc.org
Croix Rouge Camerounaise	Distribution of food to the internally displaced population once a month in partnership with CICR	Maltam, Tilde, Kousséri, Ngré	President 696037848 – 675646841
Codas Caritas	Distribution of food to the internally displaced population	Kousséri, Makary, Fotokol, Blangoua, Hile Alifa	677619876 – 699679940 aristidebortouang@yahoo.fr

In view of the above table, gaps and challenges in food security are mainly of two kinds: lack of food, and difficult access to certain areas due to insecurity and lack of road. However, in terms of presence, the majority of NGOs are based in Kousséri and organize food distribution missions to the localities of Makary, Goulfey and Mada.

Actors involved in nutrition

Nutrition needs are currently covered by four (04) NGOs. Most of the actors identified are involved in the prevention and management of cases of moderate acute malnutrition. As regards the management of cases of severe acute malnutrition, it is virtually insufficient due to inadequate resources, including staff, therapeutic food and medicines. This situation is even more serious for SAM cases with complications, which can not be adequately addressed due to the lack of a reference system. Only four (04) health facilities (03 OTP and 01 SC) in the health district of Kousséri benefit from the care of SAM children aged 0 to 59 months because they are supported by Médecins Sans Frontières (MSF).

***Table 5** : Actors in the field of nutrition*

Organization	Services delivered	Intervention Zones	Contacts
MSF	Management of SAM with or without complication in children 0-59 months	Annex of the Kousseri regional Hopital IHC Amchedire, IHC Madana, IHC Madagascar	Field Co MSF Kousséri 655458421 – 0041225103448 Msfch-kousseri-fieldco@geneva.msf.org
IEDA Relief	Management of MAM in PLW and children 6 to 59 months.	Makary, Biamo, Fotokol, Amchiga, Blangoua, Darak, Dabanga, Zimado,	Head of Office IEDA Kousséri 669801510

	Implementation of the BSFP pilot project in children 6-23 months (systematic supplementation with Plumpy sup, CSB++ or Supercereal +) and the management of MAM in children 6-59 months with the same food supplements Sensitization and nutritional education in PLW	Logone Birni, Goulfey, Waza	
Croix Rouge Camerounaise	Community screening and referral of cases of malnutrition (MAS, MAM) to health facilities. Target (Children 6 - 59 months and pregnant and lactating womene)	Health Districts of Mada, Makari, Goulfey, Kousséri	Nekambaye Gaisson 696429949 – 675472956 nekgaisson@yahoo.fr
Codas Caritas	Prevention of malnutrition in children 6 - 59 months	Health Districts of Mada and Makary (All health facilities)	Project coordinators 677619876 – 699679940 aristidebortouang@yahoo.fr

Nutrition gaps remain high throughout the Division of Logone & Chari in terms of care for MAS children, pregnant women and nursing mothers. The Goulfey Health District is the one that benefits less from the nutrition responses currently being made. In the health district of Mada, the Hile Alifa health area is the most vulnerable in terms of managing cases of malnutrition. Section IX of this report provides a more in-depth analysis of the nutrition needs of the health areas targeted by this evaluation.

Actors involved in Health

Five organizations were identified at the time of the evaluation as a health worker, as illustrated in the table below. The health services offered only partially meet the real needs because the majority of actors intervene sporadically in health facilities due to insecurity. Of the thirty-eight (38) health facilities in the Division, only five (05) have emergency minimum health services in line with SPHERE standards. These include the Maltam Health Center, the Kousséri Regional Hospital, the Madana Health Center, the Madagascar Health Center and the Amchidire Health Center.

Table 6 : Actors in the field of health

Organization	Services delivered	Intervention Zones	Contacts
CICR – Geneva	Comprehensive care for patients of all ages Reference of serious cases to the regional annex hospital of Kousséri Motivation and Payment of Employee Premiums District of Goulfey	***Goulfey District*** IHC de Maltam	Head of Office CICR Kousséri 690557177 radjei@icrc.org
MSF	Primary health care and severe acute malnutrition for children under 5 years of age Pediatrics for children under 5 years General surgery except traumatology and orthopedics Support for routine EPI including catch-up of children for VAR Mental health in sight	***Kousséri District*** Annex of the Kousseri regional hospital IHC Amchedire, IHC Madana, IHC Madagascar	Field Co MSF Kousséri 655458421 – 0041225103448 Msfch-kousseri-fieldco@geneva.msf.org
Croix Rouge Camerounaise	Vaccination (Routin EPI and campaigns) Epidemiological surveillance of vaccine preventable diseases + cholera & dracunculiasis	***Health Districts of Mada, Makary, Goulfey, Kousséri*** All health areas of the 4 health districts	Mbadembaye Agée 242765207 – 674632206 mbadembaye_agee@yahoo.fr
Masanté	Communty based epidemiological	**DS Mada** (Blaram,	Benjamin Azike 679011722, 697285810

	surveillance of cholera Prevention-Early detection (establishment of early -warning systems) Management of cholera cases	Blangoua, Kobro, Naga) **DS Kousséri** (Pagui, Hile Haoussa, Madana, Zimado, Dabanga)	benjamin.azike@masante-cm.org Regional supervisor REMMOCC
	Hospital-based surveillance of cholera (Research)	**DS of Kousséri** (All 13 health facilities) **DS Mada** (CMA of Blangoua)	
Codas Caritas	Primary health care, reproductive health and mental health for host and internally displaced populations	Fotokol, Hile Alifa, Makary, Blangoua, Darak, Kousséri	Bortouang Sassou Aristide 677619876 – 699679940 aristidebortouang@yahoo.fr
	Vaccination against meningitis (2015 and 2016)	Fotokol et Makary	

In view of the above, it can be said that in health, the most important gaps are observed in the districts of Goulfey, Mada and Makary, which receive little support in primary health. Unmet needs still exist in the provision of primary health care, prenatal care, childbirth care, postnatal care, family planning, PMTCT and mental health. Moreover, the optimal reference of complex clinical cases is not yet well assured in all the districts visited. Currently, only the ICRC provides some references from the Maltam health area to the Kousseri district, but this response remains largely insufficient compared to the needs of the host and displaced communities. The needs for the rehabilitation of infrastructures and equipment are also present in most health facilities. Finally, human resource requirements (quantity and quality) are also important, particularly in the health districts of Goulfey, Makary and Mada. More details on health needs are provided in sections X and XI of the report.

Actors involved in protection

Current activities in the field of protection are mainly carried out by the NGO Intersos with the support of UNHCR. These activities mainly involve the prevention of gender-based violence (GBV), and the response to child protection and GBV. Existing gaps are of two types: the incompleteness of the response offered in terms of GBV and the incompleteness of the geographical coverage of the Division in protective services. In terms of GBV response, survivors of rape identified by Intersos currently do not always receive good medical follow-up in remote areas due to the unavailability of health personnel able to manage clinical cases of rape. The majority of activities are the identification of GBV cases, psychosocial support to victims and advocacy meetings. With regard to geographical coverage, the health districts of Mada and Goulfey enjoy virtually no response in terms of child protection and GBV. The

avenues of intervention in the field of GBV will be better explained in the recommendation section.

Table 7 : Actors involved in the field of protection

Organization	Services delivered	Intervention Zones	Contacts
Intersos	GBV prevention Child Protection et GBV response Referal of rape case to health centers.	Makary, Kousséri, Waza, Fotokol, Hile Alifa	Manager of Logone & Chari information center 695176805 – 675736486 paulngidjoi@gmail.com pngidjoilipoo@yahoo.com
Croix Rouge Camerounaise	Restoring family ties	Kousséri, Maltam	President 242765207 – 674632206 mbadembaye_agee@yahoo.fr
Codas Caritas	Etablishment of birth certificates for displaced children	Zina, Makary, Fotokol	Project coordinator 677619876 – 699679940 aristidebortouang@yahoo.fr
	Financing of small businesses for the empowerment of women Kousséri	Kousséri	

Actors involved in WASH

An insufficient response has been made in Logone & Chari in WASH since the beginning of the crisis. At the time of the evaluation, most of the activities in this area were carried out by CODAS Caritas with the support of UNICEF. Despite the start-up in October 2016 of a construction / rehabilitation program of 98 boreholes the need for drinking water supply remains great in the Division. After the completion of this project, a gap of 373 water points will remain in the health districts of Makary, Mada and Kousséri.

In addition, there are also urgent needs in environmental health, excreta management, medical waste management, hygiene promotion and latrines in health centers and schools. The WASH needs analysis in sections VII and VIII will provide further clarification as to the extent of existing gaps.

Table 8 : Actors in the field of WASH

Organization	Services delivered	Intervention Zones	Contacts
ONG Saheli	Treatment and maintenance of water points	Makari, Darak, Hile Alifa	Coordinator 696380738 – 699696978 – 670312120 saheli_maroua@yahoo.com
Croix Rouge Camerounaise	Mass sensitizatioin and door-door sensitization Human investment	Kousséri urbain	President 242765207 – 674632206 mbadembaye_agee@yahoo.fr
Codas Caritas	Distribution of WASH kits (bucket, kettle, cups, soap) Construction of boreholes and latrines Mass sensitization	Goulfey, Makary, hile Alifa, Fotokol, Logone Birni (Dabanga), Kousséri	Project coordinator 677619876 – 699679940 aristidebortouang@yahoo.fr
	Project to rehabilitate 98 boreholes under UNICEF financing (the first phase of the project starts in November 2016 with 40 boreholes) Makary, Fotokol, Blangoua	Makary, Fotokol, Blangoua	

Actors involved in Shelter and Non-Food Items (NFIs)

The needs for shelter and non-food kits are also partially covered. As IDP camps were built spontaneously by populations fleeing the terror imposed by Boko Haram, the nature of the materials used is not of a quality to ensure a minimally decent shelter for the people who live there. Some kits were distributed urgently in 2015 and 2016, but the need remains great especially in the localities of HileAlifa and Afade.

Table 9 : Actors involved in shelters and NFI kits distribution

Organization	Services delivered	Intervention Zones	Contacts
ADES	Construction of shelters for IDPs Distribution of NFIs kits (savons, mats, mosquito nets, blankets, cloths, buckets, pots, tarpaulins) to the internally displaced population	Makari, Goulfey, Mada, Darak, Fotokol, Kousséri,	Head of Office ADES Kousséri 678787971 – 662231632 idriss_sharuf@yahoo.fr
ONG Saheli	Distribution of NFIs kits to the internally displaced populations (IOM partnership)	Makari, Goulfey, Hile Alifa, Blangoua, Darak	Coordinator 696380738 – 699696978 – 670312120 saheli_maroua@yahoo.com
CICR - Geneva	Distribution of NFIs kits	Tilde, Maltam	Head of Office CICR Kousséri 690557177 radjei@icrc.org
Croix Rouge Camerounaise	Distribution of NFIs kits (pots, buckets, soap, mosquito nets, mats, blankets, tarps, hygiene kits) to displaced households	Tilde, Maltam, Kousséri urbain, Ngré	President 242765207 – 674632206 mbadembaye_agee@yahoo.fr
Codas Caritas	Distribution of NFIs kits to the displaced	Fotokol	Coordinator of projects 677619876 – 699679940 aristidebortouang@yahoo.fr

United Nations Agencies

Six United Nations agencies are currently working in partnership with program implementation organizations in the Logone & Chari Divisions; these include WFP, WHO, UNICEF, UNFPA, IOM and UNHCR. These agencies are all based in Maroua and carry out regular missions in Logone & Chari for the operational monitoring of the actions carried out in the field. The table below summarizes the interventions carried out by these agencies and the partners identified by our evaluation team.

Table 10 : Agencies of the United Nations intervening in Logone & Chari

Agency	Nature of interventions	Partnership[10]
WFP	Coordination of food security activities Provision of inputs for the management of moderate malnutrition	Plan, IEDA Relief, Codas Caritas, ONG Saheli
WHO	Supervision of preventive activities (Vaccination and epidemiological surveillance) Coordination of the activities of the health sector in the Division	Croix rouge camerounaise,
UNICEF	Support for water rehabilitation activities	Codas Caritas
UNFPA	Strengthening the capacities of health personnel and training in the field of reproductive health Support to reproductive health in health districts (distribution of dignity kits, family planning, emergency contraception)	Districts de santé de Makary, Kousséri, Goulfey, Mada
IOM	Identification and update of IDP demographic data Coordination distribution of NFI kits	ONG Saheli, ADES
UNHCR	Coordination of the activities of the protection and shelter sectors	Intersos

VII. Priority needs by locality and target population

The information obtained from the focus groups allowed us to define a hierarchy of priorities for girls, boys, women and men. The analysis is done according to the localities and whether the interviewees belong to the host populations or to the internally displaced populations.

Needs of IDPs

Mostly, internally displaced populations have subsistence needs and survival needs. Almost all of the focus groups in all villages cited famine as the main problem. The fact is that this widespread famine affects females (girls, women) as much as males (boys, men).

By analyzing the needs in a specific way, it was realized that girls are mainly asking for an environment to ensure their safety, to preserve their privacy.

> « *Life has become very dangerous and difficult here since Boko Haram began. We can no longer go to school and since our parents have no money we have nothing left to eat, we do not have the necessities for our toilet. When it's the period of menstruation, I do not go to school because I lack sanitary napkins.* »
>
> A girl, girls' focus group, displaced populations, HileAlifa.

For boys, health problems (especially malaria) and the unavailability of school infrastructures represent a serious handicap to their development. As far as women are concerned, unemployment and the difficulty of accessing good quality water are the major challenges.

[10] The list of partnerships may not be exhaustive. Further information could be collected at the United Nations regional office in Maroua

Finally, men want their home villages to recover peace so that they can have the chance to return and resume their normal occupations as they were before the crisis.

The following sections will present the specific needs of displaced communities in terms of health, nutrition, protection and WASH.

Needs of IDPs in health, nutrition and food security

Malaria is doing a lot of harm to children in displaced communities. Especially girls and boys under five. Many families no longer have mosquito nets because dads who still have the courage to go to the lakes use mosquito nets to fish so that they can feed their children. Some diseases such as typhoid, malnutrition, and anemia are also widespread among IDPs, according to information gathered in the focus groups. Furthermore, since health centers are not adequately equipped and lack staff, patients do not always have access to health care as they would like. This plunges the displaced community into despair as the lives of people are increasingly threatened.

« Before when people were sick, they often went to the Biamo health center. But since there are almost no medications out there and sometimes because they lack the money to pay for consultations, people prefer to stay home, even when they are severely ill. As they stopped fishing because of the insecurity in the village, they have nothing left to pay for hospital care. To get by, the women found a trick. They go to the savannah to look for the wood they sell in order to have money to bring their children to the hospital. But the sale of the wood does not give enough money and sometimes the agents of the Ministry of Water and Forests forbid that the wood is cut in certain places. People really suffer too much. Moms who are pregnant do not go to the hospital because it costs too much for them, sometimes they are asked to pay up to 7000FCFA (about 14 USD) to give birth at the health center. Since they have no money, they are obliged to resort to traditional birth attendants. »

Excerpt from an interview with a canton chief in the health district of Makary

Members of displaced communities were forced to abandon their farms. For more than two years, women have not really harvested maize, millet or groundnuts. Now they are feeding on food donated by WFP, but it is still very insufficient. Men can no longer trade and fish because of insecurity on the road and in lakes, which aggravates famine. Men spend hungry days because they have neither money nor fields. Commercial activities have stopped because the roads are blocked, and even access to neighboring Nigeria has become impossible because after the borders it is Boko Haram. Men want NGOs to distribute more food because what is currently given is not enough. Many IDPs are still hungry and have not yet received food aid.

« The food aid we currently receive is insufficient to meet the needs of everyone. We received food aid from the Head of State, WFP and IEDA. Despite this help, many people continue to suffer from famine here. »

A man, IDP discussion group, HileAlifa

The table below summarizes the health needs of displaced persons by health district.

Table 11 : *Priority Health and Nutrition Issues for Internally Displaced Populations*

Group/District	Kousséri	Makary	Mada	Goulfey
Girls	Malaria and anemia	Cough and famine	Painful rules and STIs	Malnutrition, dysentery
Boys	Malaria and cough	Malaria, scabies	Diarrhea	Diarrhea
Women	Typhoid, anemia	Difficult deliveries	Malaria	Malnutrition
Men	Rheumatism and eye disease	Malaria	Foot pain stomach ache	Malnutrition

Needs of IDPs for protection

Most of the displaced girls and boys interviewed say they do not have clothes. They are left to themselves, especially when they are orphans. The intimate hygiene of girls is not assured, their dignity is deeply undermined. Displaced girls are forced to live in host families of host populations in order to have food to survive. Sometimes they are forced to marry early to survive.

« We are also afraid for our girls who are finding it increasingly difficult to stay in the village. They prefer to live in Kousséri because there they have the opportunity to meet men who will give them money. Some girls even flee marriages and abandon their children to go to Kousséri. »

A Woman, Focus Group of Displaced Women, Goulfey

The displaced boys say they feel their future compromised because of the lack of teachers. Displaced boys are also very afraid of insecurity. Some of them have lost sight of their classmates and friends for several months. They think that Boko Haram has kidnapped them and they are very afraid that it will happen to them too.

Women need to occupy their days, now they spend them in the tents or in the courtyards of the houses to do nothing. They want help to finance small businesses to support their children, to send their daughters to school.

Proximity to Nigeria pushed men to flee their lands. They have to re-adapt to a new way of life, without home, without cattle, without fishing. The majority of interviewees believe that safety is the priority to enable them to return to a normal life. Displaced men need to take care of themselves to provide for their families. Some complain that their women no longer want them because they have become poor. They can no longer send the children to school; they can no longer give money to their wives to buy food. This situation creates separation in homes and children are the main victims.

« Dads are becoming poorer and the inclusion of children in schools is no longer a priority. The IDPs who are here in Zimado are living in some families and these families are already exhausted because they are not supported, they need to be encouraged by NGOs or the government to continue helping displaced children who are orphans or Abandoned. »

A canton chief in the health district of Kousséri

The priority protection issues identified in the displaced persons' focus groups are set out in the table below.

***Table 12** : Priority protection issues for IDPs*

Groupe/Localités	Kousséri	Makary	Mada	Goulfey
Girls	Commercial Sexual intercourse	Early marriage	Abductions	Lack of clothing
Boys	Consumption of narcotics	Loneliness due to parents' deaths	Abductions	Unemployment due to lack of schooling
Women	Domestic violence	Deprivation of resources	Loneliness due to the death of husbands	Unemployment due to insecurity
Men	Unemployment	Abductions	Physical assaults	Loneliness due to abandonment of spouses

Needs of IDPs in WASH

Displaced women and girls are forced to spend several days without bathing. They have abandoned their homes and have no easy access to water sources. To have water, they have to travel long distances (up to ten kilometers in some villages) with the calabashes (a gourd container to hold water) on their heads and under the sun. As several families no longer have their canaries (traditional water containers made of clay) because they have abandoned them in their shelters while fleeing, the majority of the families do not have containers to store their drinking water in the shelters. Most children are obliged to drink in the backwaters and small lakes near the villages where the displaced have settled. Since the water in the lakes is not drinkable, it makes children sick. Many of them suffer from dysentery or diarrhea.

The majority of families in the area did not already have latrines before the onset of the crisis because of the widespread cultural practices[11] in the communities. The arrival of the IDPs made the situation worse; with almost all of the focus groups which presented the lack of latrine as a priority problem in the field of WASH. Some key informants even requested outreach sessions for internally displaced people to help limit the practice of open defecation in the villages. According to some heads of health centers, if nothing is done, when the next rainy season arrives in July and August, there is a risk of a large cholera epidemic and a high incidence of diarrheal diseases in all the division. The situation is all the more worrying as each season of rains is accompanied by great floods.

« The water we drink here is not really drinkable. We have some wells that are not covered and in which we draw our water to drink, as well as water for cooking and bath water. When the rainy season arrives these wells are flooded and people are forced to drink contaminated water. »

-A head of health center in the district of Mada

[11] The use of latrines is not very well perceived in the majority of communities living in the Far North region, especially for women. Indeed, according to the prevailing considerations, the fact that a woman uses a latrine implies that she would no longer have children because she would be throwing her future children into the pit.

As summarized in the following table, in all health districts the lack of latrines was the most cited problem, followed by lack of drinking water.

Table 13 : *WASH Priority Issues for Internally Displaced Populations*

Group/District	Kousséri	Makary	Mada	Goulfey
Girls	Lack of latrines	Lack of drinking water	Lack sources of drinking water	Lack of latrines
Boys	Lack of latrines	Lack of latrines	Lack of latrines	Lack of latrines
Women	Lack of latrines	Lack of containers for drinking water	Lack of latrines	Lack of latrines
Men	Lack of drinking water	Lack of latrines	Lack of sources of drinking water	Lack of containers to conserve water

Needs of host populations

The populations of the host communities interviewed are almost all concerned about their safety; All the more so because they feel overwhelmed by the arrival of the IDPs who have fled their villages and whose identity is not always well controlled by the hosts. The insecurity mentioned by the host communities is at two levels: physical insecurity of people and property, and food insecurity.

The analysis of needs by group allowed us to note that girls are more concerned about the difficulty of accessing school. According to them, the lack of teachers, classrooms and latrines in schools greatly undermines their chances of success for their future lives. Boys say they are more affected by lack of food and unemployment. For them, food is no longer available because their parents do not have the necessary agricultural equipment for working the land. For women, they want to empower themselves to meet the needs of their households because they are mostly widowed, and now have to look after their children on their own. Men feel threatened by the presence of too many displaced people in their villages. According to them, it is important to restore peace in the home villages of the displaced. Indeed, the men of the host communities say they live a situation of injustice because they see that the IDPs are taken care of by the humanitarian actors, while they do not benefit from anything, while they peacefully welcome these displaced people in their villages.

« *We agreed to receive the displaced here at home, but when NGO people come they do not even look at us. They only give things to the displaced and it encourages people to flee the village because they know that when they are displaced they will also receive food, soap and other things for free.* »

A man, Focus group of men, host populations, Dabanga village.

In order to better understand the needs of the host communities, we will analyze their needs by sector.

Health and nutrition needs of host populations

According to the host communities, food is finished in their villages, because many waves of displaced populations have arrived in the fields. Since they are very hungry, they take whatever

they find to eat without permission. In order to alleviate the problem, the host communities want WFP to provide food, as is the case for displaced communities. Boys would like to help parents in the fields, but for lack of materials they can do nothing. Motor pumps were requested by boys and girls in order to help their parents, so they would be able to channel water from the Logone and Lake Chad to the farms, in order to irrigate them and increase the productivity of the fields.

According to men, drought has caused a decline in crop yield over the past decade. The displacement of populations makes the villages more vulnerable because the labor force declines considerably in abandoned localities. People from insecure villages come to settle in the most secure villages and cohabitation with the host communities begins to become difficult. Food is becoming scarce and children are increasingly affected by malnutrition.

« We have a hard time feeding ourselves here in Goulfey. In addition to the drought that disturbs us a lot, the food situation has become critical since Boko Haram began. Children are very affected by this lack of food. We no longer have the opportunity to give two meals a day. Our children are all thin, if we do nothing for them, they will certainly start dying. »

Laments a woman, from Host community focus group, Goulfey-Gana village

In the health district of Kousséri, the main health concerns are malaria, malnutrition and anemia. For the specific case of women, difficult deliveries in community were cited as a major health concern. In the health district of Makary, boys and men cited typhoid as the main disease, women complained of back pain and girls cited malnutrition and malaria. The Mada health district is more affected by malnutrition and dysentery in the host communities. In the district of Goulfey, girls and boys say they are more affected by respiratory diseases while women suffer from gastritis and men from rheumatism and diarrhea.

The following table summarizes the priority problems expressed by the host populations of Logone & Chari.

Table 14 : *Priority health and nutrition issues for host populations*

Group/District	Kousséri	Makary	Mada	Goulfey
Girls	Famine and malaria Malaria,	Malaria and Malnutrition	Malnutrition	Cough and malnutrition
Boys	Malnutrition	Typhoid	Malnutrition	Cough and Cold
Women	Difficult deliveries anemia	Backache	Malnutrition	Gastrities
Men	Malaria, famine	Typhoid, famine, malnutrition	Dysentery	Rheumatism, diarrhea

Needs of hosts in protection

The creation of a more secure environment for girls is necessary because, due to insecurity, girls are afraid to move around the villages. They fear rape; many of them have already been victims.

« Our village is very close to Nigeria and villages where Boko Haram has already committed attacks such as Bargaram and Tchika. This places us at great risk in terms of safety. Especially the girls, boys, women and old people in our village have a lot of trouble to lead a normal life. When the people of Boko Haram come to a village, they kill all the men, they rape the girls and the women, and they bring the boys by force with them. »

Explained a girl, from the Girls focus group, host population, Hile Alifa.

Boys and girls want to go to school in order to improve the living conditions of their mothers. They are convinced that school alone can help them support their parents. Some girls want to go to urban areas for the chance to train well. Lack of activities for young people is one of the major concerns of boys. In addition to the lack of schools and the lack of teachers, young boys are constantly wandering around the villages. Some even begin to consume narcotics because of idleness.

Women in the host communities are unable to travel to the fields because the roads are blocked. Nocturnal activities such as hunting locusts are no longer possible, which women relied heavily on the sale of locusts to make money when the security situation was normal. The majority of women interviewed said they were in severe financial poverty. This situation makes them vulnerable and weakens their autonomy. They believe it is vital to reorganise agropastoral activities to enable women to take control. Women are ready to engage in trade, sewing or any other activity that would allow them to earn money to support them. Today the days are summarized to go to draw water and to look for dry wood in the savanna for sale. These activities do not allow them to live decently because the sale of timber is not profitable. A woman can work all day to earn only 300 CFA francs (US $ 0.50).

The main source of problems after men is insecurity. They think that famine and invasion are the consequences of this insecurity. According to them, the peace in the villages must soon be restored; otherwise the situation will get worse. The focus groups with the men allowed us to realize that they were very concerned about the threat that the terrorist movement poses to their villages. They are particularly afraid of being abducted or killed by Boko Haram, as they have seen the consequences of the killings of their friends and brothers on the children who remained orphans. They want assistance to the women of their brothers who have become widows because of Boko Haram and an accompaniment of abandoned children born of this conflict.

The most highlighted problems in the various discussion groups by various localities were recorded in the priority table below.

Table 15 : Priority Protection Issues for Host Populations

Group/District	Kousséri	Makary	Mada	Goulfey
Girls	Early marriage	Fear of kidnappings	Rape	Darkness
Boys	Unemployment and idleness	Consumption of drugs	Fear of kidnapping	unemployment
Women	Deprivation of resources	Domestic violence	Fear of kidnapping	Rape
Men	Loss of financial autonomy	Fear of kidnappings	Assaults and assassinations	Unemployment

Needs of host populations in WASH

Generally, the most significant problems in WASH for host communities are access to water and environmental health. For girls and boys, lack of latrines and potable water in schools, and health centers are their main WASH concerns. The virtual absence of latrines in schools for girls is difficult to bear because their privacy is not preserved. They are obliged to relieve themselves in the wild in case of need, with all the humiliating considerations that this entails for them who are on the way to women's emancipation. Sometimes they are forced to give up school because of the lack of latrines. Boys are more in need of drinking water. In most of the discussion groups with boys, drinking water has returned to each time as first or second priority. This problem is especially accentuated in the health districts of Kousséri and Mada where the boys insisted that water is the main thing they would like to have above all else. In fact, they are drinking contaminated water from wells, rivers and lakes that make them vulnerable to dysentery and other diarrheal diseases.

Women have expressed the need to have containers for the transport and storage of water at home. In health centers, they want latrines to be constructed and water to be drunk for the patients. They also believe that their children must have boreholes in the schools in order to allow them access to drinking water easily at school as this is where they spend most of their days. The men mentioned the lack of latrines in households and hospitals, as well as the lack of landfill sites and the lack of water in the health centers.

Sharing the concerns of host communities suggests immense public health risks related to water and sanitation in the four health districts assessed. These risks include the unavailability of sufficient and adequate water, inadequate latrines, and the limited ability of host populations to cope with these challenges. There is an urgent need to provide a WASH response in all divisions in order to avoid the worst health consequences that the realization of these risks could have from an epidemiological point of view. A more specific analysis of water supply and management needs of waste is made in Section VIII of this report.

The table below presents the WASH needs of the host communities by health district as expressed in the focus groups.

Table 16 : WASH Priority Issues for Host Populations

Group/District	Kousséri	Makary	Mada	Goulfey
Girls	Lack of garbage at school	Lack of latrines in schools	Lack of soap for personal hygiene	Lack of water to drink at school
Boys	Lack of drinking water at school and at home	Lack of drinking water and lack of latrines	Lack of water to drink at school	Lack of latrines at school
Women	Lack of drinking water in the village	Lack of containers to store water	Lack of container for drinking water in school	Lack of latrines in hospital
Men	Lack of disposal sites	Lack of latrines in hospital	Lack of latrines in houses	Lack of water in hospital

VIII. Water Hygiene and Sanitation in the community

Drinking water supply for the communities

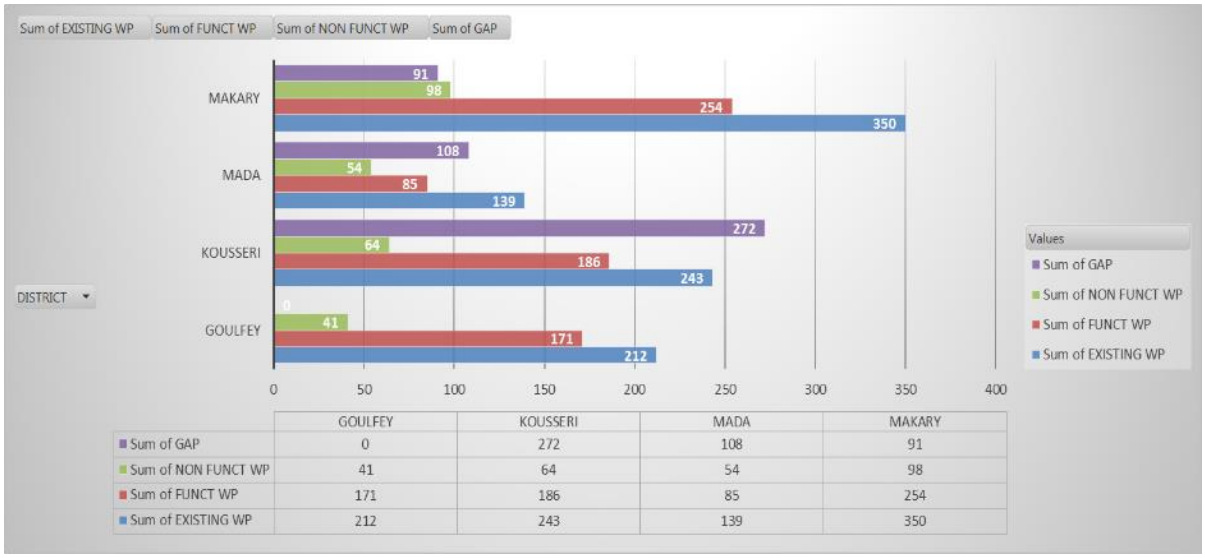
The sources of drinking water in the communities vary according to whether they reside on the western side (Nigerian border) or on the eastern side (Chadian border) of the Logone & Chari Division. The populations living in the eastern part of Logone & Chari are close to the Logone River, which is the natural border between Cameroon and Chad. Thus, it is usual for these populations to obtain water in the Logone River for everyday use: bathing, cooking meals, laundry, and some households even use it as drinking water with all the risks that this implies for health. The exchanges with the men of the host community of the village of Zimado made it clear to us those children naturally drink water from the river because it is available and easily accessible.

« *Here we are a community of fishermen, farmers and breeders. Our principal wealth is the river Logone; we, and especially our children, spend most of our time in contact with the water of the river. For children, drinking water from the Logone is quite natural.* »

A man, from focus group of host communities, Zimado Village.

In the western part, populations mainly go to wells, boreholes and Lake Chad to obtain water. Analysis of the data from the MINEE database allowed us to make a comparative analysis of water requirements in the health districts studied.

The analysis in the figure below shows that there is a deficit of 471 water points (shown in purple) in all four (04) health districts from the point of view of Sphere standards (1 drill per 500 inhabitants). This gap was evaluated by UNICEF on the basis of the map of existing water points and the demographic data of the health districts. The Kousséri health district is the one for which the need for water infrastructure is greatest (272 water points are required), followed by Mada health district (108 water points), and finally Makary health district (91 water points).



	GOULFEY	KOUSSERI	MADA	MAKARY
Sum of GAP	0	272	108	91
Sum of NON FUNCT WP	41	64	54	98
Sum of FUNCT WP	171	186	85	254
Sum of EXISTING WP	212	243	139	350

Figure 1*: Distribution of water points by health district (Source: HNO Data and Water Point Database of the MINEE Divisional Delegation - Logone & Chari - September 2016)*

A thorough WASH assessment should be conducted in a timely manner by the IMC WASH engineering team to accurately identify the specific water and sanitation needs of each health area and community. Guidance for this in-depth evaluation will be given in the recomendations section of this report.

Community waste management

The interview with the Hygiene Service Department and the exchanges with the community leaders allowed us to identify needs in terms of waste management at the household level as well as at the community level.) Components of waste management have been briefly explored along the lines of analysis proposed by the SPHERE standards and by the United Nations Environment Program (UNEP). These components are synthesized in the graph below.

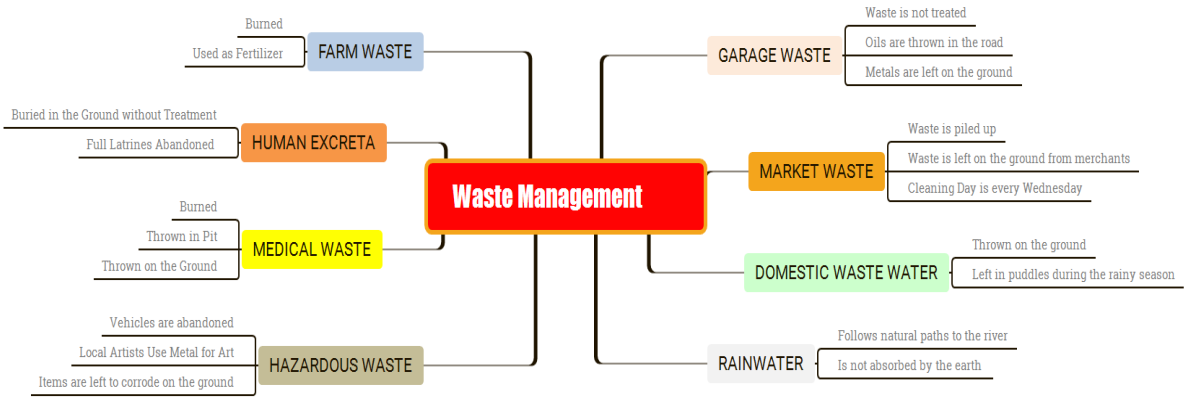


Figure 2: Waste Management Practices in Logone & Chari

Farm Waste

In most areas visited, garbage is burnt or reused as fertilizer on farms. Although it can be noted that this garbage does not represent a major risk of contamination, attention must be paid to the practices of open defecation in the fields.

Human Excreta Waste Management

The fate of waste from septic tanks is also a major public health challenge in the areas assessed. In the town of Kousséri, there are some artisans who use chlorine and motor pumps for the disinfection and emptying of septic tanks. The final destination of the excreta is nature, particularly the beds of streams. In the other villages visited, the populations reported to us two dominant practices: the abandonment of the full septic tanks and the emptying of latrines with buckets by young people specialized in this field and recognized by all in the village.

« *Here at home, when the septic tanks are full, either we abandon them in the wild or we call a young man in the village who takes care of that. He draws the waste with the bucket and throws them into the fields or into the river.* »

Says village chief, in the locality of Zimado

Ultimately it can be said that the destination of sanitary sludge depends on the type of latrines used. In rural areas, households with improved latrines solicit the services of small craftsmen who empty pits with buckets. The waste thus collected is then discharged into the environment after mixing with quicklime.

Households with no improved latrines abandon the full pits or simply cover them to create new ones in another space. It should be made clear here that no drainage service exists in the four health districts.

Medical waste

The widespread practice for the management of medical waste is burned in incinerators constructed in an artisanal way. The separation of medical waste is not made. The heads of district health services reiterated the need to equip the facilities with incinerators. More details on the management of medical waste are given in Section IX of this report.

Hazardous waste

Hazardous waste refers here to all non-biodegradable waste which represents a risk of toxicity and high pollution. Within the meaning of the United Nations Environment Program, and in accordance with our study environment, we have limited the list to: non-use vehicles, batteries and accumulators, phytosanitary waste. The opinions gathered allowed us to realize the systematic abandonment of waste of this type in nature. This can be explained, however, by the incorrect regional and even national hazardous waste management policy.

Waste from Garages

In general, hazardous waste is the waste from the garages here, mainly consisting of polluting oils and scrap metal. The dominant practices stated are the reuse of metals that can still be exploited by artisans and the rejection of waste oils in nature.

Waste from Markets

Garbage from markets is most often crammed by traders in a transit site defined by the hygiene services. The garbage thus collected is subsequently collected by the hygiene services to be transported to the main landfill. It should be noted, however, that in the districts of Makary, Mada and Goulfey, landfill sites are not used due to lack of means of transport.

Domestic waste and domestic waste water

The dominant practice for domestic waste is their discharge into the streets, or simply into the streams. As far as domestic waste water is concerned, households do not produce much, so they are poured into the courtyards in front of houses.

Rain water

Rainwater runs through natural channels, as there is no sewer system in both urban and rural areas. During the rainy season, floods are frequent. Polluted waters infest houses in some areas and demolish houses made of temporary materials. The majority of internally displaced people find themselves without shelter once the rainy season arrives.

« *When it starts to rain here, we do not know what to do. We do not have anywhere to sleep because the rain carries away our shelters and the children are often sick.* »

A woman, IDP discussion group, Hile Alifa explained.

IX. Specific Nutrition Requirements in the Assessed Health Areas

In light of the latest SMART nutrition assessments conducted in Cameroon in the last ten (10) years, malnutrition is the major public health problem in the Far North region. Preliminary results from the UNICEF SMART survey in August 2016 show that the Division of Logone & Chari remains the Division most affected by malnutrition in the region. As can be seen from the graph below, the prevalence of acute severe malnutrition is at the 2% emergency level and overall acute malnutrition is at the alert threshold with a prevalence of 10.8%.

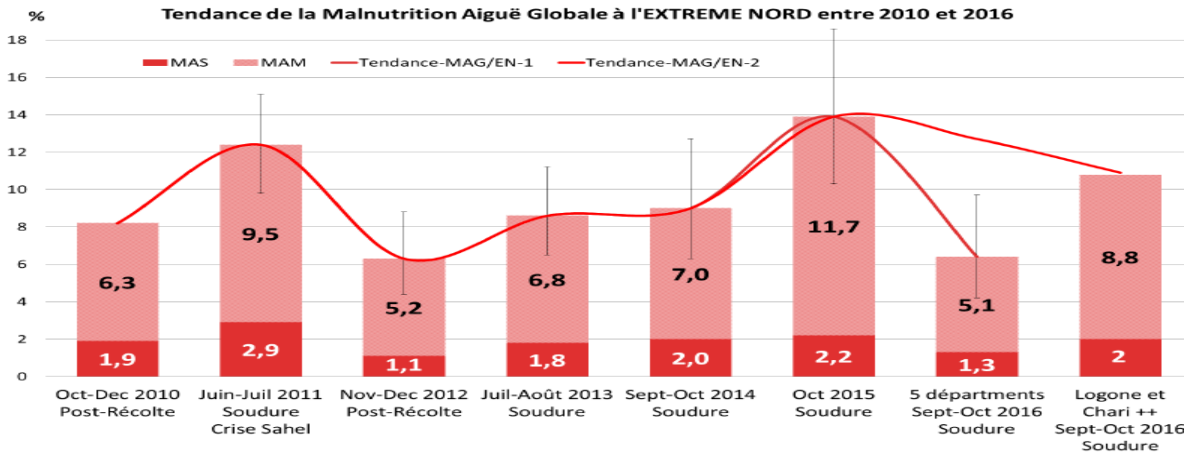


Figure 3 *: Prevalence of malnutrition in the Far North over the last six years (Source: UNICEF-MINSANTE Preliminary results of the SMART 2016 nutrition survey)*

The compilation of reporting data from the health districts of Makary, Mada, Kousséri and Goulfey reported that malnutrition accounts for 75% of the pathologies recorded in children aged 0-59 months in the first half of 2016. For the case Specific situation of severe acute malnutrition in the health areas visited, the situation is globally precarious in all four health districts. The prevalence of severe acute malnutrition exceeds the 1% precarious threshold in 80% of the health areas assessed for the month of September 2016. The situation is particularly alarming in the Dabanga and Goulfey health areas. The graph below shows the comparative

situation of the prevalence of severe acute malnutrition in September 2016 among children aged 6-59 months in targeted health areas for this assessment.

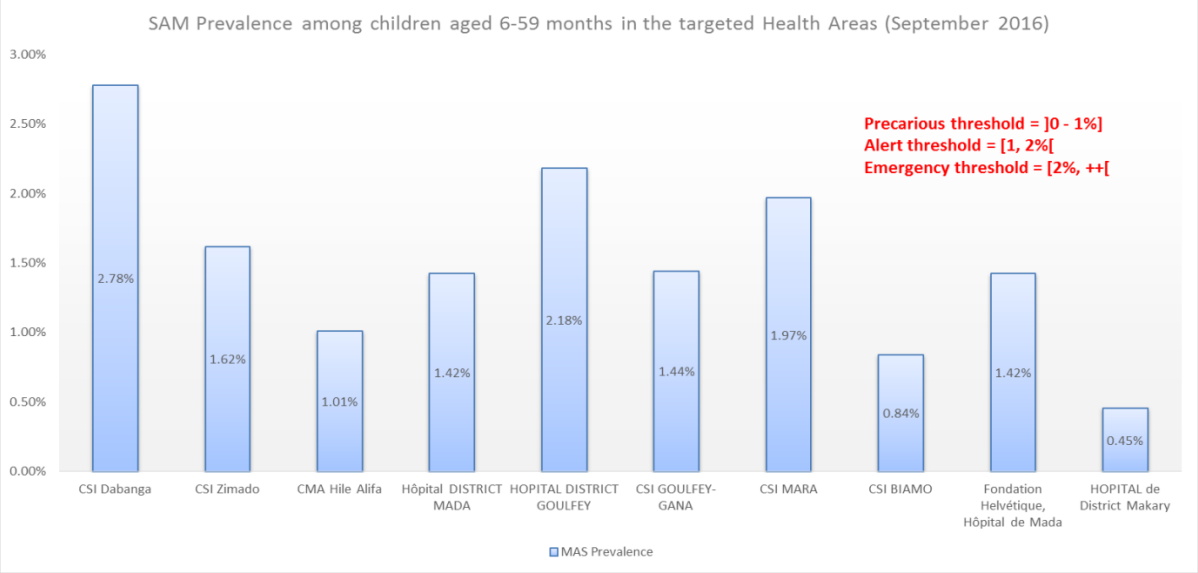


Figure 4 : Prevalence of malnutrition in the target health areas of the project (Source: SCs and OTPs consultation registers of the health facilities visited)

This situation is more worrying when we take into account the situation of generalized food insecurity prevailing at the moment in the Logone & Chari Division. The need for intervention in the management of acute malnutrition is becoming increasingly necessary to prevent the occurrence of new cases of malnourished children in host and internally displaced communities and to limit deaths due to malnutrition by ensuring rapid identification and management of identified cases. Furthermore, the fact that only 4 out of the 46 health facilities in the Division of Logone & Chari have a program to manage severe acute malnutrition in children aged 0-59 months, increasing the risk of child deaths due to malnutrition. In the health district of Goulfey, the SC has been inactive for a little over a year, making it impossible to manage cases of severe acute malnutrition with complications throughout the district.

None of the existing SCs meet the minimum standards. Beds are not equipped with insecticide-treated mosquito nets; walls are run down by the flow of rainwater and cracked in places. In addition, SCs do not have toys or mats for children. Community health workers and staff are not trained in Infant and Young Child Feeding (IYCF). This situation is almost identical in the SCs of Goulfey, Makary and Mada, which currently do not have any support in the management of acute malnutrition.

The destructuring of the health system in the health areas visited led to a lack of monitoring of the care of pregnant and lactating women, so that statistics are non-existent for this category of beneficiaries, which is a critical target of malnutrition management. This lack of information reflects a lack of care for pregnant and lactating women suffering from malnutrition, especially since the majority of women's discussion groups say it is one of the major problems they face (see Section VII of the report).

X. Community access to health services

Financial access

Exchanges with key informants, the host community and the internally displaced have shown us that the populations living in the localities are so poor that they would like to benefit from free health services. Thus, whether it is curative consultations, prenatal or postnatal consultations or the procurement of essential medicines, the wish of the community is to be able to benefit from it without having to pay any money. The extreme poverty in the villages since the beginning of Boko Haram permanently poses a dilemma for people who have to choose between buying food to survive and buying medicines to treat themselves.

Yet, when we summarize the costs of the various health facilities evaluated, we realize that there is a great financial barrier that prevents people staying in these localities from using health services. For example, the average cost for curative consultations is 475 FCFA (about 1USD) for all health facilities, which is difficult for the population to afford due to insufficient financial resources. At the District Medical Center of Hile Alifa, for example, the prenatal consultation costs 1000 FCFA, this prevents pregnant women for close medical follow up. They are regularly obliged to give birth at home with traditional birth attendants. The table below shows the costs incurred for the provision of certain basic health services in the various health centers visited.

***Table 17**: Cost of the various types of consultation practiced at the HiléAlifa District Medical Center and in the integrated health centers of Dabanga, Zimado, Goulfey-Gana, Mara and Biamo, 2016*

Consultation types	Hilé Alifa District Medical Center	Dabanga Integrated Health Center	Zimado Integrated Health Center	Goulfey-Gana Integrated Health Center	Mara Integrated Health Center	Biamo Integrated Health Center
Curative Consultation	350 FCFA	300 FCFA (registered) 4000 FCFA (new patient)	300 FCFA	300 FCFA	200 FCFA	200 FCFA
Antenatal Consultation	1000 FCFA	400 FCFA	0 FCFA	500 FCFA	200 FCFA	100 FCFA
Post-natal Consultation	0 FCFA	350 FCFA	0 FCFA	0 FCFA	0 FCFA	0 FCFA

Access to health services in district hospitals is even more difficult for the communities visited. The average cost of a curative clinic in district hospitals is estimated at 730 CFA (about US $ 1.5) and for prenatal clinics; women may be required to pay up to 1,000 CFAF (approximately USD 2). This situation increases the risk of neonatal deaths and maternal deaths in displaced and host communities.

***Table 18**: Costs of consultations in the hospitals of Makary, Mada and Goulfey District, 2016*

Consultation types	Makary District Hospital	Mada District Hospital	Goulfey District Hospital
Curative Consultation	600 FCFA	1000 FCFA	600 FCFA
Antenatal Consultation	500 FCFA	1000 FCFA	500 FCFA
Post-natal Consultation	0 FCFA	0 FCFA	0 FCFA

Geographical access

Road conditions in the localities visited are particularly challenging for the people staying there. The difficulty of these road conditions varies depending on whether one is in the rainy season or in the dry season. One of the main difficulties during the dry season is heat; the temperature can reach peaks of 45°C in the shade. This overwhelming heat coupled with the lack of means of locomotion makes geographical access to healthcare structures particularly perilous. In the rainy season, rising water causes flooding of roads, making them impassable and dangerous. In some localities such as Mbardi, Hilele and Sagme it is even impossible for populations to receive health care.

Interviews with heads of health facilities identified difficulties setting up a referral system for emergency cases, especially during the rainy season. This situation is particularly devastating since it leads to many deaths in the villages. With the emergence of the Boko Haram crisis and the increase in the number of IDPs, this situation is likely to get worse if no adequate response to this problem is provided.

The reference system is so limited that the majority of the health facilities located in the western part of the Logone & Chari Division are often forced to refer cases by canoe to Chad via the Logone River. It is not uncommon for this particularly dangerous reference system to lead to drownings.

« We are very often forced to refer some people to Chad for lack of means of transportation and because of the long distance to the district hospital. Patients borrow canoes to cross the Logone and sometimes it happens that the canoe capsizes causing deaths by drowning. »

Head of the GoulfeyGana Health Area explained

The tables below present the conditions of population access to health centers and health services in the districts of Makary, Mada, Goulfey and Kousséri.

***Table 19**: Presentation of geographical conditions of access to health care in the 09 Health areas visited*

Health Area and health center evaluated	Average Distance between all the villages and of the health area and health facility	Name of the village of the health area furthest from the health facility	Distance between furthest village of the Health Area and the health facility	Average time of the journey in hours between the furthest village of the Health Area and the health facility and the cost
Dabanga : Intergrated health center, Dabanga	10 km	SKLIO	18 km	**Car** : 1h and 500 FCFA only duiring the dry season **Motorcycle** : ½ h and 1000 FCFA only during the dry season **Foot** : 3 h during the dry season and 4 h in the rainy season
Zimado : Zimado IHC	25km	MBARDI	60 km	**Motorcyle** : 2h and 5,000 FCFA in the dry season **Motorcycle+ canoe** : 48h and 20,000 FCFA during the rainy season
Makary : Makary district hospital	11 km	BONANE	19 km	**Car** : 1.5h, 2,000 FCFA in the dry season and 2,5h, 3,000 FCFA in the rainy season **Motorcycle**: 1h and 2,500 FCFA in the dry season and 1.5h and 3,500 FCFA in the rainy season. **Foot** : 2.5h in the dry season 3h in the rainy season
Biamo : Biamo IHC	12 km	GUIDANSAMA	18 km	**Car** : ¾ h and 1,500 FCFA only in the dry season **Motorcycle** : ½ h and 1,500 FCFA in the dry season and 3h and 4000 FCFA in the rainy season **Foot** : 3h in the dry season 4h in the rainy season
Mada : Helvetic Fondation, Mada Hospital	09 km	LARISKI	20 km	**Car** : ¾ h and 400 FCFA in the dry season, 1h and 700 FCFA in the rainy season **Motorcycle** : 1/2h and 500 FCFA in the dry season ¾h and 1000 FCFA in the rainy season **Foot** : 2h on average in the dry season and 2,5h in the rainy season

Health Area and health center evaluated	Average Distance between all the villages and of the health area and health facility	Name of the village of the health area furthest from the health facility	Distance between furthest village of the Health Area and the health facility	Average time of the journey in hours between the furthest village of the Health Area and the health facility and the cost
Hilé Alifa : Hilé Alifa district medical center	12 km	KARAMA 1	40 km	**Car** : 1.5 h and 2000 FCFA in the dry season only **Motorcycle** : 1h and 3000 FCFA in the dry season only **Car+ canoe** : 3h and 4000 FCFA in the rainy season **Moto+ canoe** : 2.5 h and 6000 FCFA in the rainy season
Goulfey : Goulfey district hospital	07 km	GOURLEY	16 km	**Motorcycle** : 1h and 1000 FCFA in the dry season; 2h and 3000 FCFA in the rainy season **Foot** : 2h in the dry season and 3h in the rainy season
Goulfey-Gana : IHC Goulfey-Gana	15 km	BOUTAL-HADOUM	35 km	**Car** : 1h and 500 FCFA in the dry season; 7h and 2,500 FCFA in the rainy season **Moto** : ¾ h and 1000 FCFA in the dry season; 4h and 5000 FCFA in the rainy season
Mara : IHC Mara	12 km	MICH-MICH	28 km	**Car** : ¾ h and 500 FCFA in the dry season; 36 h and 10,000 FCFA in the rainy season **Moto** : ½ h and 1000 FCFA in the dry season; 24h and 15,000 FCFA in the rainy season

Table 20 *: Description of population access to secondary health care provided by the district hospitals of Kousséri, Makary, Goulfey and Mada*

District hospital name	Average distance between the leading health facility and the nearest district hospital	Name of the health center closest to the district hospital	Average Distance between the leading health center of the whole health area and the district hospital	Name of the most remote or furthest health from the district hospital	Average distance between the furthest and most remote leading health center and the district hospital	Average length of the distance traveled in hours between the leading health facility in the most remote or remote district health area the cost
Kousséri district hospital	04	PAGUI	40 km	ZINA	131 km	**Car+ canoe** : 6h and 6,500 FCFA in the dry season 12h and 10,000 FCFA in the rainy season **Motorcycle+ canoe :** 5h and 7,500 FCFA in the dry season 8h and 12,000 FCFA in the rainy season
Goulfey district hospital	00	GOULFEY	35 km	HILELE	80 km	**Car** : 5h and 7,500 FCFA in the dry seasons; 48h and 15,000 FCFA in the rainy season **Moto** : 4h and 12,000 FCFA in the dry season; 24h and 30,000 FCFA in the rainy season
Makary district hospital	00	MAKARY	28 km	SAGME	70 km	**Car** : 4h and 3,000 FCFA in the dry season 7h and 5,000 FCFA in the rainy season **Moto** : 3h and 4,000 FCFA in the rainy season; 6h and 10,000 FCFA in the dry season
Helvetic Foundation, Mada Hospital	00	MADA	36 km	DARAK	70 km	**Car+ canoe** : 4h and 3,000 FCFA in the dry season 12h and 8,000 FCFA in the rainy season **Motorcycle+ Canoe :** 3h, 5000 FCFA in the dry season 10h, 12000 FCFA in the rainy seaon

It is important to note here that access to health care is even more difficult for IDPs. More specifically for children under 5, women, people with disabilities, the elderly, people living with HIV / AIDS, and those that are mentally sick. Moreover, it should be noted that in all the health districts of Logone & Chari, motorcycle circulation is currently strictly controlled at night. Thus, to evacuate an emergency patient, the family is obliged to rent a vehicle. Displaced families are often forced to see their loved ones die because they cannot rent a vehicle.

XI. Basic needs of health facilities

Health personnel

Globally, there are some gaps in terms of health personnel. These gaps are observable both in terms of numbers and quality in all the health districts assessed.

Quantity

In all three district hospitals evaluated, the difference of 118 health personnel was detected in relation to the national standard. Indeed, the majority of medical personnel have been forced to flee from health districts due to the prevailing insecurity in Logone & Chari. This gap (which means that 62% of the health workforce needs are currently unmet), reflects the urgent need for an emergency response in the field of health. In reality if nothing is done, the health situation in any Division will continue to deteriorate, resulting in enormous loss of life. The table below summarizes the gaps per posts and health district compared to the national standard.

***Table 21** : Staffing Situation in Makary, Goulfey and Mada District Hospitals (Source: District Hospitals Database)*

Post or function	National standard	Mada district hospital		Goulfey district hospital		Makary district hospital	
		Existing	Gap	Existing	Gap	Existing	Gap
General practitioner (Professional experience required)	1	2	1	1	0	1	0
Dental surgeon	1	0	-1	0	-1	0	-1
TSSI (anesthetist)	1	0	-1	0	-1	0	-1
TSSI (general practitioner)	4	0	-4	2	-2	0	-4
State registered nurse (General)	10	2	-8	0	-10	0	-10
State registered nurse (Instrumentalist)	2	0	-2	0	-2	0	-2
State registered nurse (Anesthetist)	1	0	-1	0	-1	0	-1
State registered nurse (Mid-wife)	11	2	-9	0	-11	0	-11
State registered nurse (Nursery)	1	0	-1	0	-1	0	-1
TMS (Lab)	1	2	1	0	-1	0	-1
TMS (Pharmacy)	1	0	-1	0	-1	0	-1

Post or function	National standard	Mada district hospital		Goulfey district hospital		Makary district hospital	
		Existing	Gap	Existing	Gap	Existing	Gap
TMS (Radiology)	1	0	-1	0	-1	0	-1
Maintenance technician	1	1	0	0	-1	0	-1
TMS (Odonto)	1	1	0	0	-1	0	-1
TGS[1]	1	0	-1	0	-1	0	-1
IBA	8	0	-8	0	-8	0	-8
IBG	14	3	-11	1	-13	1	-13
TAL ou ATMS	2	2	0	1	-1	1	-1
ASG	9	7	-2	2	-7	3	-6
ASOL	2	0	-2	0	-2	0	-2
Administrative assistant	1	1	0	0	-1	0	-1
Secretary typist	1	1	0	0	-1	0	-1
Ambulance driver	1	0	-1	0	-1	0	-1
Mortuary attendant	1	0	-1	0	-1	0	-1
Day and night watchman	3	4	1	1	-2	1	-2
State agent	1	0	-1	0	-1	0	-1
Bursar	1	1	0	0	-1	0	-1
Maintenance agent (carrier or helper)	8	9	1	1	-7	1	-7
Ophthalmology techinician	0	1	1	0	0	0	0
Auxiliary nurse anesthetist	0	1	1	0	0	0	0
Head of operating block Anesthetist auxiliary nurse	0	1	1	0	0	0	0
Ward helpers boys and girls halls	0	9	9	0	0	0	0
Electrician	0	1	1	0	0	0	0
Pharmacy clerk	0	1	1	1	1	1	1
Total	63	**52**	-11	**10**	-53	**9**	-54

According to the health pyramid, district hospitals belong to the fourth category. Compared to national health workforce standards, there is a significant difference between the current staffing situation at the Makary and Goulfey District hospitals. The standard requires 11 midwives, but there is currently only 01 midwife in Mada District Hospital and none in the other two. There are currently 02 qualified nurses in the Mada district hospital, compared to the standard of 10. The Makary District Hospital has currently no qualified nurses.

The pharmacies are still held by clerks without adequate training; whereas the standard recommends that the management of pharmacies in hospitals be entrusted to the medical technicians specialized in pharmacy. Outside the only surgeon of the Mada District hospital, one finds no other specialist physician in all of the assessed health districts. Although the standard does not provide for mental health specialists in district hospitals, there is a tremendous need in the three hospitals in districts with no psychiatrists or psychologists. It is important to note that in all health facilities visited there is at least one staff trained in the management of acute malnutrition but no staff is trained on IYCF.

***Table 22** : Staff situation at HiléAlifa, Dabanga, Zimado, Biamo, Goulfey-Gana and Mara integrated health centers*

Category of personnel	National standard	Dabanga intergrated health center		Zimado intergrated health center		Biamo intergrated health center		Goulfey-Gana intergrated health center		Mara intergrated health center	
		Existing	Gap	Existing	Gap	Existing	Gap	Existing	Gap	Existing	Gap
TSSI (OU IDE)	1	0	-1	2	1	0	-1	0	-1	1	0
IBA	1	0	-1	0	-1	0	-1	0	-1	0	-1
IB	1	1	0	0	-1	0	-1	0	-1	0	-1
TAL	1	0	-1	1	0	0	-1	0	-1	0	-1
AS	1	2	1	2	1	1	0	3	2	1	0
State agnent	1	0	-1	0	-1	0	-1	0	-1	0	-1
Clerk	1	1	0	1	0	1	0	1	0	1	0
TOTAL	**6**	4	-2	6	0	2	-4	4	-2	3	-3

The provision of community-based health services relies on community health workers, traditional birth attendants and midwives, and traditional healers. Health policy in Cameroon advocates for coordination of public-private partnerships including public-community, public-traditional healers and public-traditional birth attendant partnerships. Despite this political motivation, these different forms of partnerships are not yet sufficiently developed.

Table 23 : Staff situation at the Hile Alifa District Medical Center

Categorie of personnel	National standard	Subdivisional Hospital of Hile Alifa	
		Existing	Gap
Doctor (Professional experience required)	1	0	-1
TSSI (General practitioner)	1	0	-1
State registered nurse	2	0	-2
TMS OPTION PHARMACIE	1	0	-1
IBA*	3	1	-2
IB**	3	1	-2
TAL***	1	1	0
AS	6	1	-5
ASOL****	1	0	-1
DENTAL TECHNICIAN	1	0	-1
STATE AGENT	2	0	-2
SECRETARY TYPIST	6	0	-6
TOTAL	**28**	4	-24

Quality

Mostly, though UNICEF, UNFPA and WHO, health workers have received various training in the areas of reproductive health, management of acute malnutrition, and emergency care obstetrics. On the other hand, staff are not trained in mental health, clinical management of cases of gender-based violence, essential care of the newborn and Infant and Young Child Feeding (IYCF). With insufficient staffing levels and some unqualified health center managers, it is imperative to maintain a system of retraining and permanent upgrading of health workers throughout the Division. International Medical Corps could position itself in this training as an intermediary between United Nations agencies and health structures in order to reach as many staff and community volunteers as possible.

Buildings

Seven sanitary units on the ten (7/10) have severely damaged buildings. This damage is due to the lack of maintenance due to the insecurity that has evolved considerably in Logone & Chari for almost three years. Delivery rooms, curative clinics and laboratories are virtually unusable in all health centers. The rehabilitation of buildings becomes urgent to provide patients with health care in a minimally decent environment.

Figure 5 : Delivery rooms District Hospital of Goulfey Integrated Health Center of Dabanga

District of Goulfey

The roofs of the three buildings of the Goulfey district hospital are in a state of deterioration. The walls and floor are split in several places. The doors of the hospital rooms and the latrine blocks are without locks. The internal latrines are not used because of their deteriorating condition. The incinerator is also in very poor condition. The roof of the GoulfeyGana Integrated Health Center is completely damaged and leaks water abundantly into the delivery room. The ceilings are flanked with cracks on the walls and on the floor.

District of Kousséri

The Dabanga Integrated Health Center is the one that requires the greatest intervention in terms of rehabilitation among the health facilities visited in the district of Kousséri. The roof of the building is partly removed and water flows into the observation room, resulting in the complete disintegration of the ceiling and the stagnation of water in the delivery room. At the health center of Zimadola, the roof of both buildings is in poor condition and lets water flow as in other health facilities. The walls are fragile by the weather and can collapse at any time.

District de Makary

The state of degradation of the buildings is very high at the Makary district hospital. This concerns the three buildings that house the hospital and the district health unit. All the compartments of the buildings are affected, namely the roof, the walls, the windows, the doors of the hospitals, and the plumbing in the indoor toilets. The building of the health center of Biamo has cracks on all the walls, the ceiling is completely destroyed and in some places the metal roof is torn.

District of Mada

At the Mada district hospital there are cracks on the walls, on the ground and the roof of the maternity ward is damaged letting water flow inside and causing the degradation of the ceiling. Windows are mostly degraded in the building of the SC, leaving mosquitoes in rooms without

mosquito nets. The roofs of the 06 buildings of the medical center of Hile Alifa are in poor condition. There are numerous cracks on the walls and on the ground. The doors of the hospital wards and latrines are missing locks. The water system feeding the hospital rooms, offices and latrines is completely damaged.

Pharmacy

Pharmacy needs are numerous in all health facilities evaluated. The health facilities housing the CNAM and CNAS all have a community pharmacy. But the ruptures of medicines of systematic treatment are almost permanent. This is a real need to be covered. There is also a significant deficit in essential medicines. This situation, coupled with the fact that the majority of health facilities do not have functional cold chains, makes the clients of the health centers particularly vulnerable. Emergency action is required to provide health facilities with essential medicines in order to provide them with the capacity to respond effectively to the urgent needs of displaced persons and the most vulnerable host populations

Table 24 *: Situation of Medicines and Medical consumable tracers in the district hospitals of Makary, Goulfey and Mada*

Drug type	Makary District Hospital[12]	Mada District Hospital	Goulfey District Hospital
1. Amoxicillin caps /tabs 500 mg	1	1	1
2. Amoxicillin sirup 250 mg/ 5ml	1	1	1
3. Artesunate tabs 50 mg – amodiaquine 135 mg ou AL	1	0	1
4. Cotrimoxazole tabs 480 mg	1	1	1
5. Diazepam 10 mg / 2ml – injectable	1	1	1
6. Iron – folic acid 200 mg + 25 mg	1	1	1
7. Mebendazole tabs 100 mg	0	1	0
8. Syntocinone amp 10 Unités	1	1	1
9. Metronidazole tabs 250 mg	1	1	1
10. Paracetamol tabs 500 mg	1	1	1
11. Artésunate injectable/Quinine comp and quinine injectable	1	1	1

[12] This is the score specifying the availability (1) or unavailability (0) of the drug or medical consumable at the time of the evaluation. The table shows the situation in October 2016.

12. ORS / oral sachet	1	0	1
13. Steril gloves	1	1	1
14. Sterile gauzes	1	1	1
15. Glucose solute 5%	1	1	1
16. Ampicilline PPI 1 g vial	1	1	0
17. TDF 300 mg + 3TC 300 mg + EFV 600 mg (TELE)	1	1	1
18. Névirapine	1	1	1
Total points on 18	16/18	15/18	16/18

***Table 25** : Situation of Medicines, Medical supplies and Vaccined in the Subdivisional Hospital de Hilé Alifa and in the Intergrated Health Centers of Dabanga, Zimado, Goulfey-Gana, Mara and of Biamo*

Drug type	**Subdivisional Hospital Hilé Alifa**	**IHC Dabanga**	**IHC Zimado**	**IHC Goulfey-Gana**	**IHC Mara**	**IHC Biamo**
1. Amoxicilline caps /tabs 500 mg	1	1	1	1	1	1
2. Amoxicilline sirup 250 mg/ 5ml	1	0	1	0	0	1
3. Artesunate tabs 50 mg – amodiaquine 135 mg or AL	1	1	1	1	1	1
4. Cotrimoxazole tabs 480 mg	1	1	1	1	1	1
5. Diazepam 10 mg / 2ml – injectable	1	1	1	1	1	1
6. Iron–folic acid 200 mg + 25 mg	1	1	1	1	1	1
7. Mebendazole tab 100 mg	1	1	1	0	1	0
8. Syntocinone amp 10 Unités	0	0	0	1	0	1
9. Metronidazole tab 250 mg	1	1	1	1	0	1
10. Paracetamol tab 500 mg	1	1	1	1	1	1
11. Artésunate injectable/Quinine tab and quinine injectable	1	1	1	1	1	1
12. ORS / oral sachet	1	1	0	1	1	1
13. Sterile gloves	1	1	1	1	1	1
14. Sterile gauzes	1	1	1	1	1	1
15. Glucose solute 5%	1	1	1	0	1	1

16. Ampicilline PPI 1 g vial	1	1	1	0	1	0
17. TDF 300 mg + 3TC 300 mg + EFV 600 mg (TELE)	0	0	0	0	0	0
18. Nevirapine	0	0	0	0	0	0
Total points on 18	15/18	14/18	14/18	12/18	13/18	14/18

Health Information Management

The management of health information is one of the major concerns of Logone & Chari at the moment. Indeed, the decline in health system activities due to widespread insecurity in the Division has considerably affected the reporting system. This situation makes health decision-making particularly difficult. Unanimously, district medical doctors reiterated the need to strengthen health centers in order to optimize the management of health information. This optimization is all the more necessary as the Logone & Chari Division is exposed to major epidemiological risks such as cholera, poliomyelitis, meningitis and measles.

XII. Water Sanitation and Hygiene in health facilities

Water supply in health facilities

Most of the health facilities visited do not have an adequate water supply system. In certain health centers, the containers used do not allow the storage of clean water. At the Biamo Health Center, for example, water is stored in canaries (traditional water containers made of clay). In addition most of the water towers are non-functional and require rehabilitation. This is the case, for example, with the water tower of the Goulfey district hospital, which has been shut down for almost three years. Emergency response is required to enable health facilities to have clean water and adequate water storage kits for hand washing.

Figure 6: Canaries - water containers in the Biamo intergraterd health center

State of latrines

The latrines are in an advanced state of deterioration. Some are already collapsing due to their advanced age and recurring flooding in the region. At the GoulfeyGana health center, we found the latrines sinking into the pit. If nothing is done urgently to rehabilitate the latrines in the health facilities before the next rainy season, a cholera epidemic could be triggered in the area with serious consequences for the internally displaced populations and host communities that is most vulnerable.

Figure 7*: Latrines in the intergrated health centers of Goulfey Gana and Biamo*

Medical waste management

The management of medical waste is practically not guaranteed in all health facilities. All incinerators in health centers and district hospitals are non-functional or partially functional. Emergency response is required to limit the public health risks associated with poor medical waste management. In some health areas, it is not unusual for children to find themselves playing with worn-out medical equipment such as old syringes or worn out infusion bags. The urgent needs for rehabilitation and construction of incinerators were mainly identified in the health structures of Goulfey, Zimado and Mara. In addition, garbage pits are required for the treatment of sharp medical garbage such as blades or needles. In addition, pits for after-birth waste such as placentas are also urgently required.

Figure 8: *Incinerators in the district hospital of Goulfey and the intergrated health center of Zimado*

XIII. Recommendations

A. Humanitarian Institutions in Logone & Chari

In order to succeed in a good intervention in Logone & Chari, International Medical Corps must have a good command of its environment. This requires knowledge of all humanitarian stakeholders involved in the Division. These stakeholders have been represented in the form of an institutiogram. (See diagram in fig 9)

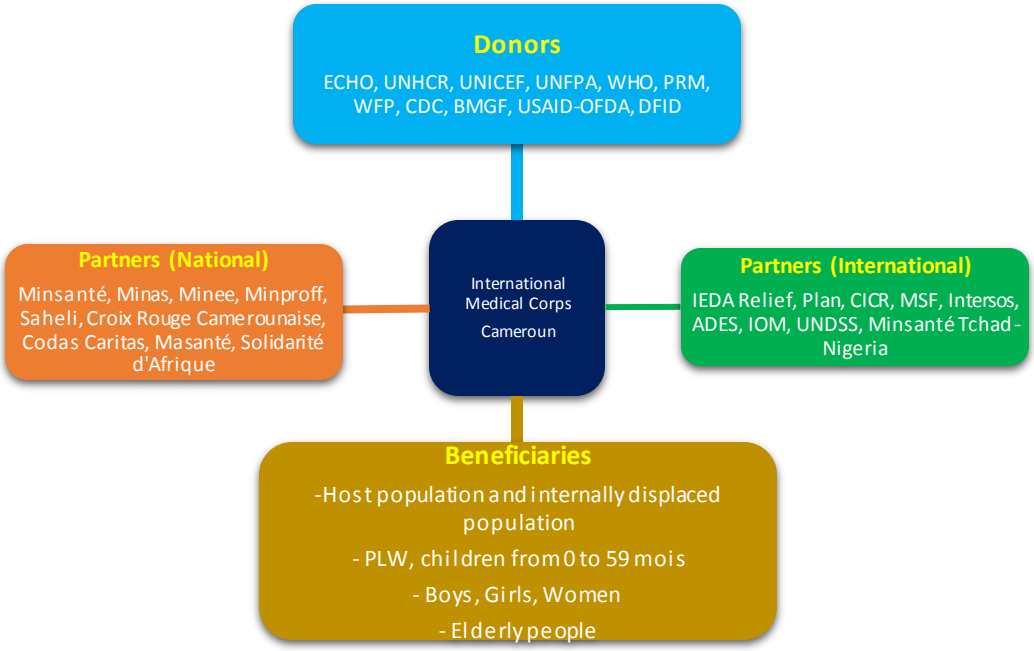


Figure 9: Humanitarian Institutiogram of Logone & Chari (October, 2016)

Donors

This brings together all the donors currently working in Cameroon who have identified Logone & Chari as a financing target for the budget year 2017. The list is not exhaustive, but the eleven may already constitute a potential source of funding for a possible intervention in this Division. International Medical Corps can use its current or previous experience with most of them to satisfactorily execute a project in case of funding. Indeed, experience in the management of emergencies and its capacity to integrate and gain acceptance by beneficiary communities, as is the case in the Mayo-Tsanaga Division in the Far North Region, and in several Divisions in the Regions of Adamaoua, East and North, are a major asset for a quick response and adapt to the needs identified.

National partners

State actors and non-state actors are the two types of national partners identified in Logone & Chari. Among the state actors, we can mention in the front line the Ministry of Public Health with which IMC already has a good and long working relationship of almost eight (08) years in Cameroon. We also have MINAS and MINPROFF with whom IMC is currently working closely on child protection programs and the fight against gender-based violence in the Mayo Tsanaga Division. Finally, there is the MINEE with which IMC works in partnership within the framework of the programs of Water Hygiene and Sanitation in the Division of Mayo-Tsanaga.

Among the non-state actors presented here, there were mainly national NGOs. IMC in its Strategic Action Plan for Logone & Chari could consider the establishment of partnerships with some local NGOs that already have a good knowledge of the field and have community volunteers practicing in the four (04) assessed health districts. In this context, a partnership could be established with the NGO Solidarité d'Afrique and the Codas Caritas group for interventions in various areas targeting certain areas considered very dangerous for international NGOs. The ongoing partnership with the NGO Masanté under the Global HealthSecurity Agenda (GHSA) will need to be consolidated. In the future, IMC will need to identify community-based organizations with a view to including them in its intervention in order to increase the resilience of the beneficiary populations and their self-determination with a view to ensuring the sustainability of interventions in the event of funding.

International partners

They include United Nations agencies other than donor agencies, international NGOs and health authorities in neighboring countries. IMC is integrated into existing coordination frameworks in addition to those already operational at Maroua to ensure cooperation and complementary interventions with other actors in the area. Collaboration with other implementing partners who are conducting or planning to conduct assessments need to have a broader and more up-to-date view of the changing humanitarian situation in context, which is very dynamic in this part of the Far North.

Beneficiaries

The needs assessment conducted by IMC has led to a better understanding of the need to measure the services offered to the different categories of beneficiaries. First, it is important to take into account existing disparities between host communities and internally displaced communities. This distinction is crucial to enable IMC to address fairly the specific expectations of each group. On the other hand, discussions with adults have revealed the need to pay particular attention to the elderly who have great difficulty surviving in this particularly hostile area of the country. Finally, pregnant women, nursing mothers, children under five, adolescents and teenagers must also receive interventions tailored to their needs.

Equity in interventions is crucial because of the degree of animosity that sometimes leads local populations who find that humanitarian aid is more oriented towards the displaced when they also consider themselves victims of this humanitarian crisis. The insecurity engendered by the terrorist movement Boko Haram and the massive presence of the displaced in their village has aggravated the problems of malnutrition and access to pre-existing care.

B. Protection

Opportunities for protection predominantly exist for girls, women, boys and the elderly. Discussions with participants in the focus groups of girls and women revealed a greater vulnerability of women and girls exposed to prostitution and rape due to famine and widespread insecurity in the intervention. Boys, for their part, are exposed to juvenile delinquency and drug use as a result of unemployment and the virtual absence of school activities. The elderly are seriously threatened by the risk of physical aggression in order to deprive them of their property, especially when they are members of host communities.

In order to succeed in an intervention in the field of protection, International Medical Corps would benefit from harmonizing its efforts with the NGO Intersos which is currently the best

established in protection in the Division of Logone & Chari. In order to make possible this collaboration work, IMC should conduct a comprehensive protection assessment in the Dabanga, Hile Alifa, Biamo, Makary, Mada and GoulfeyGana localities that were the targets of this multisectoral needs assessment. In this way, IMC will be able to refine its analysis and identify precisely the specific needs in the areas of child protection and the fight against gender-based violence for both host populations and internally displaced persons. This in-depth evaluation should be included as a core activity in project proposals that would be drafted in the field of protection. Community-based organizations will also need to be identified and a good platform for collaboration between these organizations, the Divisional Delegations of the Ministry of Social Affairs and the Ministry of Women's Empowerment and the Family will need to be established and regularly facilitated.

Based on the results of a subsequent evaluation, specifically designed for the protection sector for the ongoing analysis of existing gaps, the intervention of International Medical Corps should focus on:

- Identification of separated children and unaccompanied children in displaced communities;
- A comprehensive census of children with special needs;
- The restoration of family ties;
- Re-enactment of birth certificates for children in need;
- Creating, equipping and facilitating activities in child-friendly spaces;
- Establishment of a reference system for survivors of rape;
- The creation, equipping and running of activities in centers for the protection of women and girls;
- Training of displaced communities and host communities on the guiding principles of child protection;
- Training women and girls in income-generating trades to give them autonomy

The localities in which IMC could deploy activities in the field of protection are:

- Mada Health District (Mada Health Areas, Blangoua and Hile Alifa)
- Goulfey Health District (Goulfey, Gana, Afade, and Mara Health Areas)
- Kousséri Health District (Dabanga Health Areas, Madiako, Zimado, Ngodeni, Zina, Pagui)
- Makary Health District (Makary Health Areas, Fotokol, Biamo and Woulky).

C. Water Sanitation and Hygiene

With regard to the mapping of actors and the sectoral analysis WASH made under point VII, it can be realized that the water hygiene and sanitation sector is not yet sufficiently covered in Logone & Chari. Although the field assessment was not thoroughly carried out because of the multi-sectoral nature of this needs assessment, the water and environmental health needs of the communities visited exists. As part of a WASH intervention in Logone & Chari, International Medical Corps will give priority to the construction / rehabilitation of water points, waste management, training of water point management that exists in the communities, and mass awareness campaigns. In urban and semi-urban areas, greater emphasis will have to be placed on waste management at the household and market levels. In rural areas, improving drinking water supply should be the priority. This improvement will mainly involve the rehabilitation of existing infrastructure and the training of households in the treatment of water at home.

The key success factors for an intervention in the WASH sector are mainly a combination of two factors: good involvement of the municipal authorities and a successful collaboration with the district medical officers. Thus the municipal authorities will facilitate the appropriation of measures environmental sanitation at the community level, while district leaders will boost this program in the health structures. In addition, a permanent situational analysis will have to be carried out in order to successfully coordinate actions in this sector. In this respect, there is opportunity for collaboration with the Codas Caritas association, which is about to start a major rehabilitation-construction project of 98 boreholes in the localities of Makary, Fotokol and Blangoua under the financing of UNICEF.

More specifically WASH in Logone & Chari, IMC will:

- Be participating in collaboration with UNICEF and MINEE to continuously monitor the actions taken by the various actors involved or wishing to intervene in the sector;
- Conduct a comprehensive KAP (Knowledge Attitude and Practice) WASH assessment in the health districts of Makary, Goulfey, Mada and Kousséri to identify the current level of coverage for good hygiene practices in displaced communities;
- Focus on strengthening the capacity of health workers and community health workers to improve the response in WASH (sensitization on good hygiene practices, sensitization on home water treatment, waste management in areas The most vulnerable, etc.);
- Improve the supply of drinking water through the rehabilitation of out-of-service water points and the construction of new water points in the health districts of Makary, Kousséri and Mada;
- Identify, create and train management committees for water points in order to ensure the sustainability of constructed and rehabilitated structures;
- Build latrines, incinerators and garbage pits in health facilities and latrines in schools;
- Participate in coordinated evaluations with the Ministry of Health and UNICEF to identify open-air defecation practices in communities to consider CLTS interventions when needed;
- Strengthen community-based surveillance of diarrheal diseases and cholera by identifying and training community volunteers;
- Provide health centers with a washing station with hands and soap;
- Distribute emergency WASH kits to households of IDPs in the four health districts assessed.

In summary, the localities in which IMC would like to deploy activities in the WASH field are:

- Mada Health District (Mada Health Areas, Blangoua and Hile Alifa)
- Goulfey Health District (Goulfey, Gana, Afade, and Mara Health Areas)
- Kousséri Health District (Dabanga Health Areas, Madiako, Zimado, Ngodeni, Zina, Pagui)
- Makary Health District (Makary Health Areas, Fotokol, Biamo and Woulky).

D. Nutrition and food security

The mapping of actors shows that the Goulfey health district is the one for which the nutrition response is weakest in the Logone & Chari Division. The comparative analysis of the prevalence of malnutrition revealed that Goulfey, Dabanga and Mara are the health areas for which the prevalence of severe acute malnutrition among Children aged 6-59 months is at the emergency threshold level. Immediate intervention is therefore required to enable rapid case management. This intervention should also include the health areas of Hile Alifa, Blangoua,

Zimado, Afade, Fotokol and Makary to maximize the nutritional needs of the internally displaced populations and host communities.

The analysis made in the results presentation section also points out that the nutritional responses currently provided by the other actors are mainly focused on the management of moderate malnutrition, with minimal response to malnourished patients with and without complications. The IMC package for intervention in the nutrition sector should focus more on the prevention and management of severe acute malnourished children, pregnant women and nursing mothers.

The recommended approach to ensuring the success of a nutrition intervention in Logone & Chari should be based on the following elements:

- Strengthening the capacity of health workers in identified health centers;
- Establishment of activities to prevent malnutrition in vulnerable communities and in health facilities (ANJE, PFE, BSFP, TSFP, Micronutrient supplementation);
- The intensification of active detection of acute malnutrition through remobilization of health personnel and training of community volunteers;
- Strengthening case management by improving the system for managing stocks of nutritional inputs (plumpynuts, plumpysup, vitamin A, dewormers, etc.) through on-the-job training, data collection, analysis and reporting;
- Strengthening the referral system for cases of malnutrition from the community to OTPs and OTPs to SCs;
- The emergency rehabilitation of the SCs at Makary and Goulfey, which were found to be virtually stationary at the time of the evaluation;
- Strengthening the intersectoral approach by combining WASH, Health and Food Security responses in the nutritional response by planning sensitive and nutrition-specific actions in the different sectors;
- Development of community autonomy in the prevention of malnutrition through culinary demonstrations and learning about the composition of a balanced diet based on local agro-food resources;
- Monitoring of actions and key performance indicators in the management of malnutrition, by updating monitoring and evaluation tools in line with the response environment and the answers provided;
- Participation in the coordination meetings organized by the United Nations agencies obtain up-to-date overview of the nutritional situation of the Far North Region

In summary, the localities in which IMC would like to deploy activities in the field of nutrition are:

- Mada Health District (Mada, Blangoua and Hile Alifa Health Areas)
- Goulfey Health District (Goulfey, Gana, Afade, and Mara Health Areas)
- Kousséri Health District (Dabanga, Madiako, Zimado, Ngodeni, Zina Health Areas)
- Makary Health District (Makary, Fotokol, Biamo and Woulky Health Areas).

E. Reproductive health

Reproductive health care covers a wide range of services defined in the Program of Action of the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in September 1994 as follows:

- Counseling, information, education, communication and family planning services;

- Education and services for prenatal care, safe delivery and postnatal care, mother and child care;
- Prevention and appropriate treatment of infertility;
- Prevention of abortion and management of its consequences;
- Treatment of genital infections, sexually transmitted diseases including HIV / AIDS;
- Prevention, early detection and treatment of breast and genital cancers and any other reproductive health problems;
- Active deterrence of dangerous traditional practices such as female genital mutilation.

For the implementation of all these services, the availability of qualified personnel including specialists (gynecologist-obstetricians, midwives, nurses specialized in reproductive health, etc) is essential, as is the availability of reproductive health medical supplies. Our assessment noted a shortfall in the minimum emergency response service provision in most health facilities. To support the implementation of reproductive health services in the health districts of Logone & Chari, IMC should:

- Emphasize the training of personnel in family planning, post-abortion care, essential care of the newborn, reproductive cancers and the psycho-social and medical management of sexual violence within the framework of the gender-based violence sector;
- Encourage health educators to raise awareness and support mothers in the early initiation of breastfeeding and exclusive breastfeeding during the first six months;
- Strengthen the technical platform of the sanitary facilities by suction cup and aspirator to bring all basic emergency obstetric care
- Provide district hospitals with a blood bank, with the exception of the hospital in Mada that already has them;
- Train doctors at the Makary and Goulfey District Hospital in emergency surgery
- Equip the theatre of the District Hospital of Makary and Goulfey
- Strengthen the availability of medicines and medical supplies for emergency kits (male and female condoms, family planning pills, PMTCT inputs including HIV testing, PEP kits, etc.) in health facilities and communities for free ;
- Training peer educators to raise community awareness of HIV / AIDS and other components of reproductive health and the provision of community-based reproductive health services such as family planning;
- Training of health personnel on the management of chronic diseases, such as high blood pressure and diabetes, which contribute to the reproductive health problems of the elderly;
- Organizing clinics for the provision of primary health care services in remote villages, including reproductive health services;
- Support the Regional Health Delegation for the Far North and the health districts in the implementation reproductive health services, namely formative supervision, monitoring and evaluation, and coordination.

In summary, the localities in which IMC would like to deploy activities in the field of reproductive health are:

- Mada Health District (Mada Health Areas, Blangoua and Hile Alifa)
- Goulfey Health District (Goulfey, Gana, Afade, and Mara Health Areas)
- Kousséri Health District (Dabanga Health Areas, Madiako, Zimado, Ngodeni, Zina)
- Makary Health District (Makary Health Areas, Fotokol, Biamo and Woulky).

F. Mental Health

The evaluation of the hospital structures allowed us to realize generally that the provision of mental health and psychosocial care and services (SMSPS) is not well developed in the health districts of the Logone & Chari Division. To improve the situation, IMC should focus on:

- Training of health personnel in the use of the "mhGAP Intervention Guide to fight Mental, Neurological and Psychoactive Disorders in Non-Specialist Care Facilities";
- The provision of referral hospitals, including district hospitals and the regional annex hospital in Kousséri, specialized psychological and psychiatric staff;
- Improving the reference system between communities and health facilities for nutritional care, mental health care and psychosocial support;
- The provision of mental health medicines and psychosocial support for health care facilities free of charge;
- Implementation of the project for the management of mental illness and community-based psychosocial support by training community health workers;
- Improvement of the mental health information system;
- As with reproductive health services, support activities will also be required.

In summary, the localities in which IMC would like to deploy activities in the field of mental health are:

- Mada Health District (Mada Health Areas, Blangoua and Hile Alifa)
- Goulfey Health District (Goulfey, Gana, Afade, and Mara Health Areas)
- Kousséri Health District (Dabanga Health Areas, Madiako, Zimado, Ngodeni, Zina, Paguy)
- Makary Health District (Makary Health Areas, Fotokol, Biamo and Woulky).

G. Primary Health Care

Primary Health Care at Community Level:

Regardless of the geographical and financial barriers to people's access to care in four districts assessed, strengthening community health care is essential. In order to achieve this, the following actions are recommended:

- The training of community health workers gradually at first, starting with the community IMCI (Integrated Management of Childhood Illness) in support of the main killer childhood diseases (malaria, diarrhea, and respiratory tract infections) and the registration of births and deaths in communities. Gradually we could integrate STI / HIV / AIDS, IYCF, mental health, chronic diseases, psycho-social care of sexual violence etc, in their training agenda. Community Health Agents are already available in all health areas but it is mainly men (70%). These trainings will contribute to the implementation of the community IMCI project, the community-based STI / HIV project and the Chronic Disease and Gender-Based Violence Project.
- Improved permanent availability of inputs for community activities: IMCI inputs, male and female condom for free distribution, injectable Depo-Provera etc.
- Improvement of community-based health services through formative supervision, monitoring and evaluation, coordination and enhancement of stakeholder motivation through financial and non-financial incentives.

Primary Health Care in Health Facilities:

To improve the supply of primary health through health facilities, the organizations should act to strengthen the entire health system. As with the specific case of reproductive health services, they should influence the availability of inputs, human resources in terms of quantity and quality, access to services, their use and continuity and quality. They should contribute to:

- Improve the availability of essential medicines, emergency kits, vaccines and nutritional inputs in health facilities. There is a shortage of a cold chain in the health facilities of the four health districts for the conservation of vaccines and medicines sensitive to heat (oxytocin, SAV, SAT etc);
- Support the Biamo Integrated Health Center with a nurse and a laboratory technician;
- Extending the surveillance project in the health districts of Goulfey and Makary by involving more communities;
- Train or retrain staff on RWIS and / or basic epidemiology
- Organize mobile clinic services that take into account the minimum package of activities of health centers in villages too far from the health facilities. With the Kousseri Regional Annex Hospital , District hospitals of Mada, Makary and Goulfey an ambulance and all the CSIs of (Dabanga, Zimado, Goulfey-Gana, Mara, Biamo);
- Provide the regional hospital adjoining Kousséri and the district hospitals of Mada, Makary and Goulfey in a blood bank and tests for biological examinations for safe transfusion;
- Organize the reference / counter-reference system in health facilities for all pathologies and ensure a rigorous follow-up for cases of malnutrition;
- Strengthen health district capacities (on-the-job training, support for basic medical equipment, joint supervision, revitalization of health committees, etc.)

In summary, the localities in which IMC would like to deploy activities in the field of primary health are:

Mada Health District (Mada Health Areas, Blangoua and Hile Alifa)

Goulfey Health District (Goulfey, Gana, Afade, and Mara Health Areas)

Kousséri Health District (Dabanga Health Areas, Madiako, Zimado, Ngodeni, Zina)

Makary Health District (Makary Health Areas, Fotokol, Biamo and Woulky).

XIV. Annexes

Checklist of services available Kousséri: (IC,O)

	Area/Subsectors			Health Services (RH MISP Services in bold)	CSI DABANGA	CSI ZIMADO
C. Community Care	C0	Collection of Vital Statistics	C01	Deaths and Births	N	N
			C02	Others; e.g populations movements; registry of pregnant women, newborn children	N	N
	C2	Child Health	C21	IMCI community component: IEC of child care taker + active case finding	N	N
			C22	Home-based treatment of: fever/malaria, ARI/pneumonia, dehydration due to acute	N	N
			C23	Community mobilization for and support to mass vaccination campaigns and/or mass drug	Y	Y
	C3	Nutrition	C31	Screening of acute mlanutrition (MUAC)	Y	Y
			C32	Follow up of children enrolled in supplementary/therapeutic feeding (trace defaulters)	Y	Y
			C33	Nutrition (including IYCF) education or counselling	Y	Y
	C4	Communicable Diseases	C41	Vector control (IEC + impregnated bed nets _ in/out door insecticide spraying)	Y	Y
			C42	Community mobilization for and support to mass vaccinations and/or drug	Y	Y
			C43	IEC on locally priority diseases (e.g. TB self-referral, malaria self-referral, others)	Y	Y
	C5	STI and HIV/AIDS	C51	Community leaders advocacy on STI/HIV	Y	Y
			C52	IEC on prevention of STI/HIV infections and behavior change communication	Y	Y
			C53	**Ensure access to free condoms**	N	N
	C6	Maternal & Newborn Health	C61	**Clean home delivery**, including distribution of clean delivery kits to visibly pregnant women, IEC and behavioral change communication, knowledge of danger signs and where/when to go for help, support breast feeding	N	N
	C8	Non-Communicable Diseases and Mental	C81	Promote self-care, provide basic health care and psychosocial support, identify and refer severe cases for treatment, provide needed follow-up to people discharged by facility-based health and social services for people with chronic health conditions, disabilities and mental health problems, IEC materials/CHWs promotion for information	N	N
	C9	Environmental Health	C91	IEC on hygiene promotion and water and sanitation, community mobilization for clean up campaigns and/or other sanitation activities	y	y
	P1		P11	Outpatient services	Y	Y
			P12	Basic laboratory	N	Y
			P13	Short hospitalization capacity (5-10 beds)	Y	Y

P. Primary Health		General	P14	Referral capacity : referral procedures, means of communication, transportation	N	N
	P 2	Child Health	P21	EPI : routine immunization against all national target diseases and adequate cold	Y	Y
			P22	Under 5 clinic conducted by IMCI-trained health staff	Y	Y
			P23	Screening of malnutrition (growth monitoring or MUAC or W/H, H/A)	Y	Y
	P 3	Nutrition	P31	Treatment of moderate acute malnutrition (SFP)	Y	Y
			P32	Treatment of severe acute malnutrition without medical complications (OTP)	Y	Y
			P33	Referral for treatment of acute malnutrition with medical complications to inpatient	Y	Y
	P 4	Communicable Diseases	P41	Sentinel site of early warning system of epidemic prone diseases, outbreak response (EWARN)	Y	Y
			P42	Diagnosis and treatment of malaria	Y	Y
			P43	Diagnosis and treatment of TB	N	N
			P44	Other local relevant communicable diseases (e.g. sleeping sickness, leishmaniasis)	N	Y
	Sexual and Reproductive Health	P5 STI & HIV/AIDS	P51	Syndromic management of sexually transmitted infections	Y	Y
			P52	**Standard precautions**: disposable needles and syringes, safety sharp disposal containers, personal protective equipment (PPE), sterilizer	Y	Y
			P53	**Availability of free condoms**	N	N
			P54	Prophylaxis and treatment of opportunistic infections	Y	Y
			P55	HIV counseling and testing	Y	Y
			P56	Prevention of mother-to-child HIV transmission (PMTCT)	Y	Y
			P57	Antiretroviral treatment (ART)	N	N
		P6 Maternal and Newborn Health	P61	Family Planning including emergency contraception	N	N
			P62	Antenatal care: assess pregnancy, birth and emergency plan, respond to problems (observed and/or reported), advise/counsel on nutrition and breastfeeding, self-care and family planning, preventive treatments as appropriate	Y	Y
			P63	Skilled care during childbirth for **clean and safe normal delivery**	Y	Y
			P64	**Essential newborn care:** basic newborn resuscitation + warmth (recommended method: Kangaroo Mother Care - KMC) + eye prophylaxis + clean cord care + early and exclusive breast feeding **24/24 & 7/7**	Y	Y
			P65	Basic emergency obstetric care (BEmOC): parenteral antibiotics + oxytocic/anticonvulsivant drugs + manual removal of placenta + removal of retained products with manual vacuum aspiration (MVA) + assisted vaginal delivery 24/24 &	N	N
			P66	Post-partum care: examination of mother and newborn (up to 6 weeks), respond to observed signs, support breast feeding, family planning information	Y	Y

			P67	Comprehensive abortion care including post abortion care: safe induced abortion for all legal indications, uterine evacuation using MVA or medical methods, antibiotic prophylaxis, treatment	Y	Y
		P7 Sexual Violence	P71	Clinical management of rape survivors (including emotional/ psychological support)	N	N
			P72	Emergency contraception	N	N
			P73	Post-exposure prophylaxis (PEP) for STI & HIV infections	N	N
			P74	Case management and psychosocial support (social workers)	N	N
	P 8	Non-Communicable Diseases and Mental Health	P81	Injury care and mass casualty management	Y	Y
			P82	Hypertension treatment	y	y
			P83	Diabetes treatment	N	N
				Asthma treatment	Y	Y
			P84	Mental health care: support of acute distress and anxiety that impairs functioning, front line management of severe and common mental, neurological, and drug	N	N
	P 9	Environmental Health	P91	Health facility safe waste disposal and management	Y	Y
S. Secondary and Tertiary Care	S 1	General Clinical Services	S11	Inpatient services (medical, pediatrics and obstetrics and gynecology wards)		
			S12	Emergency and elective surgery		
			S13	Laboratory services (including public health laboratory)		
			S14	Blood bank services		
			S15	X-Ray Services		
	S	Child Health	S21	Management of children classified with severe or very severe diseases (parenteral		
	S	Nutrition	S31	Treatment of acute malnutrition with medical complications (SC/IPF)		
	S 6	Maternal and Newborn Health	S61	**Comprehensive essential obstetric care:** BEmOC + cesarean section + **safe blood transfusion**		
	S 8	Non-communicable diseases and mental	S81	Disabilities and injuries rehabilitation		
			S82	Out-patient psychiatric care and psychological counselling		
			S83	Acute psychiatric in-patient unit		

Checklist of services available Goulfey in 2016: (IC,O)

	Area/Subsectors			Health Services (RH MISP Services in bold)	HD Gouley	CSI Goulfey-Gana	CSI MARA
C. Community Care	C 0	Collection of Vital Statistics	C01	Deaths and Births	N	N	N
			C02	Others; e.g populations movements; registry of pregnant women, newborn children	N	N	N
	C 2	Child Health	C21	IMCI community component: IEC of child care taker + active case finding	N	N	N
			C22	Home-based treatment of: fever/malaria, ARI/pneumonia, dehydration due to acute	N	N	N
			C23	Community mobilization for and support to mass vaccination campaigns and/or mass drug	Y	Y	Y
	C 3	Nutrition	C31	Screening of acute mlanutrition (MUAC)	Y	Y	Y
			C32	Follow up of children enrolled in supplementary/therapeutic feeding (trace defaulters)	Y	Y	Y
			C33	Nutrition (including IYCF) education or counselling	Y	Y	Y
	C 4	Communicable Diseases	C41	Vector control (IEC + impregnated bed nets _ in/out door insecticide spraying)	Y	Y	Y
			C42	Community mobilization for and support to mass vaccinations and/or drug	Y	Y	Y
			C43	IEC on locally priority diseases (e.g. TB self referral, malaria self referral, others)	Y	Y	Y
	C 5	STI and HIV/AIDS	C51	Community leaders advocacy on STI/HIV	N	N	N
			C52	IEC on prevention of STI/HIV infections and behavior change communication	Y	Y	Y
			C53	**Ensure access to free condoms**	N	N	N
	C 6	Maternal & Newborn Health	C61	**Clean home delivery**, including distribution of clean delivery kits to visibly pregnant women, IEC and behavioral change communication, knowledge of danger signs and where/when to go for help, support breast feeding	Y	Y	Y
	C 8	Non-Communicable Diseases and Mental	C81	Promote self-care, provide basic health care and psychosocial support, identify and refer severe cases for treatment, provide needed follow-up to people discharged by facility-based health and social services for people with chronic health conditions, disabilities and mental health problems, IEC materials/CHWs promotion for information	N	N	N
	C 9	Environmental Health	C91	IEC on hygiene promotion and water and sanitation, community mobilization for clean up campaigns and/or other sanitation activities	Y	Y	Y
	P 1	General clinical services	P11	Outpatient services	Y	Y	Y
			P12	Basic laboratory	Y	N	N
			P13	Short hospitalization capacity (5-10 beds)	Y	Y	Y
			P14	Referral capacity : referral procedures, means of communication, transportation	N	N	N
		Child Health	P21	EPI : routine immunization against all national target diseases and adequate cold	Y	Y	Y
			P22	Under 5 clinic conducted by IMCI-trained health staff	Y	Y	Y

P. Primary Health	P		P23	Screening of malnutrition (growth monitoring or MUAC or W/H, H/A)	Y	Y	Y
	P 3	Nutrition	P31	Treatment of moderate acute malnutrition (SFP)	Y	Y	Y
			P32	Treatment of severe acute malnutrition without medical complications (OTP)	Y	Y	Y
			P33	Referral for treatment of acute malnutrition with medical complications to inpatient	Y	Y	Y
	P 4	Communicable Diseases	P41	Sentinel site of early warning system of epidemic prone diseases, outbreak response (EWARN)	Y	Y	Y
			P42	Diagnosis and treatment of malaria	Y	Y	Y
			P43	Diagnosis and treatment of TB	Y	N	N
			P44	Other local relevant communicable diseases (e.g. sleeping sickness, leishmaniasis)	Y	N	N
	Sexual and Reproductive Health	P5 STI & HIV/AIDS	P51	Syndromic management of sexually transmitted infections	Y	Y	Y
			P52	**Standard precautions**: disposable needles and syringes, safety sharp disposal containers, personal protective equipment (PPE), sterilizer	N	N	N
			P53	**Availability of free condoms**	Y	N	N
			P54	Prophylaxis and treatment of opportunistic infections	Y	Y	Y
			P55	HIV counseling and testing	Y	Y	Y
			P56	Prevention of mother-to-child HIV transmission (PMTCT)	Y	Y	Y
			P57	Antiretroviral treatment (ART)	Y	N	N
		P6 Maternal and Newborn Health	P61	Family Planning including emergency contraception	Y	N	N
			P62	Antenatal care: assess pregnancy, birth and emergency plan, respond to problems (observed and/or reported), advise/counsel on nutrition and breastfeeding, self-care and family planning, preventive treatments as appropriate	Y	Y	Y
			P63	Skilled care during childbirth for **clean and safe normal delivery**	Y	Y	Y
			P64	**Essential newborn care:** basic newborn resuscitation + warmth (recommended method: Kangaroo Mother Care - KMC) + eye prophylaxis + clean cord care + early and exclusive breast feeding **24/24 & 7/7**	Y	Y	Y
			P65	Basic emergency obstetric care (BEmOC): parenteral antibiotics + oxytocic/anticonvulsivant drugs + manual removal of placenta + removal of retained products with manual vacuum aspiration (MVA) + assisted vaginal delivery 24/24 &	Y	N	N
			P66	Post-partum care: examination of mother and newborn (up to 6 weeks), respond to observed signs, support breast feeding, family planning information	Y	Y	Y
			P67	Comprehensive abortion care including post abortion care: safe induced abortion for all legal indications, uterine evacuation using MVA or medical methods, antibiotic prophylaxis, treatment of abortion complications, counseling for abortion and post-	Y	Y	Y

		P7 Sexual Violence	P71	Clinical management of rape survivors (including emotional/ psychological support)	Y	N	N
			P72	Emergency contraception	Y	N	N
			P73	Post-exposure prophylaxis (PEP) for STI & HIV infections	Y	N	N
			P74	Case management and psychosocial support (social workers)	N	N	N
	P8	Non-Communicable Diseases and Mental Health	P81	Injury care and mass casualty management	Y	Y	Y
			P82	Hypertension treatment	Y	Y	Y
			P83	Diabetes treatment	Y	N	Y
				Asthma treatment	Y	Y	Y
			P84	Mental health care: support of acute distress and anxiety that impairs functioning, front line management of severe and common mental, neurological, and drug addiction disorders	Y	N	N
	P9	Environmental Health	P91	Health facility safe waste disposal and management	Y	N	Y
S. Secondary and Tertiary Care	S1	General Clinical Services	S11	Inpatient services (medical, pediatrics and obstetrics and gynecology wards)	Y		
			S12	Emergency and elective surgery	N		
			S13	Laboratory services (including public health laboratory)	Y		
			S14	Blood bank services	N		
			S15	X-Ray Services	N		
	S	Child Health	S21	Management of children classified with severe or very severe diseases (parenteral	Y		
	S	Nutrition	S31	Treatment of acute malnutrition with medical complications (SC/IPF)	N		
	S6	Maternal and Newborn Health	S61	**Comprehensive essential obstetric care:** BEmOC + cesarean section + **safe blood transfusion**	N		
	S8	Non-communicable diseases and mental health	S81	Disabilities and injuries rehabilitation	N		
			S82	Out-patient psychiatric care and psychological counselling	Y		
			S83	Acute psychiatric in-patient unit	Y		

Checklist of services available Mada: (IC,O)

	Area/Subsectors			Health Services (RH MISP Services in bold)	FONDATION HELVETIQUE HOPITAL DE MADA	CMA HILE ALIFA
C. Community Care	C0	Collection of Vital Statistics	C01	Deaths and Births	N	N
			C02	Others; e.g populations movements; registry of pregnant women, newborn children	N	N
	C2	Child Health	C21	IMCI community component: IEC of child care taker + active case finding	N	N
			C22	Home-based treatment of: fever/malaria, ARI/pneumonia, dehydration due to acute	N	N
			C23	Community mobilization for and support to mass vaccination campaigns and/or mass drug	Y	Y
	C3	Nutrition	C31	Screening of acute mlanutrition (MUAC)	Y	Y
			C32	Follow up of children enrolled in supplementary/therapeutic feeding (trace defaulters)	Y	Y
			C33	Nutrition (including IYCF) education or counselling	Y	Y
	C4	Communicable Diseases	C41	Vector control (IEC + impregnated bed nets _ in/out door insecticide spraying)	Y	Y
			C42	Community mobilization for and support to mass vaccinations and/or drug	Y	Y
			C43	IEC on locally priority diseases (e.g. TB self-referral, malaria self referral, others)	Y	Y
	C5	STI and HIV/AIDS	C51	Community leaders advocacy on STI/HIV	Y	Y
			C52	IEC on prevention of STI/HIV infections and behavior change communication	Y	Y
			C53	**Ensure access to free condoms**	N	N
	C6	Maternal & Newborn Health	C61	**Clean home delivery**, including distribution of clean delivery kits to visibly pregnant women, IEC and behavioral change communication, knowledge of danger signs and where/when to go for help, support breast feeding	N	N
	C8	Non-Communicable Diseases and Mental	C81	Promote self-care, provide basic health care and psychosocial support, identify and refer severe cases for treatment, provide needed follow-up to people discharged by facility-based health and social services for people with chronic health conditions, disabilities and mental health problems, IEC materials/CHWs promotion for information	N	N
	C9	Environmental Health	C91	IEC on hygiene promotion and water and sanitation, community mobilization for clean-up campaigns and/or other sanitation activities	Y	Y
	P1	General clinical services	P11	Outpatient services	Y	Y
			P12	Basic laboratory	Y	Y
			P13	Short hospitalization capacity (5-10 beds)	Y	Y
			P14	Referral capacity : referral procedures, means of communication, transportation	N	N
		Child Health	P21	EPI : routine immunization against all national target diseases and adequate cold	Y	Y
			P22	Under 5 clinic conducted by IMCI-trained health staff	Y	Y

P. Primary Health	P		P23	Screening of malnutrition (growth monitoring or MUAC or W/H, H/A)	Y	Y
	P 3	Nutrition	P31	Treatment of moderate acute malnutrition (SFP)	Y	Y
			P32	Treatment of severe acute malnutrition without medical complications (OTP)	Y	Y
			P33	Referral for treatment of acute malnutrition with medical complications to inpatient	NA	Y
	P 4	Communicable Diseases	P41	Sentinel site of early warning system of epidemic prone diseases, outbreak response (EWARN)	Y	Y
			P42	Diagnosis and treatment of malaria	Y	Y
			P43	Diagnosis and treatment of TB	Y	N
			P44	Other local relevant communicable diseases (e.g. sleeping sickness, leishmaniasis)	Y	Y
	Sexual and Reproductive Health	P5 STI & HIV/AIDS	P51	Syndromic management of sexually transmitted infections	Y	Y
			P52	**Standard precautions**: disposable needles and syringes, safety sharp disposal containers, personal protective equipment (PPE), sterilizer	Y	Y
			P53	**Availability of free condoms**	N	N
			P54	Prophylaxis and treatment of opportunistic infections	Y	Y
			P55	HIV counseling and testing	Y	Y
			P56	Prevention of mother-to-child HIV transmission (PMTCT)	Y	Y
			P57	Antiretroviral treatment (ART)	Y	Y
		P6 Maternal and Newborn Health	P61	Family Planning including emergency contraception	N	N
			P62	Antenatal care: assess pregnancy, birth and emergency plan, respond to problems (observed and/or reported), advise/counsel on nutrition and breastfeeding, self-care and family planning, preventive treatments as appropriate	Y	Y
			P63	Skilled care during childbirth for **clean and safe normal delivery**	Y	Y
			P64	**Essential newborn care:** basic newborn resuscitation + warmth (recommended method: Kangaroo Mother Care - KMC) + eye prophylaxis + clean cord care + early and exclusive breast feeding **24/24 & 7/7**	Y	Y
			P65	Basic emergency obstetric care (BEmOC): parenteral antibiotics + oxytocic/anticonvulsivant drugs + manual removal of placenta + removal of retained products with manual vacuum aspiration (MVA) + assisted vaginal delivery 24/24 &	N	N
			P66	Post-partum care: examination of mother and newborn (up to 6 weeks), respond to observed signs, support breast feeding, family planning information	Y	Y
			P67	Comprehensive abortion care including post abortion care: safe induced abortion for all legal indications, uterine evacuation using MVA or medical methods, antibiotic prophylaxis, treatment	Y	Y
			P71	Clinical management of rape survivors (including emotional/ psychological support)	N	N

		P7 Sexual Violence	P72	Emergency contraception	N	N
			P73	Post-exposure prophylaxis (PEP) for STI & HIV infections	Y	N
			P74	Case management and psychosocial support (social workers)	N	N
	P 8	Non-Communicable Diseases and Mental Health	P81	Injury care and mass casualty management	Y	Y
			P82	Hypertension treatment	Y	Y
			P83	Diabetes treatment	Y	Y
				Asthma treatment	Y	Y
			P84	Mental health care: support of acute distress and anxiety that impairs functioning, front line management of severe and common mental, neurological, and drug addiction disorders	Y	Y
	P 9	Environmental Health	P91	Health facility safe waste disposal and management	Y	Y
S. Secondary and Tertiary Care	S 1	General Clinical Services	S11	Inpatient services (medical, pediatrics and obstetrics and gynecology wards)	Y	Y
			S12	Emergency and elective surgery	Y	N
			S13	Laboratory services (including public health laboratory)	Y	Y
			S14	Blood bank services	N	N
			S15	X-Ray Services	Y	N
	S	Child Health	S21	Management of children classified with severe or very severe diseases (parenteral	Y	N
	S	Nutrition	S31	Treatment of acute malnutrition with medical complications (SC/IPF)	Y	N
	S 6	Maternal and Newborn Health	S61	**Comprehensive essential obstetric care:** BEmOC + cesarean section + **safe blood transfusion**	Y	N
	S 8	Non-communicable diseases and mental health	S81	Disabilities and injuries rehabilitation	N	N
			S82	Out-patient psychiatric care and psychological counselling	Y	Y
			S83	Acute psychiatric in-patient unit	N	N

Checklist of services available Makary: (IC,O)

	Area/Subsectors			Health Services (RH MISP Services in bold)	HD MAKARY	CSI BIAMO
C. Community Care	C0	Collection of Vital Statistics	C01	Deaths and Births	N	N
			C02	Others; e.g populations movements; registry of pregnant women, newborn children	N	N
	C2	Child Health	C21	IMCI community component: IEC of child care taker + active case finding	N	N
			C22	Home-based treatment of: fever/malaria, ARI/pneumonia, dehydration due to acute	N	N
			C23	Community mobilization for and support to mass vaccination campaigns and/or mass drug	Y	Y
	C3	Nutrition	C31	Screening of acute mlanutrition (MUAC)	Y	Y
			C32	Follow up of children enrolled in supplementary/therapeutic feeding (trace defaulters)	Y	Y
			C33	Nutrition (including IYCF) education or counselling	Y	Y
	C4	Communicable Diseases	C41	Vector control (IEC + impregnated bed nets _ in/out door insecticide spraying)	Y	Y
			C42	Community mobilization for and support to mass vaccinations and/or drug	Y	Y
			C43	IEC on locally priority diseases (e.g. TB self referral, malaria self referral, others)	Y	Y
	C5	STI and HIV/AIDS	C51	Community leaders advocacy on STI/HIV	Y	Y
			C52	IEC on prevention of STI/HIV infections and behavior change communication	Y	Y
			C53	**Ensure access to free condoms**	N	N
	C6	Maternal & Newborn Health	C61	**Clean home delivery**, including distribution of clean delivery kits to visibly pregnant women, IEC and behavioral change communication, knowledge of danger signs and where/when to go for help, support breast feeding	N	N
	C8	Non-Communicable Diseases and Mental	C81	Promote self-care, provide basic health care and psychosocial support, identify and refer severe cases for treatment, provide needed follow-up to people discharged by facility-based health and social services for people with chronic health conditions, disabilities and mental health problems, IEC materials/CHWs promotion for information	N	N
	C9	Environmental Health	C91	IEC on hygiene promotion and water and sanitation, community mobilization for clean up campaigns and/or other sanitation activities	Y	Y
	P1	General clinical services	P11	Outpatient services	Y	Y
			P12	Basic laboratory	Y	N
			P13	Short hospitalization capacity (5-10 beds)	Y	Y
			P14	Referral capacity : referral procedures, means of communication, transportation	N	N
	P2	Child Health	P21	EPI : routine immunization against all national target diseases and adequate cold	N	Y
			P22	Under 5 clinic conducted by IMCI-trained health staff	Y	Y
			P23	Screening of malnutrition (growth monitoring or MUAC or W/H, H/A)	Y	Y

P. Primary Health	P 3	Nutrition	P31	Treatment of moderate acute malnutrition (SFP)	Y	Y
			P32	Treatment of severe acute malnutrition without medical complications (OTP)	Y	Y
			P33	Referral for treatment of acute malnutrition with medical complications to inpatient	NA	Y
	P 4	Communicable Diseases	P41	Sentinel site of early warning system of epidemic prone diseases, outbreak response (EWARN)	Y	Y
			P42	Diagnosis and treatment of malaria	Y	Y
			P43	Diagnosis and treatment of TB	Y	N
			P44	Other local relevant communicable diseases (e.g. sleeping sickness, leishmaniasis)	Y	Y
	Sexual and Reproductive Health	P5 STI & HIV/AIDS	P51	Syndromic management of sexually transmitted infections	Y	Y
			P52	**Standard precautions**: disposable needles and syringes, safety sharp disposal containers, personal protective equipment (PPE), sterilizer	Y	Y
			P53	**Availability of free condoms**	Y	N
			P54	Prophylaxis and treatment of opportunistic infections	Y	Y
			P55	HIV counseling and testing	Y	Y
			P56	Prevention of mother-to-child HIV transmission (PMTCT)	Y	Y
			P57	Antiretroviral treatment (ART)	Y	N
		P6 Maternal and Newborn Health	P61	Family Planning including emergency contraception	Y	N
			P62	Antenatal care: assess pregnancy, birth and emergency plan, respond to problems (observed and/or reported), advise/counsel on nutrition and breastfeeding, self-care and family planning, preventive treatments as appropriate	Y	Y
			P63	Skilled care during childbirth for **clean and safe normal delivery**	Y	Y
			P64	**Essential newborn care:** basic newborn resuscitation + warmth (recommended method: Kangaroo Mother Care - KMC) + eye prophylaxis + clean cord care + early and exclusive breast feeding **24/24 & 7/7**	Y	Y
			P65	Basic emergency obstetric care (BEmOC): parenteral antibiotics + oxytocic/anticonvulsivant drugs + manual removal of placenta + removal of retained products with manual vacuum aspiration (MVA) + assisted vaginal delivery 24/24 &	Y	N
			P66	Post-partum care: examination of mother and newborn (up to 6 weeks), respond to observed signs, support breast feeding, family planning information	Y	Y
			P67	Comprehensive abortion care including post abortion care: safe induced abortion for all legal indications, uterine evacuation using MVA or medical methods, antibiotic prophylaxis, treatment of abortion complications, counseling for abortion and post-abortion contraception	Y	N

		P7 Sexual Violence	P71	Clinical management of rape survivors (including emotional/ psychological support)	Y	N
			P72	Emergency contraception	Y	N
			P73	Post-exposure prophylaxis (PEP) for STI & HIV infections	Y	N
			P74	Case management and psychosocial support (social workers)	Y	N
	P8	Non-Communicable Diseases and Mental Health	P81	Injury care and mass casualty management	Y	Y
			P82	Hypertension treatment	Y	Y
			P83	Diabetes treatment	Y	N
				Asthma treatment	Y	Y
			P84	Mental health care: support of acute distress and anxiety that impairs functioning, front line management of severe and common mental, neurological, and drug	Y	N
	P9	Environmental Health	P91	Health facility safe waste disposal and management	Y	N
S. Secondary and Tertiary Care	S1	General Clinical Services	S11	Inpatient services (medical, pediatrics and obstetrics and gynecology wards)	Y	
			S12	Emergency and elective surgery	N	
			S13	Laboratory services (including public health laboratory)	Y	
			S14	Blood bank services	N	
			S15	X-Ray Services	N	
	S2	Child Health	S21	Management of children classified with severe or very severe diseases (parenteral fluids and drugs, O2)	Y	
	S	Nutrition	S31	Treatment of acute malnutrition with medical complications (SC/IPF)	Y	
	S6	Maternal and Newborn Health	S61	**Comprehensive essential obstetric care:** BEmOC + cesarean section + **safe blood transfusion**	N	
	S8	Non-communicable diseases and mental health	S81	Disabilities and injuries rehabilitation	N	
			S82	Out-patient psychiatric care and psychological counselling	Y	
			S83	Acute psychiatric in-patient unit	N	