The Psychosocial Impact of Parental Loss and Orphanhood on Children in an Area of high HIV Prevalence: a Cross Section Study in the North West Region of Cameroon

A child describes happy and difficult moments of his biography with the help of flowers and

Alice Behrendt & Serigne Mor Mbaye

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As the authors of this report, we are responsible for potential errors in the interpretations of given answers during the interviews and focus group discussions.

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1. Abbreviations and Acronyms

AIDS	Acquired immune deficiency syndrome
ADHD	Attention deficit/ hyperactivity disorder
CDF	Community Development Facilitator
DHS	Demographic and Health Survey
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
FGD	Focus Group Discussion
FHI	Family Health International
HIV	Human Immunodeficiency Virus
NGO	Non Governmental Organization
PTSD	Posttraumatic Stress Disorder
OVC	Orphans and Vulnerable Children
STI	Sexually Transmitted Infection
UNICEF	United Nations' Children Fund

2. Executive summary

Background and objective: According to the 2004 Demographic and Health Survey, the North West Region of Cameroon has the highest HIV prevalence of the country (8.7%) and is therefore home to many children who have lost one or both parents. The purpose of this study was to investigate the psychosocial impact of parental loss and orphanhood on children in this region of the country. The study was part of a regional research project conducted in five countries in West Africa (Togo, Burkina Faso, Cameroon, Sierra Leone and Liberia).

Method: The study was implemented over a two month period in the fall of 2007 in six rural communities in four different districts in the province of Bamenda. The field team, three Cameroonian child psychologists, conducted 18 focus group discussions, 180 individual interviews and 10 case studies. The interviews and focus group discussions were conducted in Pidgin English. The age range of the participating children was from 8 – 18 years. In order to explore the impact of parental loss and orphanhood, we compared four sub-samples: orphans, children without a mother, children without a father and non-orphans. The four groups did not differ significantly in terms of age. All quantitative and qualitative data from the individual interviews were analyzed disaggregated by sex. In the scope of the individual interviews we assessed socio-demographic data including the family situation, distressing life events and their impact, emotional wellbeing, coping and resilience as well as mental health and neuropsychological functions. For the case studies, we used a biographical exercise. The focus group discussions were stimulated with five short stories developed to identify the children's perceptions of their needs for psychosocial support. All severely affected children (*n*=33) identified during the study received individual psychosocial support after the research project over a period of at least three months.

Results: By and large, the group comparisons revealed little differences among the four sub-samples. Neither orphans nor children having lost a mother or a father are disadvantaged compared to non-orphans in terms of

- education level
- emotional well-being,
- pro-social skills and self-esteem and
- exposure to different forms of domestic violence.

Orphaned boys are more likely to present a suicide risk than non-orphan boys. In general, suicidality was low for non-orphans and children having lost a father, but high for orphans and girls having lost a mother.

Certain mental disorders such as post traumatic stress disorder (28%) and depression (45%) were highly prevalent in the total sample. Group comparisons, however, did not show significant differences among the sub-samples of orphans, children having lost one parent and non-orphans. The analysis of risk factors for mental disorders and for low point resilience showed diverse influencing variables. Problems in family affiliations, vulnerable caretakers and high incidence of road accidents are just some examples endangering the mental health of children.

We recorded a very high ratio of physical abuse, verbal violence, and neglect in all groups of interviewed children. The common experience of domestic violence is likely to have the most devastating impact on the mental health of children in the region. The rates of sexual violence are less elevated, but still endanger more than 15% of the interviewed girls and increase their risk for HIV infection. The findings indicate that domestic violence impedes emotional wellbeing and self-esteem, increases suicidality and is closely related to certain mental disorders such as major depressive and post traumatic stress disorder.

Conclusion and recommendations: The findings of the current study show that the communities have regulation mechanisms and social structures that allow well-organized assistance to orphaned children. Although the foster families are not always able to meet all needs of the children, they provide a large amount of support to them. The investigated groups - orphans, children living in single parent household and children with two parents – are practically on equal terms regarding emotional well-being, resilience and mental health. Numerous children are affected temporarily by parental loss, but it just one of multiple factors putting the psychosocial development of children at stake. A particular risk factor for the mental health outcome of children is the high degree of domestic violence in the region. We propose to develop holistic and integrated policies and programs for vulnerable children, rather than an AIDS or orphan specific response. We recommend to focus particularly on (1) strengthening family and community coping mechanisms, (2) providing social support to all children in need regardless of their status, (3) Protecting children from violence and building up their resilience.

3. Background

West Africa has ever-growing numbers of children living in very difficult circumstances. The HIV epidemic and the international concern about orphans have contributed to exposing the plight of children in West Africa who are living on the streets, who are trafficked and/or exploited for child labour, or who are forced into combat in armed conflicts. These difficult living conditions negatively affect children's development and expose them to the risk of domestic violence, discrimination, HIV infection and exploitation.

As programs and initiatives are starting to emerge to address these issues, it is becoming increasingly clear that there is little knowledge about the needs of children for psychological support in West Africa. All available studies have been either conducted in the East or in the South African region. In West Africa, the impact of poverty and other difficult life circumstances on the psychosocial well-being of children has barely been investigated. Existing studies focus more on living conditions than on mental health and coping strategies of the individual and of communities in the West African context. Plan and AWARE/FHI recognize the need to investigate pan West Africa patterns of psychosocial support for distressed children and their families. Thus, the two organizations recruited a regional research team in order to explore how children are affected, in what context and what are good practices to assist these children. The project activities focus on two sections: (1) the assessment of the mental health state and psychosocial needs of children in five different high risk contexts and (2) the analysis of existing services in all countries of the West African region. For the first activity, we conducted in-depth studies in five different countries: communities with high prevalence of child trafficking in Togo, communities with high prevalence of repatriated children in Burkina Faso, communities with high HIV-prevalence in Cameroon and communities affected by armed conflicts in Sierra Leone and Liberia. The current report presents the results from the field study in Cameroon.

3.1 Objectives

The focus of our attention for the study was to assess the mental health of children living in communities with high HIV-prevalence in the North West Region of Cameroon. The overall goal was to develop an inventory of methods and approaches adapted to the specific psychosocial needs of children in this region of the country.

The specific objectives of the study were as follows:

- Describe the mental health state of different groups of children, their resilience and their needs in terms of psychosocial support in relation to their specific life context;

- Assess the incidence of distressing events (including domestic violence), their psychosocial impact as well as the children's coping mechanisms;
- Investigate the differences in reactions of participants according to sex and age;
- Identify perceptions and experiences of orphans and children living in single parent households;
- Ascertain the specific needs of orphans and of children in single parent households in order to improve psychosocial support strategies.

4. Methods

We carried out an extensive literature review and met with representatives of different institutions working on HIV related questions for the preparation of the field study. The findings are presented in two parts: firstly, we summarize findings on the HIV-prevalence and profile in Cameroon and analyze the results of existing studies and reports regarding the psychosocial impact of HIV on children in Africa. Secondly, we present and discuss the results of the field study conducted in the North West region of Cameroon. This report does not include findings of the institutional analysis (second activity axis of the research). They are presented in a different report recapitulating the outcome of the institutional analysis carried out in several West African countries.

4.1 Organization of the field study

4.1.1 Work plan

- Literature review: 1st January to July 2007
- Preparation of the field study (including the recruitment of the researchers and their training): 16th July to 5th August 2007
- Pre-test : The pre-test took place in one community selected by the Plan Bamenda frontline team from 6. – 8th August. The pre-test was followed by a two-day evaluation (9. – 10th August).
- Data collection in six different communities: 11th August to 11th October 2007
- Data transfer from Bamenda to Yaoundé and from Yaoundé to Dakar, Senegal: October – November 2007
- Data entry: December 2007
- Data analysis : January 2008
- Report writing: February 2008
- Study result dissemination: planned for summer 2008

4.1.2 Preparation of the field studies

We recruited a team of three field experts (two women and one man), who were native to the research area and had at least a “maitrise” degree in child psychology. They received 16 days of training, partly in the capital Yaoundé and partly near the area of data collection, in Bamenda city. After the training, we carried out a pre-test of tools and approaches. The training workshop was structured in four sections:

- Study context : appraisal of HIV-situation and the socio-anthropological environment in the study communities;

- Field study approach: approach of communities, target groups and ethical considerations for the project;
- Theoretical background: introduction to child and youth psychopathology, resilience, core mental disorder of children and youth according to DSM -IV and ICD-X;
- Methods: research tools, adaptation and translation in local languages.

After the training, the researchers stayed in the field for two months. They resided during the entire time of the data collection in the study communities in order to be as close to the target population as possible and to gather multiple observations during day to day activities.

4.1.3 Selection of communities for data collection

The project covered one region of the Cameroonian territory. We opted for the North West Region as it represents the region with the highest HIV-prevalence in the country. It is also a program area of Plan Cameroon which facilitated the logistical aspects, the selection of the communities as well as the access to our target populations. Plan's community development facilitators (CDF) and their local partners gave useful information on distances between communities, road conditions and the characteristics of different districts. The selected communities and the number of interviews and focus group discussions conducted are displayed in the following table.

Table 1: Number of interviews and focus group discussion per district and per community

District	HIV prevalence*	Village	Number of interviews	Number of focus group discussions
Ndop	9.4%	Bambalang	29	3
		Bamessing	31	3
		Bafanji	30	3
Bafut	10.4%	Mambu	35	3
Mbengwi	11.1%	Kobenyang	25	3
Boyo	8.2%	Njinikom	30	3
		Total	**180**	**18**

**in pregnant women*

Our *original* intention was to adopt a methodological approach comparing low and high prevalence areas in the North West Region. Plan representatives, NGO and government partners proposed three communities that they considered to have a particularly high HIV prevalence and three communities that they considered to have a low prevalence. It took us several months to obtain HIV surveillance data from ante-natal clinics in the study area from the Department of Social Affairs. When we finally received them, we realized that they only allowed prevalence estimates at district and not at community level, and that the differences in HIV prevalence between the districts were small, covering a range from 8.2% to 11.1%.

Two of the proposed “low prevalence communities” were in the districts with the highest HIV prevalence.

Because of the lack of accurate information about HIV prevalence in the study communities, and because of the small differences between the districts, the intended research design of comparing low and high prevalence communities was no longer feasible. We opted therefore for a comparison of different groups of children in the six selected communities: children having lost both parents (or double orphans as they are often called in the HIV-jargon), children having lost a mother (or maternal orphans), children having lost a father (or paternal orphans) and children with two living parents. By comparing these four groups, we were able to evaluate if orphans or children having lost a parent are more vulnerable to impaired mental health than those growing up with two living parents (see also paragraph 4.4).

4.2 Research tools

The assessment of social variables and mental health was carried out with qualitative and quantitative research instruments. These included participative exercises, standardized questionnaires and semi-structured in-depth interviews. All interviews were conducted in Pidgin English. In order to ensure the data quality, the entire assessment kit was translated from English into Pidgin respecting the following steps: the three Cameroonian psychologists discussed each item and registered it on a taperecorder after having found a consensus. Once the entire toolkit was translated, the field team listened repetitively to the consensus translation before their departure for the data collection in order to ensure an objective application of the tools. A written translation using the back-translation technique was not possible as Pidgin English is an oral and not a transcribed language.

We used the following methods for data collection:

1. Focus group discussions
2. Individual interviews
3. Case studies
4. Observations during the stays in the communities

4.2.1 Focus group discussions

When arriving in a new community, the researchers always started their work by gathering as many children as possible. Once they had assembled a large number of children, they organized games and implemented the focus group discussions (FGD). The tool applied for moderating the FGD aim to stimulate the expression of children regarding their perceptions about adequate means of psychosocial support in different situations of distress. The researcher, taking up the function of the moderator, tells a short story in which a child is suffering from a difficult living situation. After the depiction of the story, the researcher asks

the children to share what kind of feelings the story's main character experiences and what solutions they propose. The exercise contains five different short stories that address the following situations:

- Loss of a parent
- Domestic violence
- Separation from parents
- Serious somatic problems: epileptic crisis (convulsions)
- Difficulties in school

The age of the participating children varied from 8 to 18 years. All children of the village regardless of religion, education level or ethnic groups were invited to participate in the group discussions. An advantage of the FGD is that they do not only permit the collection of information about the children's point of view about their needs in difficult circumstances. The period of FGD is also useful for establishing a relationship with the children in a playful manner and to create an atmosphere of sharing and opening up about difficulties.

4.2.2 Individual interviews

The table below summarizes the objectives and the tools used in the individual interviews. We provide detailed descriptions and psychometric data for each tool in the sections following the table. All tools were integrated in an individual interview. Participants did not have to fill out the questionnaires themselves.

Table 2 : tools used for the individual interviews

	Target indicators	Tool
1	Introduction of the research to parents and the child as well as signature of written consent	Research introduction and written consent record
2	Socio-demographic and background information	Semi-structured interview: Socio-demographic data questionnaire
3	Emotional wellbeing and resilience	Emotional well-being questionnaire of CARE/SCOPE & FHI (Zambia 2003)
4	Potentially traumatic life experiences (life-time and during the last month); identification of most traumatic life event, assessment of current post-traumatic symptoms	UCLA PTSD Index (DSM IV) (Rodriguez, Steinberg et al. 1999) completed by a domestic violence checklist from Catani, Schauer et al. (Catani submitted)
5	Short and long-term memory performance	Complex figure from Rey Osterrieth (see for example Lezak 1995)
6	Strength and difficulties of children	Strength and Difficulties Questionnaire (SDQ) (Goodman 1997)
7	Self-esteem	Rosenberg's self esteem Scale (Rosenberg 1989)

8	Axis I mental disorder of the DSM IV-TR	Structured clinical interview : M.I.N.I. KID English version 5.0 (Sheehan, Shytle et al. 2006)
9	Additional exploration of attitude, feelings and behavior of the child during the interview	Observation sheet

4.2.2.1 Semi-structured interview on socio-demographic data

The socio-demographic interview inquires about basic personal information (e.g. age, village, ethnic group, education level, family status, religion etc.). Furthermore, details on living situation and well-being at home are explored. Certain questions related to the loss of a parent/ parents and changes of life since the loss of a/ the parent(s) were evidently only posed to children who had had this experience. Finally, all children were asked HIV-related questions and perceptions about orphans and their treatment.

4.2.2.2 Emotional wellbeing assessment from CARE/SCOPE & FHI

The emotional well-being is a tool based on 23 questions. Apart from eight (8) open-ended questions, the questionnaire explores 15 structured questions on a 3-point Likert-scale. The answer of the child is matched with one of the three answer options (often, sometimes, never). Further answer options are “I don’t know” or that the child does not answer the question for whatever reason.

4.2.2.3 The UCLA PTSD Index questionnaire for adolescents and a domestic violence checklist

This questionnaire explores the exposure to potentially traumatic life experiences and the degree of post-traumatic stress. The questions assessing PTSD symptoms correspond to the diagnostic criteria of the DSM-IV and provide provisionary information on PTSD-diagnosis. We used this questionnaire to identify the frequency of exposure to stressful events and to evaluate the degree of post-traumatic-stress related to this exposure. The definitive diagnosis of PTSD was established after the application of the M.I.N.I. Kid (see paragraph 4.2.2.7). The UCLA questionnaire is divided in three parts:

- Exposure to traumatic life events (life-time and during the past month),
- Cognitions and emotions during the most distressing event (criterion A of the DSM-IV), and
- Post-traumatic symptoms [measured on a 5-point Likert-scale from 0 (“never”) to 4 (“most of the time”)].

To the first part of questionnaire we added an item-list assessing the incidence of domestic violence developed by Catani (2002) including questions about physical abuse, verbal

violence, neglect and sexual abuse. We extended the list with one question about transactional sex ("*Have you ever made love to someone for gaining money or presents?").*

4.2.2.4 The Rey-Osterrieth Complex Figure: assessment of short and long-term memory performance

The Rey-Osterrieth Complex Figure (Rey 1941, Osterrieth, 1944) is a non-verbal memory performance test. The participant is asked to draw a copy of a complex figure of 18 details that is handed to him (see figure 1). In a second turn, the participant is asked to reproduce the figure from memory without preparation. After a period of 20 minutes, the participant is asked to replicate the figure a third time from memory. We used the scoring system of 36 points from Lezak (1995) for the evaluation of the short and long-term memory capacity. According to Berry et al. (1991) the test has a high inter-rater reliability between 0.91 and 0.98 (cited after Lezak 1995). The retest-reliability of the Rey-figure test is also satisfactory and is estimated to be between 0.60 et 0.76 after Berry, Allen &Schmidt (1991) (cited from Lezak 1995).

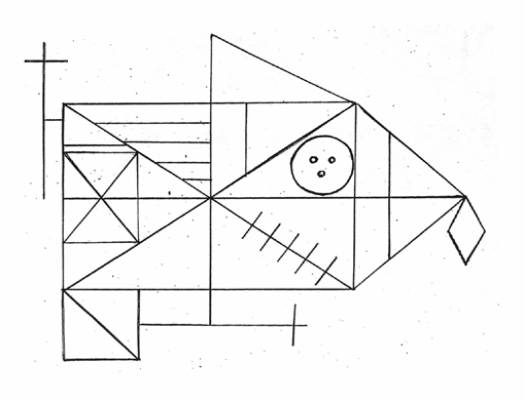

Figure 1: Complex Rey figure (reduced version)

4.2.2.5 The Strength and Difficulty Questionnaire (SDQ) (of Goodman, R. (1997)

The SDQ is a 25 question screening tool exploring strengths and problems of children from 4 to 16 years regarding emotional and behavioral factors. Strengths and difficulties are assessed on five different sub-scales:

- Emotional symptom scale
- Conduct problem scale
- Hyperactivity scale
- Peer problem scale
- Prosocial scale

For each of the scales, five questions are asked to obtain a total score. The psychometric properties of the questionnaire have been evaluated in different studies. The results show

that the validity of the questionnaire (criterion as well as construct validity) and the reliability (internal consistency test-re-test and inter-rater reliability) are acceptable (see for example Goodman 1997; see for example Goodman 1999; Goodman, Ford et al. 2003; Muris, Meester et al. 2003). For more detailed information, we refer to the webpage of the questionnaire: www.sdqinfo.com.

4.2.2.6 The Rosenberg self-esteem scale

The Rosenberg scale is one of the most commonly used tools to measure self-esteem. It has been tested several times in studies in developing countries. In East Africa, for instance, it was used to evaluate the well-being of orphans and vulnerable children (see for example Kiirya 2005). The questionnaire, developed in 1960 by Morris Rosenberg, is composed of 10 items. The response options are organized on a 4-point Likert scale from “strongly disagree” (0) to “strongly agree” (3). Five questions of the tool are positively coded and five negatively. The possible scores range from 0 to 30 points, with a maximum score of 30 points. A high score indicates a high level of self-esteem.
The questionnaire has good psychometric properties with a test-retest correlation ranging from .82 to .84. and an internal consistency from .70 to .90 (see Blascovich & Tomaka, 1993; Rosenberg, 1986; Vallières and Vallerand (1990) for further details).

4.2.2.7 Structured clinical Interview: The Mini International Neuropsychiatric Interview for children and adolescents (M.I.N.I. KID) English version 5.0

We opted for the M.I.N.I. KID for assessing mental disorders. The M.I.N.I. KID is a structured clinical interview to diagnose principal axis I disorders of the DSM-IV (mood disorders, anxiety disorders, substance related disorders, psychotic disorders and certain disorders usually diagnosed in childhood and adolescence). We used the tool in its original form except for one adaptation. Most of the proposed drugs on the substance list are not available in the research area. We therefore substituted a list of locally available drugs, using the names commonly employed in North West Cameroon.

4.2.3 Case studies

We implemented the case studies with the support of a tool named “life-line-exercise”. The tool was developed in East Africa in the scope of psychological assistance to refugee populations (Schauer, Neuner et al. 2004). The exercise represents a playful way of establishing a life trajectory of a child with the help of a rope, flowers and stones (see title page) and facilitates the documentation of important life events of the child in a chronological order. Further information about the method is available in the booklet *“Narrative Exposure*

Therapy. A Short-Term Intervention for Traumatic Stress Disorders after War, Terror, or Torture" (Schauer, Neuner et al. 2004).

4.3 Ethical considerations

Plan obtained ethical clearance for the study from the Ministry of Scientific Research and Innovations in Yaoundé. Furthermore, the research team acquired permission from the village or area chiefs in all communities participating in the research. For participation in an individual interview or a case study, a consent form was signed by all children and by their guardians.

The research project aimed to generate information on the mental health and resilience of children living in communities with high HIV-prevalence. We hope that the results will help develop and improve initiatives and strategies for child protection in rural communities. However, our intention was not restricted to providing information for future programs, but also to make available immediate assistance to severely affected children identified during the data collection. All children identified to be in serious danger at the moment of the interview (for reasons of domestic violence or/and high suicide risk) were systematically integrated in a three-month follow-up project offering psychological and social support.

4.4 Methodological approach for the individual interviews

We conducted individual interviews with 180 children in six communities. Children were recruited at random. The only prerequisites for the recruitment of the participants were the

- availability,
- age between 8 and 18 years and
- written consent given by the children and their guardians.

During the recruitment, we *neither* sought to identify children who appeared to be suffering *nor* to recruit only healthy and happy looking children. All children expressing interest and being available could participate. For data analysis, we assigned the children to the four groups: (1) non-orphans, (2) children having lost a mother, (3) children having lost a father and (4) orphans. In order to avoid misunderstanding about these categories, we give more information on classification criteria in the textbox below. We tried as much as possible to avoid the term "orphan" for children who had lost *one* parent, although this is common practice in the HIV literature. We felt it important to adopt an approach that clearly differentiated orphans from children having lost one parent.

Textbox 2: Terminology applied for the sub-samples used for data analysis

Orphan: a child without biological parents; in most cases both parents have died, but it also includes children with a deceased mother and an unknown father or children with a deceased mother and a father who had disappeared without a trace for several years.

Child without mother/ child having lost a mother: a child whose mother had died and the father is

alive and known. We also classified two children in this category for whom the mother had disappeared without a trace for several years.

Child without father/ child having lost a father: the father of a child was either deceased or had disappeared without a trace for several years. The mother of the child is alive and known. In case that the father was *unkown* but the mother was alive, the child was also assigned to this category. This included five children.

Non-orphan: The child has two living parents whose location was known..

Children in single parent households: To increase the robustness of the analysis, we often combined the categories of children without father and children without mother in the category of *"children in single parent households"*.

We did not classify the children according to the causes of death of their parents because more than 25% of the interviewed children did not know why their parents had died. Many children reported that their parents died after a long illness. This indicates that HIV infection may be an important contributor to parental death in this region.

4.4.1 Exclusion criteria for participation in individual interviews

We excluded all children younger than 8 and older than 18 from participation in the individual interviews. Further exclusion criteria were mental retardation, psychotic disorders or neurological or neuropsychological factors impeding the capacity of the child to answer interview questions.

4.4.2 Approach of the target populations

We used a participative approach for the identification of participants. The researchers emphasized during the games and the focus group discussions that they would like to work with *all* children and not with a specific category. They explained to the children that our objective was to learn more about their experiences, strengths and difficulties. The group activities facilitated the contact with first candidates for individual interviews. After the first interviews, the researchers asked the participants to present them to other children living in other compounds of the community. Another recruitment strategy of the researchers was to spend time in public places (such as markets, sport activities etc.) in order to get in touch and discuss in an informal manner with children. The partaking in day to day talks and debates helped them to identify further interested candidates for individual interviews.

4.5 Data entry and analysis

We explored all qualitative data (case studies, FGD, observation sheets) individually. In a second stage, qualitative data was organized in categories according to relevant topics while taking into consideration socio-demographic variables. This enabled us to identify and

analyze certain tendencies and to characterize and observe common factors in groups of children.

Frequencies and mean values of socio-demographic characteristics and other *quantitative* data were analyzed with SPSS software (Statistical Program for Social Sciences, French version 12.5). For statistical analysis of differences between groups, chi-square tests (nominal data) and *t*-tests and analysis of variance (ANOVA) for independent samples (metric data) were used. When the expected frequencies were lower than 5 for the chi-square tests, the results were controlled with Fisher's Exact-Test. In case of significant differences indicated by the ANOVA, we applied the post-hoc Bonferroni test to explore the differences between groups in detail. When the data did not meet the assumptions of ANOVA or of the independent *t*-test (hypothesis of Gaussian distribution and homoscedasticity), we validated the results with a non-parametric test (Mann-Whitney-*U*-Test for the independent *t*-Test and the Kruskal-Wallis-Test for the ANOVA).

4.6 Difficulties and limits of the study

4.6.1 Methodological difficulties

As explained in section 4.1.3, we initially intended to compare communities with low and high HIV-prevalence. Our first difficulty was to obtain the prevalence data for the communities in the North West Region. It took us several months to obtain the surveillance data. When we received them, we found that they were only available on a district basis and not for individual communities. We therefore changed our strategy and instead analyzed the impact of parental loss by comparing orphans, children living in single parent households and non-orphans. It was not an easy task to assign the children to the four groups. At first, we classified all children where both parents were believed to be alive in the "non-orphan" category. In the same spirit, children with one parent alive were classified in one of the two categories of children living in a single parent household. However, more detailed examination of the sample revealed that some children probably had a *living* father, but that they never knew him. After long deliberations we decided to classify all children whose father was unknown either in the category of "children having lost a father" if the mother was alive, or in the category of "orphans" if the mother was deceased. Obviously, these children do not fully fit in these categories. They have not "lost" their father, but have never known him in the first place. Nonetheless, as the father had no presence in their lives, it would have been inappropriate to classify them in the same category of children who had a relationahip to their father. Without a doubt, not knowing your father is not the same as grieving for a deceased father, but we still felt that all children without a father had a sufficiently common experience to classify them in the same category for the purpose of analysis. We tested this assumption by analyzing both scenarios, one time considering all unknown fathers as "lost fathers" and

another time considering them as being alive. This change in classification did not have a significant impact on the results of the analysis.

4.6.2 Community perceptions about the objectives of the research

Despite our efforts to communicate the research objectives to community leaders, parents and children, they were often misunderstood. Some adults remained convinced that our objective was to identify children for sponsorship by Plan. Others hoped that the participants (and their families) would receive benefits or rewards for participation in the research or for giving the "right" answers. A few community members were also convinced that we were looking for orphans. As a consequence, several parents approached the researchers and requested to include their children in the study. The researchers had to re-explain the project again and again. It was a challenge to convince parents that we were not recruiting children in order to provide material assistance.

4.6.3 Limits of the study

The main limitations of this study are the small sample size and its geographical restriction to one region of the country. The sample is not representative as we focused only on six rural communities in the North West Region of Cameroon. The findings cannot be generalized to the entire Cameroonian territory, and certainly not to other countries. Caution is also warranted for inferences to the situation of children in urban areas.

The sample of 180 children holds neither statistical representativeness for the child population of the North West Region, nor for the orphan population of the country. Many of our findings should not be accepted as conclusive evidence, but rather as hypotheses to be explored in further studies using larger samples.

Another methodological weak point is the disproportionate size of the compared groups: the number of children having lost a father is twice as high as the number of children having lost a mother. The sizes of the non-orphan group and the orphan group are situated in between these two groups. The small number of children having lost a mother prevented us from effecting some calculations. The findings about this group have to be interpreted with particular caution.

The usefulness of the data is further limited by the cross-section design of the study. A more informative study of the potential differences between orphans and non-orphans would have to use a longitudinal study design.

Finally, we relied primarily on oral testimonies, except for the analysis of the drawings in the case studies. Oral testimonies do not forcibly correspond to real facts; they might represent the reality in a distorted manner. Nevertheless, we believe that the children's voiced perceptions, even if they were sometimes misrepresenting the reality, were adequate for the

assessment of their mental health status and for the development of child protection strategies.

The discussed difficulties did not limit the overall validity of the study. Despite the methodological limitations, the study revealed important information about the impact of parental loss on the mental health of children in Cameroon.

The following chapters are structured as follows: Section 5 provides background information about the HIV epidemic in Cameroon. Section 6 presents the results of the field study. In the final sections, we synthesise the results, draw conclusions and develop recommendations for policies and programs.

5. Literature review: HIV and its impact on the life of children in North Western Cameroon

5.1 Prevalence of HIV in Cameroon

The Demographic and Health Survey (DHS) carried out in 2004 reported an overall national HIV prevalence of 5.5% in Cameroon (Institut National de Statistiques 2004). The DHS was conducted with a representative sample of 10,888 participants proportionally selected in all regions of the country. The reported prevalence was on average 3% higher in urban than in rural areas. It also varied significantly from one region in the country to another: the lowest rates were reported in the Northern Region (1.7%) and the Far Northern Region (2.0%). The highest rates were found in the North West Region (8.7%), in the Eastern Region (8.6%), in Yaoundé city (8.3%) and in the South West Region (8.0%).

The results of the DHS confirmed that women are significantly more affected by HIV infection: at national level 6.8% of women were HIV-positive compared to 4.1% of men. In our research area, the North West Region, the reported HIV prevalence among women was 11.9% while it was only 5.2% for men. Other regions that reported a particularly high HIV prevalence for women were the South West (11.0%), Yaoundé city (10.7%), Adamaoua (9.8%) and the Eastern Region of the country (9.4%). Pregnant women were found to have slightly higher HIV prevalence than non pregnant women. Among young people between 15 and 24 years the differences in HIV prevalence rates between males and females was even more pronounced. Nationally, 4.8% of the girls and 1.9% of the boys were reported to be HIV-positive, for a female/male ratio of HIV infection in this age-group of 3.4:1.

Text box 1: HIV/AIDS estimates for Cameroon (National AIDS Control Committee for Cameroon 2008)

Estimated number of **adults and children living with HIV/AIDS**: 588.107
Estimated number of **adults living with HIV/ AIDS** (older than 15 years): 543.294
Estimated number of **children living with HIV/ AIDS** (in the age range from 0-14): 44.813
Estimated number of **death** (adults and children) due to AIDS: 43.632
Estimated number of **orphans due to AIDS**: 305.000
The total population of Cameroon is estimated to be 17,795,000 (Wikipedia 2008)

5.2 Knowledge, attitudes and behavior regarding HIV and AIDS in Cameroon

The 2004 DHS in Cameroon (Institut National de Statistiques 2004) broadly explored knowledge, attitudes and behavior for HIV-relevant questions. Above 98% of the study participants had heard about HIV or AIDS, even though the overall rate in rural areas was

somewhat lower than in urban areas. In the North West Region, our research area, HIV and AIDS are familiar topics to the quasi-totality of the population (99.9%). Countrywide, the means of preventing HIV infection were fairly well known: 62% of women and 75% of men could name condom use and faithfulness as means of prevention. Sexual abstinence was also mentioned by 80% of the participants. Despite a high level of information on how to prevent HIV-infection, incorrect perceptions about how the virus is transmitted are widespread. Only slightly more than 25% of the women rejected the proposal that HIV could be transmitted by supernatural powers or mosquitoes, and knew at the same time that a healthy looking person could still be infected with HIV. Moreover, 35% of the interviewed women believed that HIV could be transmitted by sharing meals with a HIV infected person. Men were better informed than women: 39% rejected the above mentioned false perceptions and were aware that a healthy person could be infected with HIV.

As false perceptions still widely exist throughout the country, it is not surprising that stigmatization of people living with HIV is common. The DHS assessed how participants would behave in the presence of an HIV- positive person. They were asked, for example, if they would buy fresh vegetables from a salesman infected by HIV or if the participants would provide care for a person living with HIV in their home. More than 90% of the women and 80% of the men expressed openly that they tried to have as little contact with HIV-infected people as possible.

HIV-testing is not a common practice in Cameroon. Most of the participants in the DHS had never undergone a HIV-test: only 10% of the women and 14% of the participating men had ever been tested. Potentially risky behavior (sexual intercourse without condom with someone else than the husband/ partner) was reported to be widespread.

5.3 Psychosocial needs of children in the context of HIV in Africa: the point of departure for the current study

The magnitude of the HIV epidemic in Sub-Saharan Africa has deprived many children of their parents. According to UNICEF, 12.1 million children have lost one or both parents due to AIDS in this area of the world (UNICEF 2006). Most of these children are taken care of in the extended family or the community. Usually, grandparents, aunts and uncles become or continue to be caregivers (Foster 2002; Williamson, Foster et al. 2005). The impact of HIV on the social and the mental health status of children has often been explored in studies and project activities. A particular focus in Africa has been the consequences of parental loss and orphanhood on the well-being of children. The findings of these studies as well as reports declaring that the entire African continent is reeling under an “orphan crisis”, however, are ambiguous and not easy to interpret. We will try to present an overview about the situation of the so called “children on the brink” (UNAIDS, UNICEF et al. 2004) in the following paragraphs.

5.3.1 Social impact of orphanhood and parental loss

Several studies confirmed that orphans have been supported well in the past by the traditional social security system. However, more recent studies from regions with prevalence rates above 10% highlight that the steadily rising number of orphans in some communities have lead to severe economic difficulties for foster families. As they struggle to support all children, they tend to disadvantage fostered children and to give better treatment to their biological offspring. In fact, many reports state that orphans are likely to be more exposed to poverty, exploitation, abuse, malnutrition and that they have poorer access to health care and schooling than non-orphans (World Bank 2002; FHI 2003; Tadra 2004; UNICEF 2004; UNAIDS 2006; Ueyama 2007). In 2003, UNICEF reported that orphans are generally poorer and less healthy than non-orphaned children (UNICEF 2003). The analysis of the existing literature, however, clearly shows that results vary across data sources. A study from South Africa, for instant, showed negative relationships between orphanhood and school enrollment and orphanhood and health status (Case and Ardington 2006). Studies from other countries, on the contrary, such as Kenya (health) and Rwanda (school enrollment) could not confirm these findings (Lindblade, Odhiambo et al. 2003; Chatterji, Dougherty et al. 2005). The comparison of orphans and non-orphans by using data from the Demographic and Health Surveys from Sub-Saharan countries could also not reveal significant differences between orphans and non-orphans (Ainsworth and Filmer 2006). Ueyama highlights that longitudinal studies are more likely to detect negative correlations between orphan-status and schooling outcomes than cross section studies. It was also observed that maternal death has a more negative impact than paternal death on school enrolment and health (Ueyama 2007).

5.3.2 Psychological impact of parental loss and orphanhood

Many sources highlight that AIDS related distress of children starts before becoming an orphan. The long exposure to illness and suffering of a beloved person endangers the healthy development of a child. Living with and taking care of parents dying from AIDS can be a source of severe distress. Furthermore, the ill parent(s) might not be able to provide adequate nutrition and care for the child. Children often face the hardship of loosing both parents in a short period of time. The progressive illness or the parental death might lead to school drop out due to the fact that the child has to do farm work in order to contribute to the household income (Germann, Madörin et al. 2001; Mallmann 2003; Ueyama 2007).

The impact of parental loss and possible hardships of life as an orphan on the mental health of children has been investigated with the help of a *comparative* approach in several studies. In these surveys, orphans are matched up to non-orphans in order to be able to evaluate the impact of parental loss. Three studies applying such a design were conducted in Uganda. The first, conducted in 1996 in the Rakai district investigated the psychological effect of

orphanhood in a sample of 193 children. According to their findings, non-orphans were more optimistic about the future while orphans showed significantly higher levels of depression. Despite higher levels of depression, however, orphans reported better adjustment capacity that non-orphans. This result was interpreted as a "benefit-driven" bias: participants, fearing to loose assistance from the NGO financing the study, preferred giving a positive image of the orphaned children (Sengendo and Nambi 1997). The second study, implemented in two districts of Kampala, explored the impact of AIDS-related parental loss on the self-esteem of children and on their sociability at school. A sample of 70 orphans was compared with a sample of 70 non-orphans. Orphans and non-orphans did not differ in terms of interpersonal relationships (sociability) at school; orphans had even slightly higher skills than non-orphans. In terms of self confidence, on the other hand, orphans scored notably lower than non-orphans (Kiirya 2005). In the third study, 123 orphans were compared to a control sample of 110 children in rural Uganda. The age range was from 11 -15 years. The results indicated that orphans have greater level of anxiety, depression and anger compared to non-orphans (Atwine, Cantor et al. 2005).

A study in Tanzania compared 41 orphans aged between 10 and 14 to the same number of non-orphans. The research team found similar results as the third study in Uganda. The orphans scored significantly higher on the applied internalizing problem scale measuring mood, pessimism, somatic symptoms, sense of failure, anxiety, positive affect, emotional ties and suicidal tendencies than the non-orphans (Makama, Ani et al. 2002).

In 2005, a study in Ethiopia tried to compare children orphaned through AIDS to children orphaned through other causes of parental loss. The research team stated, however, that the methodological approach had little validity: many children did not know the causes of death of their parents. The large majority referred to the answer "disease" without being able to state what kind of disease their parents died from. The research team opted therefore for a descriptive approach of the mental health status of orphans due to AIDS and other reasons and compared children having lost one parent with dual orphans. They found that dual orphans had higher grief scores than children having lost one parent. The ratio of major depressive disorder and dysthymia, however was fairly low in the entire sample, a result somehow contesting the commonly stated hypothesis that depression is a main effect of orphanhood (Winkler 2006).

All studies regarding either social or psychological impact of parental loss have been carried out in East and South African countries. The findings of surveys looking into social factors are inconsistent and should rather be presented by country or even by regions within a country. Policy reports generalizing insights from one particular area to the entire African country are misleading. Regarding the studies investigating the psychological impact, the

current HIV prevalence rates of the study countries – Uganda, Tanzania and Ethiopia - are comparable to Cameroon (between 3 – 7%). However, the *specific regions* where the participants were recruited might have considerably lower or higher prevalence rates, or they might be at different stages in terms of the maturity of the HIV epidemic. Furthermore, the household size, the stability of marital unions, the rate of remarriage after divorce or a partner's death, the fostering behaviour and the extended family relationships vary widely across the African continent, and are constantly changing for reasons that are unrelated to HIV. For instance, a 40 country survey of orphanhood and childcare patterns published in 2004 reported 83% of non-orphans in Niger were living with both parents whereas only 26% in Botswana and Namibia (Monasch and Boerma 2004).

The different methodological approaches and different inclusion and exclusion criteria (differing upper age limits, inclusion or exclusion of "partial orphans") make it difficult to draw conclusions from existing studies. In most studies, children having lost one parent are considered as orphans. Research teams explain this choice with a simple reference to definitions used in reports such as "Children on the Brink" (UNICEF 2004). Children are often matched according to their age, but not to their education level. This factor, however, is very likely to influence the comparison. Finally, study participants are often enrolled in assistance programs of NGOs which is likely to bias the answers of the children as well as the behavior of the interviewers.

The common conclusion to be drawn from existing studies is that parental death is likely to endanger, at least temporarily, the development of a child and its mental health. The comparative studies indicate that orphans are more at risk for impairment on some psychological dimensions such as depression, psychosomatic problems or anxiety than non-orphans. The degree of impairment, however, seems to be highly variable.

5.3.3 Existing psychosocial assistance to children in North West Region of Cameroon

After many e-mail exchanges and personal meetings with NGOs and representatives of the Department of Social Affairs, we could not find any evidence of existing psychosocial support services for rural children in North West Cameroon. Even in the regional capital, Bamenda, counseling services are offered exclusively related to HIV-testing and diagnosis. NGOs reporting to provide "psychosocial support" carry out, in reality, programs of a purely social dimension such as offering support in housing, school enrolment or skill trainings. Material and alimentary support (food, blankets and clothes) are also endeavors commonly designated as "psychosocial support to orphans and vulnerable children".

6. Results of the field study

6.1 Socio-demographic information of the interviewed sample

We interviewed 180 children; 80 boys and 100 girls from 8 - 18 years in six different communities in the North West Region of Cameroon. Out of the total sample of 180 children, 34 (19.0%) were orphans (both parents deceased), 21 (11.7%) had lost their mother and 74 (41.3%) had no father because he was deceased, had disappeared a long time ago or was unknown to the child. The remaining 50 children (27.9%) had two living and known parents ("non-orphans"). For the methodological procedure of classifying the children into these four groups, please read section 4.4.

The large number of children without a father is at first surprising, considering the fact that the HIV prevalence among women is estimated to be more than 5% higher than among men. It is, however, a common finding throughout Africa. Fathers are on average older than mothers, and young adult men have higher non-AIDS age-specific mortality rates than young adult women (Hosegood, Vanneste et al. 2004).

Furthermore, it is very common in the study area that men, regardless of their religion, get married to or are associated with up to seven wives. A Christian man, for instance, can be married at church to one wife, but opt for polygamous marriage during the civil ceremony and can have afterwards as many civil weddings as he wants. In Bamenda province, people commonly use the word "concubine" to designate a second wife or a third wife married to a Christian. The children of the "concubines" often grow up in different households without knowing each other. Hence, if one polygamous family chief dies, more than 30 children may lose their father. Eight children enrolled in the study (4.5%) had no known father. More precisely, the mothers of these children were not able to state the identity of the father or chose not to disclose his identity. Such cases, evidently, are much less likely to be found in the group of children having lost a mother.

All children enrolled in the study were able to state their age. The age range of the participants was from 8 – 18 years, with an average age of 13.2 years. The education level of the enrolled children varied from 1 -13 years of schooling.

The average number of years of school enrolment was 7.1 years. Girls had slightly longer school enrolment than boys (7.3 years vs. 6.9 years), but the difference was not significant. At the moment of the data collection, 14.4% of the participating girls and 15.0% of the boys had dropped out of school. The majority of children who were in school attended government (71.8%) and mission schools (23.0%). The remaining 5% wee enrolled in private or vocational schools. None of the interviewed children has been to a koranic school. The great

majority of participants were Christians (90%). The following tables show socio-demographic variables for the four groups of children in the study.

Table 3: *Socio-demographic variables (girls)*

Socio-demographic variables	Total sample (girls) (*n* = 100)	Girl non-orphans (*n* = 31)	Girls without mother (*n* = 10)	Girls without father (*n* = 39)	Girl orphans (*n* = 19)
Age					
Mean	13.5	13.7	13.0	13.4	13.7
Standard deviation	2.70	3.05	3.33	2.47	2.26
Range	9-18	9-18	9 – 18	9 – 17	10 – 18
Average education level (in years)					
Mean	7.3	7.1	6.6	7.2	8.3
Standard deviation	2.55	2.81	2.91	2.33	2.34

Table 4: *Socio-demographic variables (boys)*

Socio-demographic variables	Total sample (Boys) (*n* = 80)	Boy non-orphans (*n* = 19)	Boys without mother (*n* = 11)	Boys without father (*n* = 35)	Boy orphans (*n* = 15)
Age					
Mean	12.4	12.6	12.6	13.5	13.0
Standard deviation	2.24	2.47	2.46	1.85	2.45
Range	8 -18	8-17	8 – 16	10 – 18	10-18
Average education level (in years)*					
Mean	6.9	6.7	6.8	7.0	7.0
Standard Deviation	2.10	2.82	2.09	1.92	1.56

All but one participant were presently residing in rural communities. About one quarter of the children had grown up in a different community (25.6%) than their current residence. Girls (36%) were significantly more likely to have changed their home since childhood than boys (12.5%) ($\chi^2(1) = 12.90$; $p \leq 0.01$). Table 5 shows that the proportion of the girls who had changed their residence did not differ significantly among the four groups ($\chi^2(3) = 0.78$; $p > 0.05$). Among boys, change of residence was more common among orphans than among the other three groups, however, just above the limit of statistical significance ($\chi^2(3) = 7.61$; $p > 0.05$).

Table 5: proportions of children having changed communities at least once since childhood

	Total sample (n = 180)	*Girls (n = 100)*	*Boys (n = 80)*
Orphans	34.4%	36.8%	33.3%
Children without mother	19.0%	30.0%	9.1%
Children without father	24.3%	41.0%	5.7%
Non-orphans	25.0%	32.3%	10.5%

Most participants grew up in rural areas, although an important proportion of girls grew up in cities (25%). Boys were considerably less likely to have grown up in urban areas than girls (7.5%) ($\chi^2(1) = 9.55$; $p \leq 0.01$).

A few children had already started exercising a trade, with equal proportions for boys and girls (11%). All working girls were involved in the farming and trade activities of their families. The majority of boys also worked as farmers with three exceptions (a baby sitter, a potter and a welding apprentice). Only one of the girls in the study was already married and only one participant, also a girl, had a baby.

6.1.1 Comparability of the four groups: orphans, children having lost their mother, children having lost their father and non-orphans

As described in the methodology section, we did not match children according to their education level or their age. The analysis of variance (ANOVA) confirmed that the four groups did not differ significantly in terms of age: neither for girls ($F(3) = 1.78$; $p > 0.05$), nor for boys ($F(3) = 1.73$; $p > 0.05$). The age distribution between boys and girls in the entire sample was also the same ($t(178) = 1.42$; $p > 0.05$).

As it is often reported that orphans have a lower education level than children living with one or both of their parents (UNICEF 2003; Ueyama 2007), we compared the education level of the different groups of children in our study, disaggregated by sex. The results do not show any difference in education levels (measured in number of years in school) among the four groups. We found that neither orphans nor children growing up in single parent households were disadvantaged in terms of school enrollment duration compared to non-orphans [for girls: ($F(3) = 1.36$; $p > 0.05$) and for boys ($F(3) = 0.08$; $p > 0.05$)].

6.1.2 Ethnic groups represented in the interviewed sample

The Cameroonian territory is native to more than 253 different ethnic groups. Out of this number, 13 were represented in the interviewed sample. The figure below displays the ethnic distribution of children in the study. The largest groups were the Bafut, Nsei and Chufie.

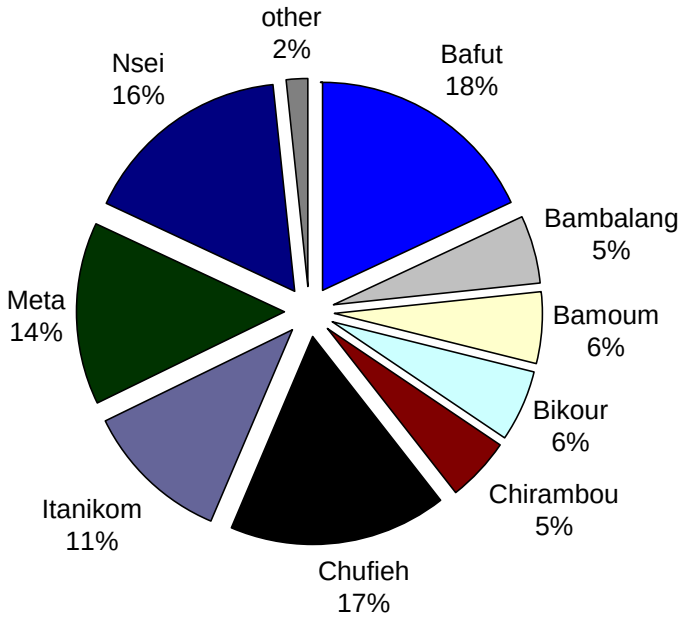

Figure 2: repartition of represented ethnic groups

6.2 Household and family situation

More than half of the children (50.6%) lived with one or both parents; 15% resided with both parents, 33.3% lived with their mother and 2.2% lived with their father. Another large proportion (42.8%) lived with relatives, such as grandparents, step-mothers, aunts and uncles. Among the groups of relatives, grandparents played the most important role in fostering children: more than 50% of the fostered children lived in their care. Older brothers or sisters were the guardians of 9.2% of the fostered children in the sample. Thus, the large majority of children (more than 96%) were residing with a closely related family member. However, a child in Cameroon naming an “aunt” or a “grand-mother” as a guardian is not necessarily applying the Western meaning of these terms. In many cases, there is no biological relationship or only a remote relationship between a child the guardian. A “grand-mother” may be a “concubine” of the deceased grandfather with no biological link to the specific child at all. An “aunt” may be, for instance, the sister of the wife of a cousin or the sister of a “concubine” of the father. Children who have lost their mother usually live with other relatives and only in less than 10% of the cases with the father. Most children, however, having lost a father lived with their mother (70%).

The death of a parent is not the only reason for confiding a child to a member of the extended family: one quarter of the non-orphans were fostered by relatives although they had two living parents. Non-orphans are fostered for diverse reasons such as divorce, chronic

illness, physical handicaps or migration of parents, the need for domestic labor support in another family or for facilitating access to education and socialization for the children. In total, 48.6% of children in the study lived in foster care in the extended family and not with one or both of their biological parents. As expected in an area with high HIV-prevalence, the proportion of fostered children was considerably higher than in Burkina and in Togo where respectively 26% and 33% of the participating children resided in foster care at the time of our data collection.

Most of the children with one or two deceased parent(s) attributed the death of their parent(s) to a long illness (45.5%). The children often did not know what illness their parent(s) died of or they listed vague symptoms such as respiratory or stomach problems. A few children named malaria, hypertension, heart problems or cancer as the cause. Only one child named the long illness as AIDS. Some children (5.8%) recounted that their parent died of a sudden complaint such as headaches, fever or coughing. Other frequently reported death causes were accidents (5.0%), witchcraft (12%) or poison (4.1%). More than one quarter of the children stated that they were not informed about the cause of their parent's death. This knowledge, however, seemed important for the children. To an open question inquiring about what they would like to know about their deceased parents, a large majority replied that they were longing to find out the real cause of their deaths.

Beside ordinary funeral ceremonies, some families (13.2%) organized rites for easing the suffering of the children about the loss of their parents. These ceremonies did not seem to be linked to a specific ethnic group or locality as they were spread arbitrarily over the sample. Many of the ceremonies include purification rituals performed by traditional healers using herbal medication for washing away the grief. Special dishes for remembering the deceased and creation of memorials were also named as rituals to ease the pain of loosing a parent. The quotes below illustrate the diversity of the rites and their potential as resources for assisting children in their grieving process after the death of a parent:

- *"My aunt prepared a special dish with enough egusi [melon seed], but without salt and we children were asked to eat it as a special sign designated to our deceased father." (girl having lost a father, 16 years, Bafanji)*
- *"All my uncles and aunts were called to meet together with the family after the death of our mother. When everybody had arrived, we were given some traditional medicine. They told us to chew it and afterwards, they sprinkled wood ash over us." (orphan girl, 10 years, Kobenyang)*
- *"We all came together. Some powder was mixed with water in a calabash. We were asked to drink it. Afterwards we were taken to the river and bathed with cold water." (girl having lost a mother, 18 years, Mambu)*
- *"After the death of our father, a traditional doctor brought a mixture of medicine in a calabash. Our mother and all the children were washed with the liquid from that calabash and then we were forbidden to take another bath for the next two days in memory of our father." (girl having lost a father, 13 years, Bafanji)*
- *"Our aunts and cousins shaved our hair and rubbed our faces with oil. Then, they placed two plantain stems next to each other. We were then asked to walk across the two stems." (orphan girl, 16 years, Bafanji)*

- *"We were made to work a ridge on our father's land as a means of always remembering him and as a symbol for our loss." (orphan boy, 15 years, Bamessing)*
- *"Special woods were socked in water and rubbed on our faces in order to help us to forget about our parents." (orphan girl, 10 years, Mambu)*

Table 8 presents the children's answers to the question about what they missed most about their deceased parent or guardian. Most answers fell into the category of missing the love, affection and advice from their deceased parent. Other frequent answers were related to problems of satisfying basic needs (food, clothes) or of coping with school related costs (text books and other materials, school fees). While girls grief more for the loss of gifts and affection, boys deplore more often the lack of help in school related costs.

Table 8: What children miss most since the death of their guardian?

What I miss most	Total of children having lost a parent (total) (*n*=120)	Girls only (*n*=63)	Boys only (*n*=57)
Gifts	9 (7.5%)	7 (11.1%)	2 (3.5%)
affection, love, advice	44 (36.7%)	26 (41.3%)	18 (31.6%)
basic needs	21 (17.5%)	10 (15.9%)	11 (19.3%)
play, fun, stories	4 (3.3%)	3 (4.8%)	1 (1.8%)
help in school related costs	33 (27.5%)	10 (15.9%)	23 (40.4%)
Nothing	9 (7.5%)	7 (11.1%)	2 (3.5%)

6.3 Perceptions of and about orphans: are they treated differently?

The majority of participants (62.2%) declared that orphans and children from families affected by AIDS are treated differently than other children. "Treated differently" implied discriminative or harmful treatments such as harder work and exposure to domestic violence. More than half of the participating orphans stated that they often felt subjected to discrimination and declared that, as a consequence, they felt sad, distressed and isolated. Several children of the non-orphan group, however, stated that they felt that orphans were treated nicer and received more support than the other children.

6.4 Emotional wellbeing

Almost 75% of the children stated that they were either "very happy" (32.8%) or "happy" (40.4%) in their current home. The remaining 25% reported to be "sad" (20.6%) or "very sad" (6.7%). This was apparently unrelated to parental loss: as depicted in Figure 3, there were no significant differences between orphans, children growing up in single parent households and non-orphans, neither among girls ($F(3) = 1.60$; $p > 0.05$), nor among boys ($F(3) = 2.13$; $p > 0.05$). The most important factor determining the children's happiness with their current living

arrangement was the level and type of domestic violence. Children that were subjected to ongoing physical abuse ($t(178) = 2.01$; $p \leq 0.05$), to ongoing verbal violence ($t(178) = 2.16$; $p \leq 0.05$), and/ or to ongoing neglect ($t(178) = 6.85$; $p \leq 0.01$) reported significantly more often to be unhappy than children not subjected to this kind of treatment. Overall, girls were significantly less likely to be happy in their current households than boys ($t(178) = 2.70$; $p \leq 0.01$).

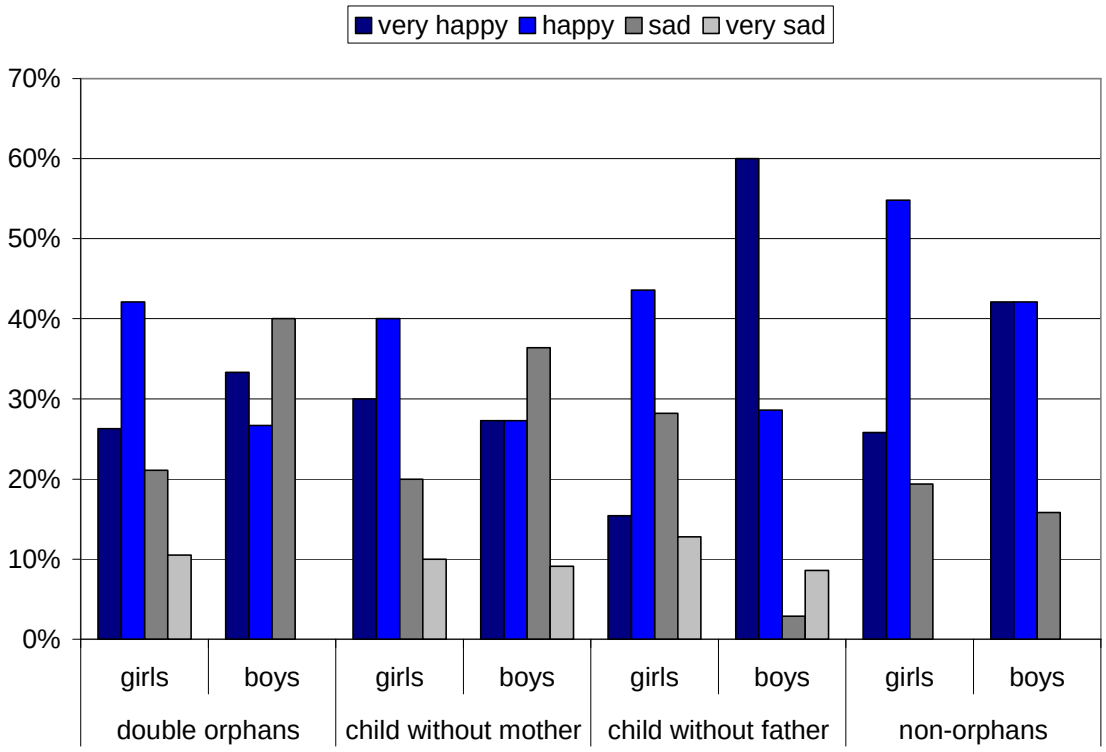

Figure 3: degree of satisfaction of different sub- samples at home

In spite of the considerable proportion of children who reported to be unhappy at home, the large majority of children (88.3%) declared to have at least one person in the family offering love and protection. The protecting person was often the mother or the step-mother (29.6%), one of the grandparents (27.6%) or another adult of the family like an aunt or an uncle (16.4%). Brothers and sisters also played an important role for the affective care; for 20% of the children they were the focal point for love and affection. Fathers were only named by 5% of the children which might be due to some degree to the large number of children who did not have a father. Only four children (2%) named a non-relative as their main protector.

If the children faced problems or needed advice, they were most likely to consult their mother (37.1%) or another member of the extended family (39.3%). This was particularly true among boys, while girls were somewhat more likely to confide problems to a sibling or to a friend.

6.4.1 What makes you happy?

We classified the responses of the participants to the question “What makes you happy” in six categories : love and affection in the family, school participation, satisfaction of basic needs and receiving gifts, playing/ being with peers, good health and church activities. The results are presented in Figure 5. The most frequent source of happiness is related to the participation in school (35.3%). The simple fact of being in school, of having one’s school fees paid, of receiving text books or succeeding in exams is a paramount source of well-being for children. The second important source of happiness is leisure time with peers (23.5%), followed by receiving gifts and satisfaction of basic needs, including having enough to eat, receiving new clothes or household material (20%). The answers of boys and girls differed significantly. For girls, care and affection in the family, receiving gifts, and satisfying their basic needs were the most important sources of happiness, whereas for boys the company of peers was the most commonly cited source of happiness.

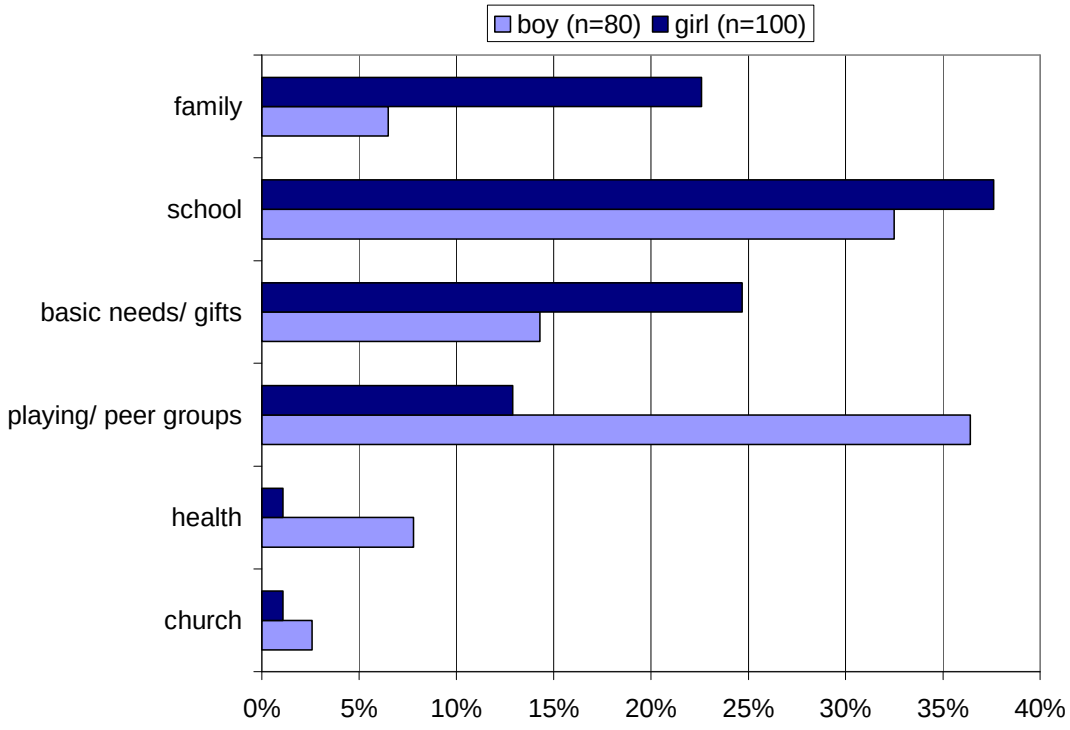

Figure 5: What makes you happy?

6.4.2 What worries you most?

Many children (86%) stated that they were worried sometimes or most of the time. We asked them to share the causes of their anxieties and clustered the responses in seven categories. Eight children gave multifaceted answers and were not retained in the analysis. The most common source of preoccupation was the death of a relative (24.3%). This was particularly common among children in single parent households. 33.9% of children who had lost a father

and 33.3% of children who had lost a mother stated that the grief for their parent's was the main reason for their worries. In the group of orphans, a smaller proportion (20%) of the children listed grief for a parent as the main cause of worries. Even in the group of non-orphans, the death of a relative accounted for the main source of worries among 6.3% of the children. The next important sources of disquiet were apprehensions about the future (15.7%), difficulties in school (15.0%) and health problems of the children themselves or of a family member (12.4%). Further common worries were related to the lack of food and clothes (12.1%), domestic violence at home (11.4%) and conflict within the family or with peers (8.6%). The comparison of boys and girls showed once more substantial differences (see Figure 6). Girls were three times more often troubled by the loss of a parent than boys, and their worries were more often related to domestic violence and family conflicts. The main concern of boys was their future. They feared lack of success in school or in learning a job. Compared to girls, they were twice as often anxious about lacking in basic living resources.

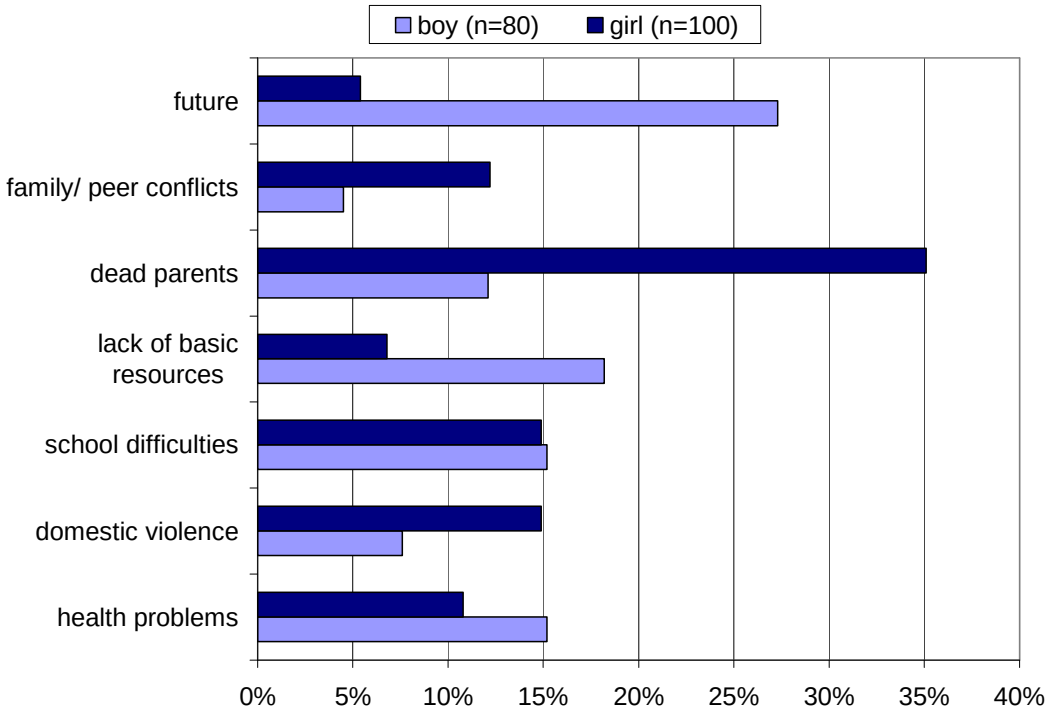

Figure 6: Factors that worry children most

6.4.3 Other factors determining the wellbeing of children

The factors analyzed regarding the emotional wellbeing of children are summarized in table 9. The proportion of children reporting to be sometimes or often unhappy is 97.2% in this study. This is a higher proportion than we found in our studies in Burkina Faso (85.6%) and in Togo (92.1%) where we applied the same questionnaires. Profound unhappiness, however, as signified by the statement that they were *never happy* was les common in Cameroon (1.1%) than in Burkina Faso (3.9%) and in Togo (3.3%).

Comparing the four groups we found little variation in the factors that impaired a child's wellbeing. Among girls, we did not detect any significant differences between orphans, children living in a single parent household and non-orphans. Among boys, only one difference regarding one specific factor (happiness) reached significance: The post hoc test Bonferonni showed that the positive result of the variance analysis was due to a significant difference between non-orphans and boys without father ($F(3,75) = 3.56$; $p \leq 0.05$; Bonferonni: $p \leq 0.05$): boys having lost a father were significantly less happy than non-orphan boys. There were, however, no further notable differences between the other groups of boys.

The comparison of girls and boys indicated that the sexes did not differ in terms of the variables of *being unhappy*, *being worried, being content, having fear of new situations, trouble sleeping* and *having difficulties to make friends*. Nevertheless, considerable differences were apparent on the scale of *being angry*, *wanting to run away from home* and of *feeling hopeful about the future*. Boys were significantly more likely to become angry about the difficulties in their lives, while girls expressed more hope about their future (see Table 9). Girls were more likely to think about running away from home and they also had a considerably higher record of putting their thoughts into action: 35.3% of the interviewed girls compared to 21.1% of the boys had already run away from home at least once in their life, and in at least half of the cases several times. The reasons for running away were usually linked to unbearable domestic violence driving children from their homes to seek refuge with relatives or friends.

Table 9: Analyzed factors regarding the wellbeing of children

Factors of wellbeing	Total sample	Girls	Boys	Difference between boys and girls
Being unhappy				No significant differences
Often	36 (20.2%)	25 (25.3%)	11 (13.9%)	($t(176) = 0.93$; $p > 0.05$)
Sometimes	137 (77.0%)	69 (69.7%)	68 (86.1%)	
Never	5 (2.8%)	5 (5.1%)	0 (0.0%)	
Being worried				No significant differences
Often	46 (25.7%)	22 (22.0%)	24 (30.4%)	($t(177) = 1.89$; $p > 0.05$).
Sometimes	108 (60.3%)	60 (60.0%)	48 (60.8%)	
Never	25 (14.0%)	18 (18.0%)	7 (8.9%)	
Being content				No significant differences
Often	33 (18.4%)	23 (23.0%)	10 (12.7%)	($t(177) = 1.36$; $p > 0.05$)
Sometimes	144 (80.4%)	75 (75.0%)	69 (87.3%)	
Never	2 (1.1%)	2 (2.0%)	0 (0.0%)	
Being angry				Boys more often angry than girls
Often	11 (6.2%)	5 (5.1%)	6 (7.6%)	($t(175) = 2.45$; $p \leq 0.05$)
Sometimes	153 (86.4%)	81 (82.7%)	72 (91.1%)	
Never	13 (7.3%)	12 (12.2%)	1 (1.3%)	
Fear of new situations				No significant differences
Often	19 (10.7%)	15 (15.2%)	4 (5.1%)	($t(175) = 1.80$; $p > 0.05$)
Sometimes	122 (68.9%)	66 (66.7%)	56 (71.8%)	
Never	36 (20.3%)	18 (18.2%)	18 (23.1%)	

Trouble sleeping				No significant differences
Often	16 (8.9%)	7 (7.0%)	9 (11.4%)	(*t*(177) = -1.21; *p* > 0.05)
Sometimes	102 (57.0%)	56 (56.0%)	46 (58.2%)	
Never	61 (34.1%)	37 (37.0%)	24 (30.4%)	
Difficulties making new friends				No significant differences
Often	15 (8.4%)	12 (12.0%)	3 (3.8%)	(*t*(177) = -0.74; *p* > 0.05)
Sometimes	52 (29.1%)	25 (25.0%)	27 (34.2%)	
Never	112 (62.6%)	63 (63.0%)	49 (62.0%)	
Being hopeful				
Often	56 (31.5%)	44 (44.4%)	12 (15.2%)	Girls more hopeful than boys
Sometimes	104 (58.4%)	43 (43.4%)	61 (77.2%)	(*t(176*) = -2.74; *p* ≤ 0.05)
Never	18 (10.1%)	12 (12.1%)	6 (7.6%)	
Wanting to run away				Girls more likely to think about running away
Often	11 (6.4%)	10 (10.6%)	1 (1.3%)	(*t*(171) = 2.22; *p* ≤ 0.05)
Sometimes	43 (24.9%)	24 (25.5%)	19 (24.1%)	
Never	119 (68.8%)	60 (63.8%)	59 (74.7%)	

6.5 Self esteem and pro-social skills

We evaluated the self-esteem of children with help of the Rosenberg questionnaire. In general, boys reported significantly higher self esteem than girls *(t*(177) = 7.30; *p* ≤ 0.01). These findings are in line with results from our study conducted in Togo, and also with some surveys in Western settings (Bagley, Bolitho et al. 1997; Chabrol, Carlin et al. 2004; Behrendt and Mbaye 2007).

Children living in single parent households and orphans did not score lower on self-esteem than non-orphans. As presented in Figure 7, differences between non-orphans, children living in single parent households and orphans were neither significant for girls *(F*(3) = 1.13; *p* > 0.05) nor for boys *(F*(3) = 0.32; *p* > 0.05).

Apart from self esteem, we also explored prosocial skills of children in the scope of the assessment of their resilience. Pro-social skills were measured by the "prosocial-scale" of Goodman's Strength and Difficulty Questionnaire (SDQ). Almost all children, 94% of the girls and 97.5% of the boys, are within the range of average scores for pro-social skills and score higher than the cut-off score proposed by the author of the questionnaire. Only 6% of the girls and 2.5% of the boys showed limited social competence in their interactions with other children and adults. Group comparisons between orphans, children living in single parent households and non-orphans do not show any significant differences in prosocial competence. (Figure 7)

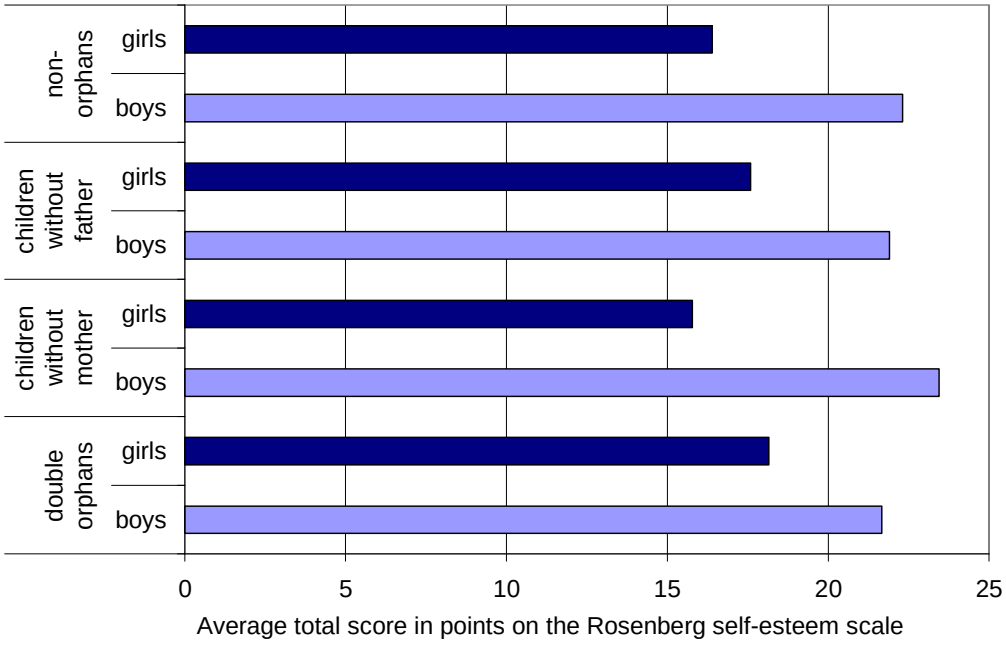

Figure 7: Total score of the Rosenberg self esteem questionnaire for the different groups of children

6.5.1 Influencing and correlating factors of self esteem

Among the children in the study, we did not find a correlation between self esteem and education level, nor a correlation between self esteem and age. Certain types of domestic violence played a more important role: the self-esteem score of currently neglected children was significantly lower than the score of non neglected children ($t(177) = -4.59$; $p \leq 0.01$). Moreover, children with lower self esteem were also more likely to be found in the category of severely mentally affected children. A high level of post-traumatic stress was significantly correlated with low self-esteem (Pearson $r = -.511$; $p \leq 0.01$). Not surprisingly, low self esteem was also significantly correlated with elevated suicide risk (Pearson = -.223; $p \leq 0.01$). Finally, children in the sample who had signs and symptoms of major depressive disorders had significantly lower levels of self esteem compared to children without depression ($t(176) = -4.26$; $p \leq 0.01$).

6.6 Suicidality

Thoughts about committing suicide were quite common among the children in the sample: more than 40% of the participants had already felt so bad on at least one occasion in their life that they wished to be dead. The children shared how suicidal ideas crossed their minds in particularly difficult moments of life. The fear of pain usually prevented them from taking action in these situations and limited their despair to mere thinking about suicide.

- *"I don't have enough food to eat; my school fees are not paid on time; I put on torn dresses and all this makes me feel that life is not worth living. It hurts me so much, especially when my aunt insults me, reminding me every day that I am going to die just like my mother [as a prostitute]. Last time when she insulted me I thought of falling in a well and of drowning myself to death". (girl having lost her mother, 13 years, Bafanji)*
- *"They have already shown me that I am different from other children. I don't eat the same food with them and everything I do is considered to be wrong. I think it is better to lie on the road and to have a car run over me." (orphan girl, 16 years, Bafanji)*
- *"I love my grandmother so much and I see her suffering to take care of my brother and me while my uncles are controlling my father's heritage and provide everything for their own children. I just think, it is better I'd die and leave the old woman in peace. What keeps me alive today is that I ask myself who will assist my grandmother in household chores once I am gone. For me, life is meaningless". (orphan girl, 14 years, Bamessing)*
- *"One morning, after a serious beating from my father, we left for school. When passing by the lake, this idea came to my head; jumping into the lake and to be eaten up by fish. I become scared of the idea and stopped. If there was a way of dying without feeling pains, I would have given an end to my life because I suffer a lot". (non-orphan girl, 18 years, Bambalang)*
- *"It is just as the world's bad luck has been poured on me. Anything I try to do is a failure. My father brought shame to our family by abandoning us and disappearing to an unknown area. When I think of my life and imagine that nothing good will come out of it, I think about killing myself. It is just because I have pity for my mother – otherwise I would have hung myself using a nylon rope on a tree. » (girl without father, 17 years, Njinikom)*

Thoughts about suicide do not signify that a person is at risk of committing suicide. In our study, we considered children as having a "*suicide risk*" or *"high suicidality"* if there was high probability that they would take concrete actions to end their life. More precisely, we considered a child to be at risk of suicide if the child

- had repeatedly wished to be dead in the past month or expressed an intention of hurting or injuring himself or herself during the interview and
- had already elaborated a concrete plan on how to commit suicide or
- had attempted to commit suicide in the past four weeks.

The prevalence of high suicide risk among the groups of children in the study is shown in Figure 8. The overall rate of suicide risk in the entire sample was 15.8%, with girls having a higher risk (18.6%) than boys (12.5%). This difference is however not statistically significant ($\chi^2(1) = 1.21$; $p > 0.05$). These findings are alarming: more than one child out of ten was feeling so bad that he or she expresses concrete intentions to commit suicide. Girls having lost a mother and double orphans girls and boys were the groups most at risk, attaining rates over 25%. The differences between girls without fathers compared to girls without mothers are significant on statistical level: girls having lost a mother were considerably more at risk for committing suicide than girls having lost a father ($F(3) = 2.63$; $p \leq 0.05$; Bonferroni: $p \leq .05$). Among boys, we found significant differences between orphans and non-orphans, suggesting that orphans are considerably more vulnerable to elevated suicidality than non-orphans ($F(3, 76) = 3.78$; $p \leq 0.01$; Bonferroni: $p \leq 0.05$). The differences between the other boy sub-groups, however, are not statistically significant. Suicide risk was elevated among boys and girls who had lost their mother, but quite low among children who had lost their father. Only

the rate among non-orphan boys was lower. The elevated rate of suicidality among non-orphan girls, however, suggests that other contextual factors than parental loss, contribute to the level of suicidality of a child.

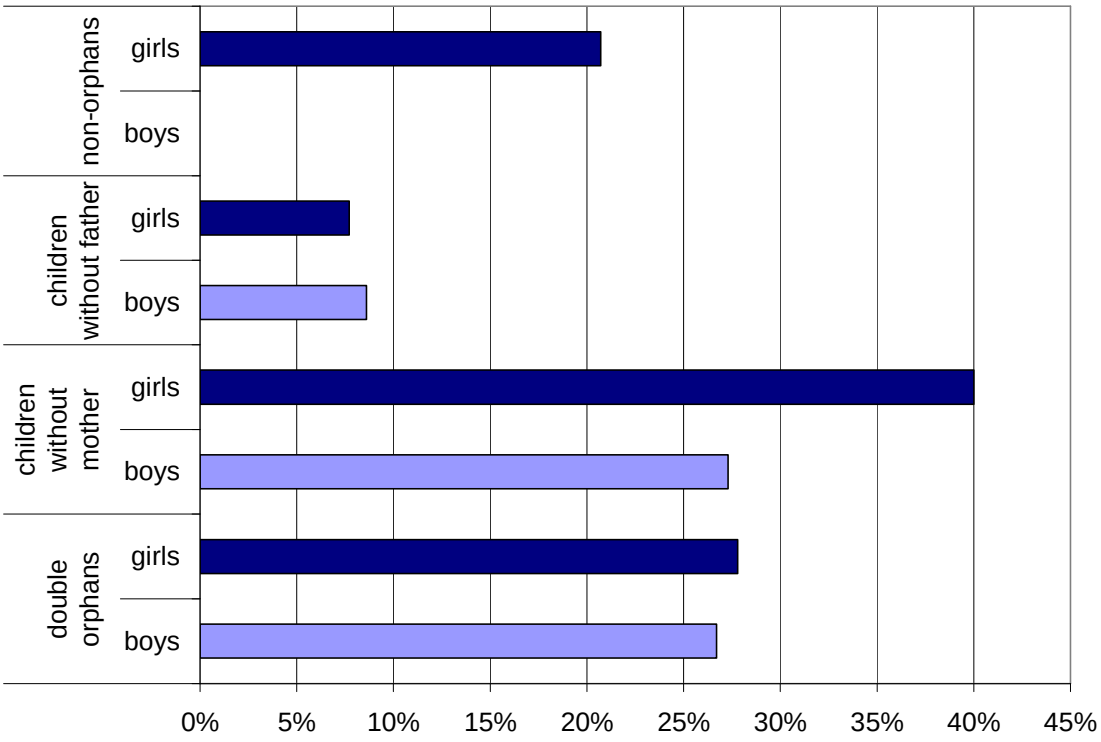

Figure 8: Prevalence of suicide risk in the sub-samples

6.6.1 Influencing and correlating factors for high suicide risk

Fostered children did not have a higher suicide risk than non-fostered children [girls*: (*$\chi^2(1) = 0.53$; $p > 0.05$); boys ($\chi^2(1) = 1.70$; $p > 0.5$)]. Elevated suicidality was significantly more common in children who reported neglect at home ($\chi^2(1) = 7.81$; $p \leq 0.01$). Moreover, children who were less happy with their household situation due to family conflicts and domestic violence also had higher suicidality ($t(175) = -3.73$; $p \leq 0.01$). Furthermore, severely depressed children and children suffering from post-traumatic stress disorders also had elevated suicide risks. (For depression: $\chi^2(1) = 45.09$; $p \leq 0.01$; for post-traumatic stress: $\chi^2(1) = 18.83$; $p \leq 0.01$).

The children who we assessed to be at high risk for suicide had lost hope.They observed other children receiving better treatment and enjoying life, and felt that they could no longer endure their own suffering. High suicidality was often linked to feelings of being rejected by their guardians or other close relatives. The testimonies of children illustrate the close relationship of domestic violence and an elevated suicidality.

- *"I have very few friends and even the few I have very often reject me since I lost one leg in an accident. Since the death of my parents, I am maltreated by my aunt. What frustrates me most, is her refusal to let me see my brothers and sisters. They are*

my only family and the only people having love for me. For my aunt, I am nothing. I often think about killing myself, I just don't see how my life could get better." (double orphan boy, 11 years, Bamessing)

- *"When I just look at the life we live in our house, I see no reason to continue living. We work on my father's farm and in return he pays our fees and he does not care about other things. I don't even talk about the beatings he inflicts when somebody makes a small mistake. I always think of drinking 'arata bomb' (poison) or falling in the lake and drowning myself. I have never done it because I am scared of the pains I will go through before dying." (non-orphan girl, 15 years, Bambalang)*

The most startling finding about the high suicidality was that numerous children had already made plans on how to commit suicide, or had even gone as far as putting their plan into action. Out of 180 interviewed children, 11 (6.1%) had already attempted suicide.

- *"Since my mother died, things are no longer the same. Nobody takes care of me, forget about giving me food. All they do is beat me up. My situation worries me so much that I tried to kill myself with a knife." (girl having lost a mother, 10 years, Kobenyang)*
- *"I have suffered enough; this life is not worth living. What can be good about my life, when people only wish you dead and even propose you ways to kill yourself? I thought of drowning myself in water or of hanging myself because of all these insults I receive at home." (non-orphan girl, 18 years, Mambu)*
- *"My guardian beats me often and even refuses to give me food as punishment. All this and all the hard labour that she forces me to do made me drink insecticides for coffee so that I can die and follow my parents." (double orphan boy, 13 years, Njinikom)*
- *"I have tried to kill myself by hanging once when I was severely beaten by my step-brother and nobody tried to take on my defense, not even my father. This feeling keeps coming to me recently since my step-brothers and step-mothers are trying to evict me from my late mother's house and also to seize her farm from me." (boy without mother, 16 years, Bambalang)*
- *"I tried to drink rat poison once and was retained by a friend. Afterwards I was badly beaten and driven from the house by my aunt in Bafoussam… I keep having this wish of dying because I suffer a lot." (double orphan boy,14 years, Njinikom)*

These testimonies are desperate calls for help. Children expressing firm intentions of killing themselves will not always take action to do so, nor is it certain that they want to die. Still, they are trying to signal to their surroundings that their capacity to cope has reached its limits and that they are not ready to go on any more. It is important to be aware that the groups of children in our study who were assessed to be highly suicidal are at considerable risk of seriously harming themselves or others in the near future.

6.7 Exposure of children to traumatic life experiences

The children in our study had come face to face with a wide range of life threatening events. Common experiences included witnessing of people getting beaten up or killed (80.6%), witnessing the violent or sudden death of a loved one (57.5%), and being beaten up and threatened to be hurt badly (52.2%). Other frightening experiences related to painful hospital treatments (44.7%), natural disasters such as fire or heavy rainfalls (37.2%), road accidents (30.6%) and seeing a dead body (outside a funeral) (35%). Girls were significantly more often victims of beatings and threats by non-relatives (70%) than boys (30%) ($\chi^2(1) = 28.50$;

$p \leq 0.01$). Severe road accidents were reported considerably more often (30.4%) than in our study in Burkina Faso where only 3.4% of the children had already been involved in severe car accident. The frequency in Cameroon was comparable to our study in Togo among communities with a high prevalence of child trafficking. In the Togolese sample of children who were highly mobile, 29.0% reported to have witnessed or experienced motor vehicle accidents.

The exposure range for different types of traumatic life experiences is from 1 – 25 events. On average, the children in our study had been exposed to 13 different events in their life. We used an analysis of variance (ANOVA) for exploring potential differences between the four groups. Among the boy sub-samples, there were no statistically significant differences ($F(3, 76) = 0.37$, $p > 0.05$). The comparison among girls suggests that orphan girls had experienced slightly lower numbers of traumatic life experiences than the other groups of girls, but this difference is of marginal statistical signficance ($F(3, 95) = 2.10$, $p > 0.05$). In general, parental loss did not seem to have an impact on the numbers of traumatic experiences lived. This result indicates that non-orphans are just as exposed to danger as children living in single parent households and orphans. While parental loss had little effect on exposure to traumatic life experiences, the gender factor seemed to be of more importance. Boys were significantly more often exposed to life-threatening events than girls ($t(178) = 2.43$; $p \leq 0.05$). The number of traumatic life events experienced by a child is an important factor for the mental health outcome. We found a highly significant positive correlation between the number of traumatic experiences and the degree of post traumatic stress (Pearson $r = .30$, $p \leq 0.01$).

6.8 Life-time exposure of children to domestic violence

To assess the prevalence of exposure to domestic violence we collected two sets of data. We inquired if the children had experienced a specific type of violence at least one time in their lives. If the answer was affirmative, we asked whether they had experienced this type of violence within the past month. The large majority of children had been exposed to different forms of maltreatment at least once in their life. As shown in Figure 10, physical and verbal abuses were the most commonly reported experiences, especially by boys. The children's testimonies demonstrate the humiliating and devastating effects of repeated domestic violence. Decisive life stages are disrupted by experiences of exclusion, physical abuse, insults and neglect.

- *"My father got me well beaten because I met my friends who were selling things and I stopped to discuss with them. He humiliated me in front of my friends telling them that I am a bad girl, and that none of them should be friendly to me. I have very little friends because my father does not allow anybody to visit me. I spend now all my time in the farm and prefer to be alone than instead of being ridiculed in front of others." (non-orphan girl, 17 years Bambalang)*

- *"About three years ago, when I was still in primary school, I misplaced my school bag with all my books. When I got back home and was asked for them, I told that the bag was looked up in the classroom. The next day, my uncle took me to school to make sure that I was telling the truth. When we got there, I could not produce the bag ands its content. I was severely beaten by both my uncle and my grandmother. I had cuts all over my body." (boy without father, 14 years, Kobenyang)*
- *"I was sent to pick something up from the kitchen and when I was about to cross the fire to take it, my grandmother slapped me. I found myself in the fire and my legs were burnt. My grandmother did not remove me from the fire, but when I came out, she had me well beaten and did not look at the burns. I had a very big wound and nobody cared about it. I struggled with it alone and the thing is almost getting dry now. When I look at it, I'm very sad and tired and find it difficult to feel love." (non-orphan girl, 12 years, Njinikom)*

Most differences between non-orphans, children having lost one parent and orphans are not significant: boys of all groups were exposed to equal levels of physical abuse ($\chi^2(3,1) = 1.28$; $p > 0.05$), neglect ($\chi^2(3,1) = 2.30$; $p > 0.05$) and sexual abuse ($\chi^2(3,1) = 2.61$; $p > 0.05$). An exception is verbal violence where non-orphans had a significantly lower exposure rate than the other groups of boys. Among girls, the picture was similar: groups did not differ significantly for physical abuse ($\chi^2(3,1) = 6.87$; $p > 0.05$), verbal violence ($\chi^2(3,1) = 1.42$; $p > 0.05$), neglect ($\chi^2(3,1) = 2.27$; $p > 0.05$) or sexual abuse ($\chi^2(3,1) = 7.43$; $p > 0.05$). The group differences for physical and sexual abuse almost reach statistical significance. The differences, however, are positively in *favor* of orphans: orphaned girls reported the lowest rates of corporal punishment and of sexual abuse.

In our study, parental loss was not found to be a determining factor for life-time exposure to domestic violence. Gender played a more important role for the different types of domestic violence: boys were significantly more often victims of physical abuse ($\chi^2(1) = 9.90$; $p \leq 0.01$) and verbal violence ($\chi^2(1) = 5.46$; $p \leq 0.05$) than girls. On the other hand, girls were more often victim of neglect ($\chi^2(1) = 6.00$; $p \leq 0.05$) and sexual abuse ($\chi^2(1) = 9.51$; $p \leq 0.01$) than boys. The descriptions of sexual abuse provided by the children illustrated that the abuse usually took place in the community, sometimes perpetrated by family members. Even if the family was informed about the abuse of their daughter, they did not necessarily take action to protect the child from further harm. The molested child was often accused of lying or having provoked the situation. Furthermore, if the information about the sexual abuse became public, the girl was stigmatized and her chances of ever finding a husband decreased. This was one of the main reasons why girls felt discouraged to speak out about their experiences. They also reported that shame and fear paralyzed them into inaction. None of the raped girls had a medical follow up after the rape.

- *"My half-brother asked me to sleep with him. When I refused, he tried to force me to do it. I could defend myself, but he beat me up terribly for that refusal. I told my father, but since he does not care about me, he did not listen and accused me of lying and beat me very severely as well. A few days later, my father sent me another time to the farm to do work for him. The same half-brother followed me and tried to rape me. I ran back home, but my father chased me away from the house and I had to sleep out of the house." (non-orphan girl, 17 years, Bambalang)*

- *"I was raped by the age of six years by a man that visited our village. He escaped and we had not proof for what he had done. My mother tried to take the case to the police but they could not find the man. My mother was very ashamed. Our neighbors did not allow their children to play with me and I was very alone." (non-orphan girl, 18 years, 6 years at the incidence of abuse, Njinikom)*
- *A man of 27 years forced me to make love with him. I felt a lot of pain and it was not like for the other girls who made love with their boyfriends. I lost my virginity to someone I did not know and who disappeared later on. My father gets angry very easily and does not care a lot about us. I did not dare to tell him because I know he would have beaten me very badly. I also did not tell my mother in fear that she would tell my father. I feel guilty and angry with myself." (non-orphan girl , 15 years, Bambalang)*

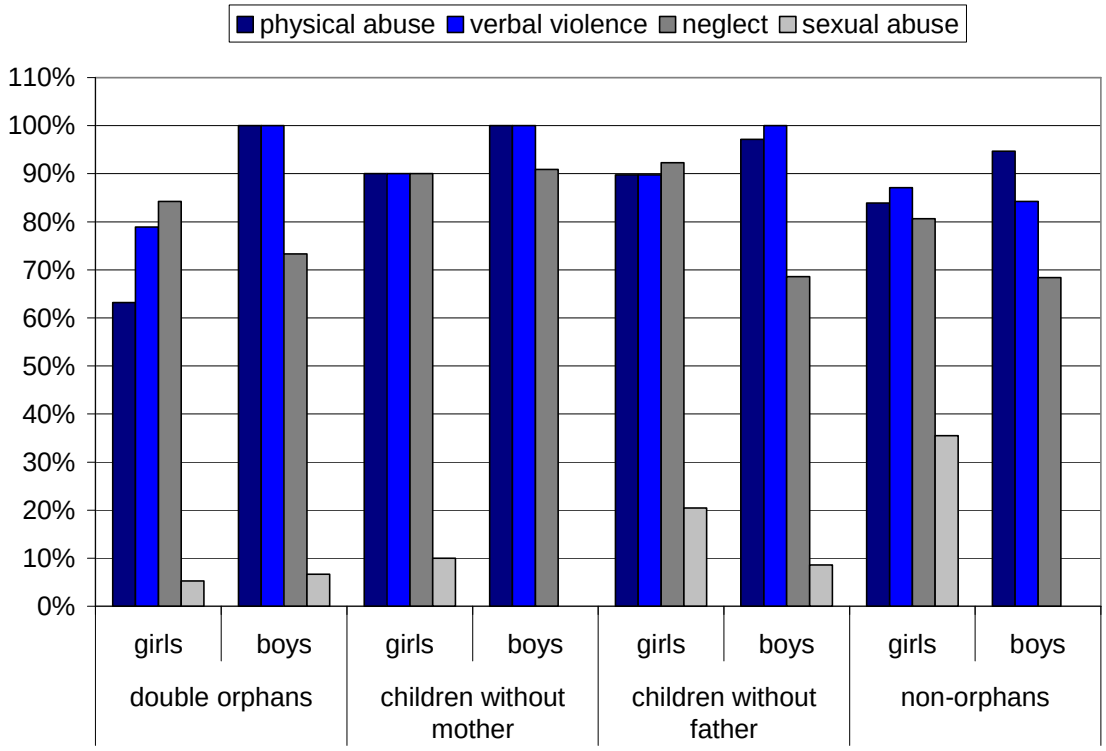

Figure 10: Life-time exposure to different forms of domestic violence

The fact that boys tended to be more subjected to physical and verbal abuse is also underlined by the analysis of specific types of physical violence. Boys were significantly more likely to:

- Be slapped, kicked or punched in the face ($\chi^2(1) = 27.43$; $p \leq 0.01$),
- Be slapped, kicked or punched on the body, arms or legs ($\chi^2(1) = 9.00$; $p \leq 0.01$),
- Be hit with an object (e.g. gas tube, shoes, belt, broom, stick, stones) ($\chi^2(1) = 13.33$; $p \leq 0.01$),
- Have things thrown at them ($\chi^2(1) = 24.12$; $p \leq 0.01$),
- Be tied up or locked up ($\chi^2(1) = 3.85$; $p \leq 0.05$).
- Be threatened verbally ($\chi^2(1) = 18.54$; $p \leq 0.01$)

The multiple examples of higher exposure of boys to domestic violence indicate that they are less protected at home and in their socio-professional life. The age of the participants is no explanative factor for that as girls and boys in our study did not differ significantly in terms of age *(t*(178) = 1.42; $p > 0.05$). Our results indicate that the communities in the study offered better protection from physical and verbal abuse to girls than to boys. While adults tended to inflict open aggressions and violence on boys, girls were more often subjected to less visible, but just as harmful types of domestic violence: neglect and sexual abuse. The gender comparison showed that the neglect reported by girls was primarily associated with a lack of food. 55% of the girls compared to only 30% of the boys repoted that they had suffered from hunger in their lifetime ($\chi^2(1) = 11.28$; $p \leq 0.01$.). Girls were also at higher risk for sexual molestation (19% for girls versus 5% for boys); ($\chi^2(1) = 7.82$; $p \leq 0.01$) and rape (15 % for girls versus 1.3% for boys); ($\chi^2(1) = 10.38$; $p \leq 0.01$). Although we found a high lifetime exposure to sexual abuse, we did not come across children involved in transactional sex.

6.9 Recent exposure of children to domestic violence

We asked the children who reported a life-time experience of domestic violence whether this type of violence had also taken place in the past month in order to ascertain current levels of domestic violence. The prevalence rates of children subjected to different forms of domestic violence are summarized in Figure 11. The most common type of domestic violence reported by boys was verbal abuse and by girls neglect. However, the differences in prevalence of domestic violence between boys and girls were not statistically significant. We also found that parental loss was not related to the rates of domestic violence: non-orphans, children living in single parent households and double orphans are equally exposed to ongoing domestic violence. Among boys there was no significant difference for physical abuse ($\chi^2(3,1) = 5.29$; $p > 0.05$), verbal abuse ($\chi^2(3,1) = 5.23$; $p > 0.05$), neglect ($\chi^2(3,1) = 2.61$; $p > 0.05$) and for sexual abuse ($\chi^2(3,1) = 1.30$; $p > 0.05$). Among girls, there was no significant differences for physical abuse ($\chi^2(3,1) = 4.18$; $p > 0.05$), verbal abuse ($\chi^2(3,1) = 0.36$; $p > 0.05$), neglect ($\chi^2(3,1) = 1.30$; $p > 0.05$) and sexual abuse ($\chi^2(3,1) = 1.44$; $p > 0.05$). The accounts of several orphans who participated in case studies, however, illustrate that orphans *felt* to be more often discriminated against and to be more frequently excluded from benefits that their step-brothers and –sisters received. Orphans perceived that they had to work harder and that they were punished more severely than the other children for making mistakes. Nonetheless, the collected data did not confirm this perception. Neither orphan girls nor orphan boys had higher exposure to particularly severe forms of domestic violence (e.g. being tied up or locked up, being burnt or being hit with objects). Furthermore, case studies with non-orphans also illustrated how badly some of them were maltreated or neglected. A possible hypothesis is that orphans are subjected to a higher intensity of domestic violence in their foster families in comparison to their step-brothers and -sisters. But

when compared to the community average, they are treated equally or even better than most children.

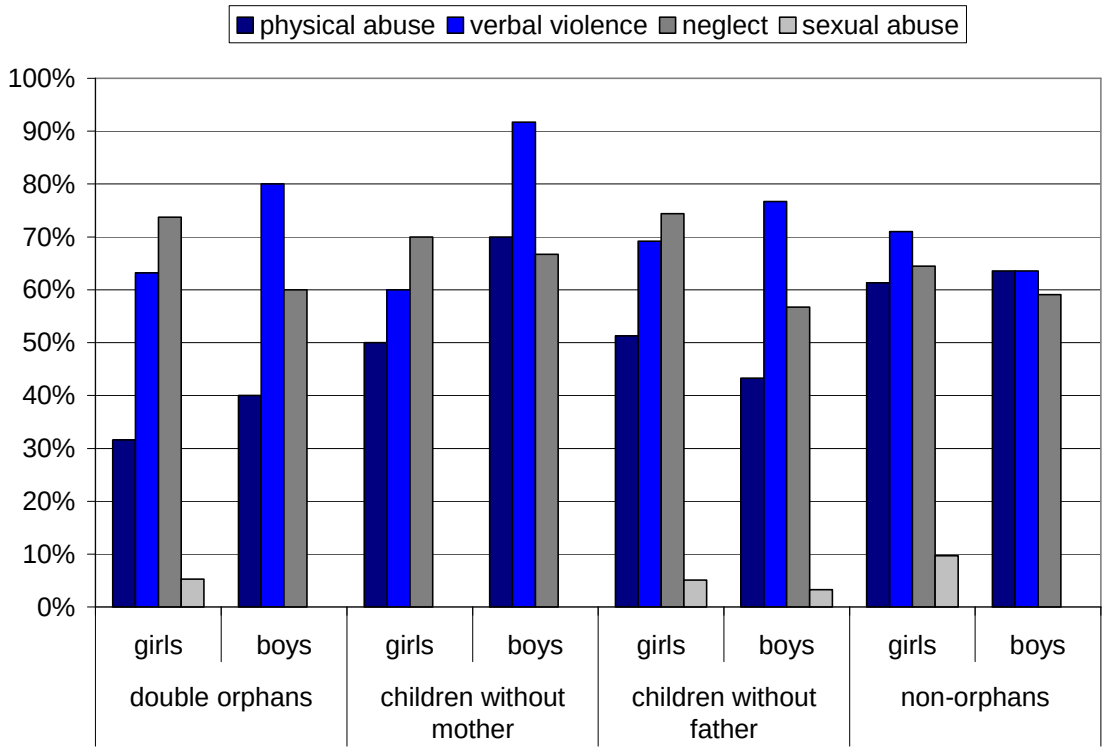

Figure 11: Reported prevalence rates of different types of domestic violence within the past month

6.10 Risk factors for domestic violence

Reports of domestic violence were very common among the children in our study, and parental loss did not emerge as a decisive variable. We therefore conducted a risk factor analysis in order to better understand the profile of maltreated children. We used physical abuse and neglect as determining variables for risk of maltreatment in the family. The results of the analysis showed that:

- Age was a risk factor for physical abuse among boys. Young boys were more often subjected to physical abuse than older boys ($t(78) = 2.51$; $p \leq 0.01$). The age did not influence the maltreatment of girls ($t(98) = 0.81$; $p > 0.05$). Neglect, however, did not depend on age, neither for girls ($t(98) = 1.60$; $p > 0.05$) nor for boys ($t(78) = 0.41$; $p > 0.05$).
- Religious affiliation was not a risk factor. The proportion of children who reported neglect and physical abuse did not differ among Muslim and Christian participants [for girls ($\chi^2(2) = 1.47$; $p > 0.05$); for boys ($\chi^2(4) = 1.18$; $p > 0.05$)].

- Ethnic group affiliation did not play a role. Comparisons of maltreatment and neglect reported by children of different ethnic groups showed no significant differences.
- Maltreated children showed little differences in terms of education level: Children exposed to neglect had the same education level as non neglected children [for girls ($t^2(98) = 0.20$; $p > 0.05$); for boys ($\chi^2(78) = 0.41$; $p > 0.05$)]. Physically abused boys had on average the same number of years at school ($t(78) = 0.77$; $p > 0.05$). The only difference we found was that physically abused girls showed on average a lower education level than non-physically abused girls.
- The level of physical abuse and neglect did not differ between fostered children and children living with their parent(s) ($\chi^2(1)) = .077$; $p > 0.05$)

The group comparisons provided limited information to explain the dynamics of maltreatment of children. The analysis of the *qualitative* data shed considerably more light on the risk factors. First of all, it indicated that lack of attachment to a protective and supporting guardian was important in putting children at risk of domestic violence. This guardian could be anyone of the wider family and did not have to be a (biological) parent. Parental death was only a risk for domestic violence if the child did not have a protective attachment to a caretaker in the wider family. Furthermore, children were more likely to be affected by the death or disappearance of their "guardian" than by the death of a parent. The death of an aunt or an uncle or any other friendly-minded person who was supporting the child emotionally and financially and who payed the school fees was found to be much more distressing than the death of a father who rarely took part in the educative and affective tasks.

- *"My aunt who was my sponsor died. I felt very depressed and disappointed and my entire life changed negatively. I came back to stay with my mother and life changed since my mother's husband does not love me. I have to do all the household work and my mother treats me like a housemaid." (non-orphan girl, 18 years, Njinikom)*
- *"My life became better when a friend of my mother decided to sponsor my primary education. This gave me hope about life and I was happy again. But after some years, he disappeared and ever since my life has become sad and difficult. I dropped out of school and I do even have to worry about where to get money for my day to day needs. Now, no one cares about me any more." (children without father, 17 years, Njinikom)*

Moreover, the case studies showed that nuclear family structures and safe ties for children are threatened or even broken by multiple factors. Many of them were not linked to HIV or parental loss. A non-HIV-related risk factor, for example, was a caretaker who was mentally ill, maltreated, or lived in extreme poverty. Children growing up with a mentally ill mother were found to be at a higher risk for domestic violence, particularly neglect, than orphaned children. Another non-HIV-related risk factor was residence in a polygamous household with many wives and more than 30 children. The case studies indicated that the dynamic between the numerous wives and children of all ages can easily become a catalyst for family conflicts that weaken family protection mechanisms. Children born to a rejected or less accepted wife

in the polygamous compound are often severely abused and neglected while the children of the favorite wives enjoy more care and protection.

- *"My father has seven wives and my mother is the fourth. My mother was given to my father because my grandfather borrowed money from my father and did not have the money to pay back his dept so he decided to use my mother to settle the payment for his debt. My father does not love my mother and he really hates me as I am the first child in my mother's family. I have to work very hard to survive..[..].. my mother likes me, but she has nothing and our father takes all the decisions in the family. We are more than 35 children and we all live in the same compound with our father, mother and stepmothers and step-brothers and sisters. According to my father, our mother is the cause of any bad thing that happens in the family and anything associated to my mother brings him bad luck. That is why he hates her so much. My half-brothers have often tried to rape me, but I cannot complain to anyone since father does not like me and my mother is ill. My father also beats my mother and he does not care whether our needs are met or not. I work in my father's farm from Monday to Sunday, often without food and at times my father forbids me to return home within the week until I have finished the portion of land he gives me to work. Sometimes, when I am not too hungry, I even prefer that. It is better than to come back home and to be insulted or beaten." (non-orphan girl, 17 years, Bambalang)*
- *"Whenever I make a small mistake, my older brothers or half-brothers beat me. My father has six wives and my mother is the third. There are always conflicts between my father and the mothers, mothers and mothers, and between us and our half-brothers and -sisters. My mother tries to be nice, but she cannot do anything against our father who is scaring everybody and always taking position against me. One day I had a quarrel with an older brother and he got me well beaten, leaving me with wounds and a swollen eye. Although I was injured, my father did not blame him. They said that I don't have the rights to quarrel with elders." (non-orphan girl, 15 years, Bambalang)*

Another risk factor that emerged from our analysis of case stories was the high mobility of family members. Spouses often get separated for long period of times during migration periods. As a consequence, fathers may have doubts about their paternity of certain children in theirhousehold, and punish the presumed adultery of his wives by neglecting and abusing the child. Furthermore, children born to young non-married parents often end up between two families: both, father and mother, end up wedding someone different and the child may be excluded from the mother's as well as its father's home. A child whose father is unknown or has "disappeared" was also more likely to report insults and harsh treatment.

- *"My mother got mad when I was nine years old. She was taken to a traditional doctor and became normal again and our life at home became better. But then, she collapsed into madness again and things got worse. My brothers and sisters and I were given for some time to relatives. I came back to my mother, but she becomes often violent and drives me out of the house. It is so frustrating and I feel so helpless. One day, my mother was badly wounded on the head by some boys and they ran away. This gave me stress, I had to take care of my mother's wound." (girl without father, 17 years, Njinikom)*
- *"My mother had me and she was not married. Later she got married to a different man. My father, too, got married to a different woman. The husband of my mother did not like me. When he died, my mother sent me to stay with my father. My father's wife did not like me either and beat me a lot and finally send me back to my mother. My mother did not support me and was very mean to me, we argued a lot because she did not want to give me anything, but she beats me as well. I had to drop out of school and I got pregnant soon after. I have no idea where I belong as my mother does not like me and my father has abandoned me. My mother does not want to let me marry the father of the baby and does not allow me to see him. All this makes*

my life very difficult and people make fun of me because I already have a baby, but no father to support my living." (non-orphan girl, 18 years, Njinikom)

6.11 The most distressing event experienced ever

We asked all children during the interview to let us know which life experience had been the most frightening and difficult to cope with. Their narrations were marked by close confrontations with death or perceived death threats against themselves or another person. The responses to this question are clustered in nine categories and summarized in Table 10. The most common category was witnessing the death of a beloved person: more than 25% of the children reported the death of a beloved person as the most frightening experience of their lives. This was not surprising knowing that more than 70% of the participating children had lost one or both parents. The death of a parent or a relative was particularly traumatizing when accompanied by one or more of the following factors:

- the child discovered the body;
- the child witnessed the process of dying and was present at the moment of death;
- the child witnessed a long process of suffering before the person died;
- the death occurred unexpectedly without prior signs of illness.

- *"My uncle used to be a very handsome man when he was healthy. Later he became sick and the doctor diagnosed him with liver problems. He was seriously sick and became very black and ugly. He suffered so much before he died and the moment of his death, one could not recognize his corpse. It was so different from when he was alive. When I think of it, still spoils my day." (non-orphan girl, 9 years, Bamessing)*
- ***"**My mother was sick for a long time. She became more and more thin and very dark in complexion. She went to all hospitals and the doctors did not say what she was sick off. She came back to the village to live with my grandmother to take traditional treatment. About three weeks after, our aunt, with whom we were staying in town, took us back to the village. There were many people in our compound crying. We got in and I saw my mother already in the coffin. I did not believe she was the one because she was very small. We cried and finally she was buried. Our aunt went back to town and since then we have never gone back. We live with my grandmother in the village and go to school." (orphan girl, 14 years, Bamessing)*
- ***"**I slept with my mother in our bed, talked with her, she promised me many good things in the future and then we slept. I got up in the morning and discovered her dead. I felt so scared and surprised, until today I feel like it did not happened and that it is still not real." (girl having lost her mother, 10 years, Kobenyang)*
- *"I was with my father in the hospital. He loved me so much. My mother went to cook food. My father told me not to worry about anything and that my mother will take good care of me in his absence. After some time, he stopped talking and breathing. I called him and he did not respond. I was very frightened. My father died in my arms." (girl having lost her father, 14 years, Njinikom)*
- *"My father was poisoned and he got ill for long. I was the person taking care of him. I used to sleep with him all the nights: Whenever we slept, I got up late in the night to lead him to the toilet. One night as we were sleeping, I got up and tried to wake him up. I realized he was very cold. I called his name several times and shook him and shook him, but there was no reaction. My grandmother heard me from the other room and came in. It was only when she started screaming and crying that I knew my father was dead." (boy having lost his father, 14 years, Bambalang)*
- *"I was sleeping with my sick father when he started shaking on the bed. I got up and asked him what was happening, but he just kept rolling from one side of the bed*

to the other. I was very frightened; I ran out and started calling for help. My grandmother who was in the next building came out. When we went back in the room my father was not living anymore. My grandmother started shouting that he is dead. I got more frightened.“ (boy having lost a father, 12 years, Mambu)

Other commonly reported disturbing experiences were injuries, severe illness and hospital treatments, domestic violence and road accidents. The number of children who had witnessed or were harmed in serious road accidents is alarming. They recounted that they witnessed people dying in most of these accidents, often including the sight of distorted corpses. We observed several factors contributing to the high proportion of road accidents. Firstly, alcohol use appeared to be widespread, even early in the morning and among drivers. Secondly, many road accidents involved motorcycles, often the only possible transport from one community to another, driven by inexperienced riders. Finally, the failure of breaks in the highly mountainous area was a common cause of serious accidents.

- ***“****The car lost breaks and went into the river. Many people were injured. Blood changed the color of the water to red. The driver died immediately and five persons were badly wounded. Everybody in the village ran to the site. My father helped removing the people from the river.” (non-orphan girl, 16 years, Bamessing)*
- ***“****I was playing with my friend on the road when a bicycle on very high speed knocked me down. The shock was so violent that I had the bone of my left leg crushed. All attempts to save my leg at the hospitals failed. It was later cut off because it was already getting rotten.” (orphan boy, 14 years, Njinikom)*
- *“I was going to Bamenda one day when our bus stopped at a crowd around Ashong village. Everybody came out to see what was happening. I got out, too, and saw a corpse that had just been crushed by a truck. It was a woman who had fallen from a bike and the truck crushed her. The corpse was very horrible to look at.” (orphan boy, 14 years, Njinikom)*
- *“My parents and I went traveling to the village in a 70 “*seaters*” bus. We got to a point where the bus stopped and my mother bought me yoghurt. After that point we drove for some time and I fell asleep. I just heard a loud noise and the vehicle stumbled. I don’t know what happened afterwards. When I woke up, I found myself in the hospital. 43 people died on the spot including my mother and father. My aunty took care of me until I was well and afterwards, I was taken to the village to live with my grandmother.” (orphan boy, 15 years, Kobenyang)*

Witnessing the traditional punishment of thieves was another source of trauma for children. More than 80% of the children had witnessed a suspected thief being beaten or killed in their village. For more than 13%, this was the most terrifying and distressing event of their life. These events usually occured when a suspected thief was submitted to the “traditional justice” and beaten, stoned and sometimes even burned alive by community members. Children were attracted by the crowds and the screaming, but they were unprepared for such violence.

- ***“****We were selling groundnuts in the market one day when we heard people shouting: “Thief! Thief!” They followed the thief, caught him up and got him well beaten. Blood was flowing from his body. He was taken to the police. I was afraid that he would die” (girl without father, 13 years, Bafanji)*
- *“One day, when I was still in Douala with my uncle, I heard people shouting at the road junction near our house. I ran to see what was happening and I saw a man naked being beaten by the crowd. I learnt that he was a thief. They beat him until he*

was almost dead, someone poured petrol on him and he was burnt alive." (non-orphan girl, 13 years, Njinikom)

- *"Last year in August, I went with my uncle to Bamenda to buy my school needs. As we got to the market we saw a thief being beaten by the crowd. He was later burnt to death. I was very afraid. My uncle took me away so that I shouldn't watch the horrible scene." (orphan boy, 15 years, Bamessing)*
- *"I saw a thief being beaten up by the crowd. He was accused of stealing a goat. Everybody in the village came out with his sticks and stones to beat him up to death, but he later was freed by the chief of the village." (boy having lost a father, 15 years, Kobenyang)*

Domestic violence is also captured in a number of narratives about the most distressing events. For 14% of the participants an event of domestic violence (not including sexual abuse) was the most terrifying life experience. Their testimonies illustrate the harmful impact of domestic violence on their psychological development, and indicate the degree of injuries sustained as a consequence of physical abuse in the home.

- *"Early on a Sunday morning, my grandmother asked me to go to the farm and to fetch firewood. I told her that I would like to go to the church before I go and fetch the wood. She took a stick and had me well beaten with it. She had my left leg broken and then refused to take me to the hospital. After this, she left for the church. It was more than pain that I felt; I was so sad and angry." (girl having lost a mother, 12 years, Bafanji)*
- *"My father is a specialist in beatings. It never bothered me a lot until this special beating which hurt me so much because I believe I was right. After his sales [farm products], I asked him for a pair of school shoes because the ones I got were spoiled. He called me to his room where he was hiding four canes. He beat me up severely and said I was getting out off hands. He also said my mates are able to take care of themselves. My whole body was swollen and I got a black eye which only cleared after two weeks. After the beating, he looked me up until the afternoon. I can never forget this day." (non-orphan girl, 18 years, Bambalang)*
- ***"**My uncle came back one afternoon and met me sleeping. He started beating me up because he thought that I refused to go to the farm whereas I was sick. I succeeded to escape from the room and he picked up a machete and started chasing me with it, shouting that he was going to kill me. I ran and succeeded to escape from him. That night I slept in the bush because I was so afraid." (boy having lost a father, 15 years, Bamessing)*
- *"One day, I went to play with friends and left the kitchen open. A dog came and ate the meat that my aunt had kept on the fire to dry. When I came back home, she had me well beaten and tied up my legs and arms for the whole night. The next day, when she untied me, I felt so sick." (boy having lost a mother, 10 years, Mambu)*

Girls were more likely than boys to name sexual violence and injuries, illnesses or hospital treatments as their most terrifying experience. Among 15 girls who reported to have been raped, 6 recounted this event as their most frightening experience. This indicates the particular harmful impact of sexual violence on the wellbeing of girls. However, it is also notable that sexual violence was the most frightening experience for the one boy who reported to have been raped.

- *"When I'm left alone with my aunt's son in the house or in the farm, he always forces me to sleep with him, touching me on my private parts. When I refuse, he beats me and when I report to my aunt or any other person in the house; they don't believe me, but instead beat me up and tell me that I am a spoiled girl." (non-orphan girl, 10 years, Bamessing)*

- *"My mother sent me to the market to buy some food stuff. On my way back, I met a friend of my father who asked me to follow him to his place and take something to my father. When he entered his house, he looked the door and closed my mouth and pushed me to the bed. As I was wearing a skirt, he did not struggle too much to touch me. I was screaming, but no one could hear me as his house is isolated and he also covered my mouth with his large hand. After a few minutes, he left me after penetrating into me and after warning me seriously that if I let my father know, he was going to kill me and he will tell him that I am lying. Being so afraid of my father, I did not tell him. He was a stranger in our village and he left two months later for his own village. Since then, I have never seen him and I hate that day that it happened." (non-orphan girl, 15 years, Bambalang)*

Further gender comparisons draw attention to the fact that boys were more likely to be affected by experiences attributed to witchcraft supernatural powers, such as seeing ghosts or enchanted animals.

- *"When I was still living with my mother and her new husband in Bamoun, one of my uncles bewitched me and my right leg started swelling. My leg got swollen to an extent that I could not even stand nor walk. It was very painful and I thought I would die or that I was going to loose it. I was only treated some, four month later." (non-orphan boy, 14 years, Bambalang)*

Table 10: categories of the most disturbing events ever lived by the children

Event category	Total sample (*n* = 156)	Girls (*n* = 79)	Boys (*n* = 77)
Victim of rape/ rape attempt	7 (4.5%)	6 (7.6%)	1 (1.3%)
Illness/injury/ painful hospital treatment	23 (14.6%)	16 (20.3%)	7 (9.0%)
contact with wild animal	7 (4.5%)	2 (2.5%)	5 (6.4%)
Victim of domestic violence (other than sexual abuse)	22 (14.0%)	8 (10.1%)	14 (17.9%)
Road accident	20 (12.7%)	10 (12.7%)	10 (12.8%)
Death/ loss of a loved one	43 (27.4%)	23 (29.1%)	20 (25.6%)
witness of injury or death of strangers	21 (13.4%)	10 (12.7%)	11 (14.1%)
Victim/ witness of supernatural powers	9 (5.7%)	2 (2.5%)	7 (9.0%)
natural disaster	5 (3.2%)	2 (2.5%)	3 (3.8%)

6.12 Mental disorders

The diagnostic criteria for psychological disorders do not only require the existence of psychopathological symptoms, but also a critical impairment of the social and professional capability of children in day-to-day activities, for example, not being able to succeed in school and not having any friends because of disturbed behavior. Although we excluded children with obvious psychosis during the sampling process, we still found a high prevalence of mental disorders among the children in the study, as well as neurological disorders such as epilepsy. The symptoms were sources of inconvenience to the children and severely bothered and upset them in every day life. Children with severe mental or neurological

disorders, marked by "bizarre" or socially non-acceptable behavior, reported that they were stigmatized, mocked and sometimes punished.

- *"Life is a nightmare to me. As my mother is mad and my grandma as well, other children laugh at me and call me "the child of the mad family". I have lost all hope and I just try to stay alive. Probably one day, I will also go mad as I am always surrounded by mad people. I am not interested in anything anymore. I spend most of my time alone wondering what life is for. I think I should rather be dead than to live in such miserable conditions. I cannot be with other children, it makes me feel inferior. I cannot sleep because I am so scared of all the bad things people have done to me, all the beatings." (non-orphan girl with a major depressive disorder, 17 years, Njinikom)*
- *"I had convulsions in school for the first time and all my friends ran away from me. I was very embarrassed and ashamed as I had never had it before. The worst is that my closest friend avoided me, and when I asked her why, she told me that her mother warned her not to continue keeping my company or I was going to contaminate her with the illness. I just thought of locking myself somewhere up. I did not want to contaminate anybody. I am sad and frustrated and angry with myself." (non-orphan girl, suffering from epilepsy and major depressive disorder, 15 years, Bambalang)*
- *"Since I was raped, my life has become different. I am afraid to leave the house alone and my mother screams and shouts at me all the time because I am too afraid to look for a job in town. I somehow believe that all men are wicked and cannot forget the day it happens. I feel guilty because I am too afraid to go and look for work like other girls do. I just sit around at home, doing nothing." (girl suffering from posttraumatic stress disorder, 17 years, Mambu)*

6.12.1 Mood and anxiety disorders

Among the childen in our study, we recorded three mental disorders with high frequency: Major depressive disorders, dysthymia (a less severe, but chronic form of depression spanning at least two years) and post-traumatic stress disorder (PTSD). Figure 12 summarises the prevalence of these conditions among the groups of children in the study. Major depressive disorders were equally common among boys and girls, attaining frequency rates above 20% for all groups except non-orphan boys. Dysthymia was more common among orphaned boys and children having lost a father. Post traumatic stress disorder was the most frequent mental disorder found with prevalence rates ranging from 23% to 48%, except among the groups of boys having lost a father and non-orphan boys who had considerably lower rates (between 5 and 9%). The statistical analysis revealed that post-traumatic stress disorders were significantly more common among girls than among boys ($\chi^2(1) = 8.07$; $p \leq 0.01$). Other differences that are noticeable in the figure did not reach statistical significance levels.

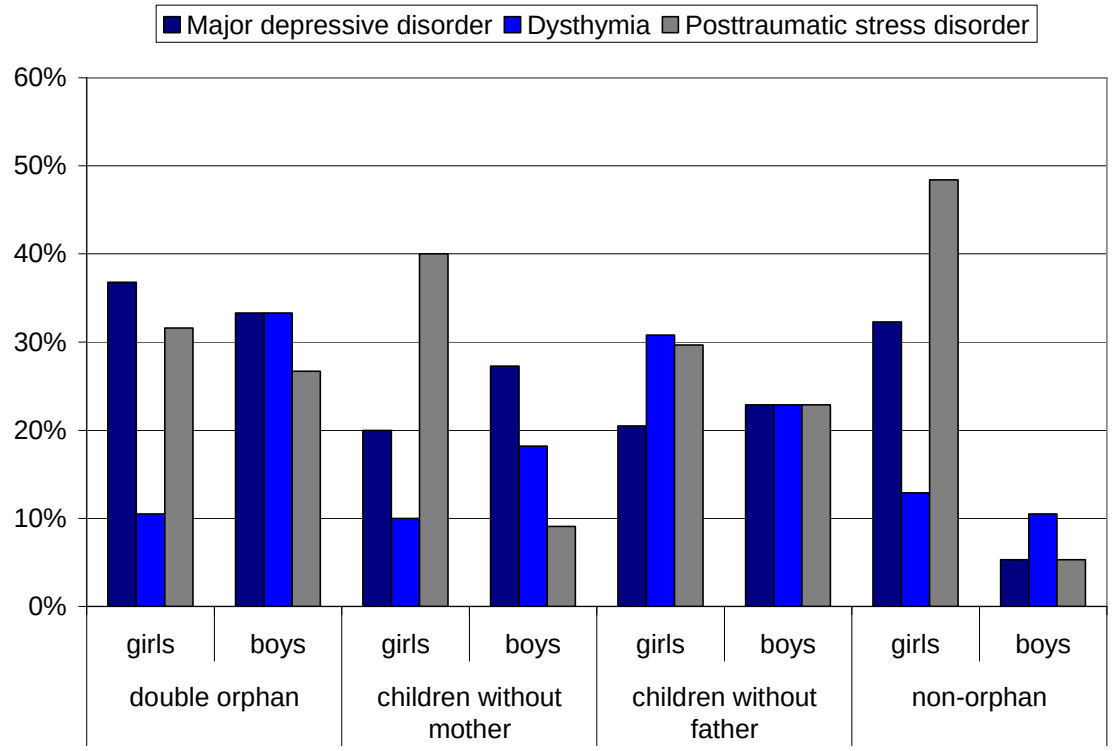

Figure 12: prevalence of mood and anxiety disorders in the different sub-samples

6.12.2 Substance related disorders

We asked all children whether they consumed substances that could lead to abuse or addiction. In contrast to our findings in Togo and Burkina Faso (Behrendt and Mbaye 2007; Behrendt and Mbaye 2008), none of the interviewed children reported frequent use of alcohol (beer), cannabis or locally available stimulants. Substance use does not appear to be an important risk factor for the mental health of children in the research area. .

6.12.3 Disorders usually diagnosed in childhood and adolescence

A diagnosis of conduct disorder requires that the child has exhibited persistent and repetitive antisocial behavior over a period of at least on year including:

- aggression towards people and animals,
- destruction of property,
- deceitfulness or theft,
- serious violations of rules.

Among the children in our study, conduct disorder was significantly more common among boys (22.5%) than among girls (9%) ($\chi^2(1) = 6.21$; $p \leq 0.05$). As shown in Figure 13, boys without a father were more likely to exhibit conduct disorders than boys without a mother ($\chi^2(3) = 6.53$; $p \leq 0.05$). Among girls, orphans had the highest rates of conduct disorders, but

the differences between the four groups were not statistically significant ($\chi^2(3) = 6.05$; $p > 0.05$).

The diagnosis of attention deficit/ hyperactivity disorder (ADHD) requires a group of signs and symptoms including distractibility, difficulties in concentrating and focussing, forgetfulness, problems organizing ideas, tardiness, impulsivity, and difficulties in planning and execution. These are common symptoms that can only be classified as a *disorder* if they seriously impair performance in school and relationships with others, or if they are a source of anxiety or depression. Among the children in our study ADHD was significantly more common among boys than among girls ($\chi^2(1) = 4.50$; $p \leq 0.05$). Figure 13 suggests that it was more common among boys living in single parent households, but the differences between the four groups of boys nor among the four groups of girls were not statistically significant (For boys: $\chi^2(3) = 4.70$; $p > 0.05$; for girls $\chi^2(3) = 2.01$; $p > 0.05$).

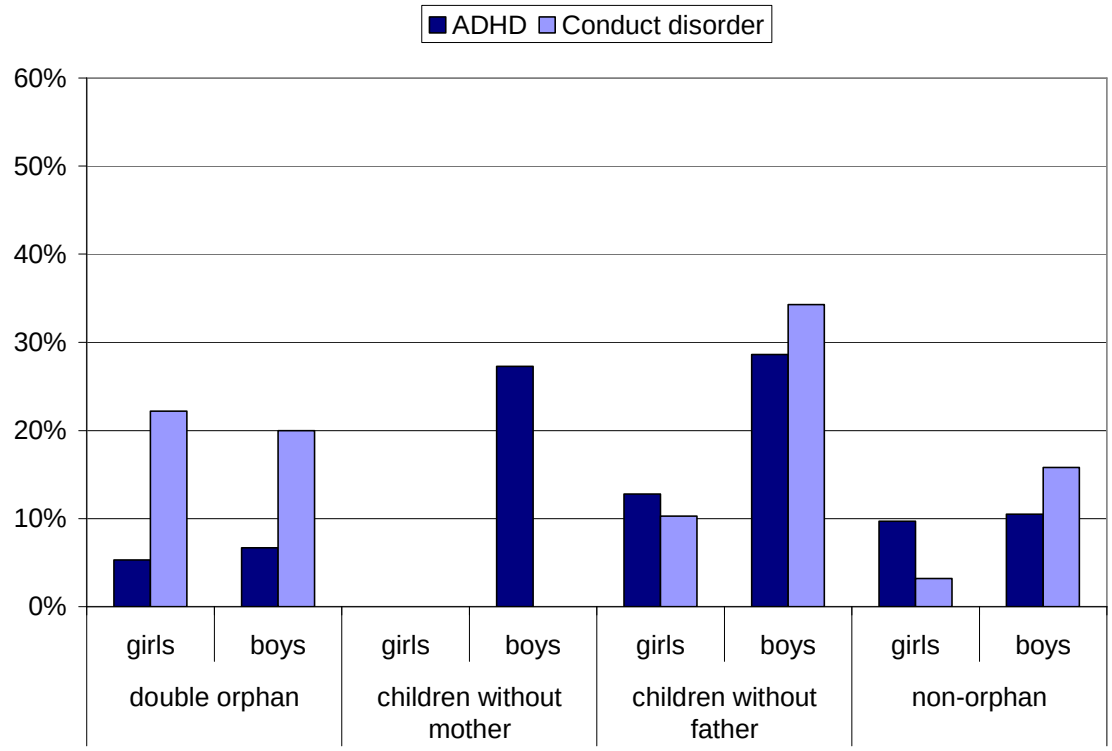

Figure 13: Prevalence rates of attention deficit/ hyperactivity disorder (ADHD) and conduct disorder in the interviewed sample

6.13 Results of the focus group discussions with the children

The aim of the focus group discussions was to gather information about what kind of help the children would like to receive when confronted with situations of distress. We conducted a total of 18 focus group discussions in the six research communities. As described in the methodology section, the focus groups were structured around standardized stories of children in difficulties. The children identified themselves easily and with much empathy with

the main characters of the stories. They discussed the feelings of these characters in terms of pain, sadness, shame, rejection, fear and loneliness. They proposed a number of solutions on how to ease the suffering of the story's characters which can be categorized in two types: "temporary mitigation" of the suffering and "concrete efforts to eliminate the problem".

Suggested solutions of the type "temporary mitigation" were

- Provision of comfort and consolation by covering the basic needs of the child (give food/ clothes);
- Distraction and peer solidarity: playing with the child or do story-telling;
- Praying for the distressed child.

Solutions of the type "concrete efforts to eliminate the problem" were

- Running away from home;
- Removing the child from the person responsible for the suffering;
- Supporting the suffering child in his or her chores in order to decrease the exposure to violence or humiliation;
- Make sure that the child gets treatment/ gets tested for HIV;
- Give advice to the child on how to avoid situations of pain and distress;
- Give advice to the parents for enhancing the assistance to the suffering child.

The results of the focus group discussion illustrated that children in situations of distress – regardless of the origin of their suffering – would like first of all to receive two kinds of support: provision of their basic needs and distraction and solidarity of peers and family in order to prevent loneliness and rejection. This temporary mitigation is for children just as important as addressing the roots of the problem: as long as children feel emotionally supported and their basic needs are taken care of, they are able to cope with the situation even if no concrete solution to the cause of their suffering is found. Once the distress is mitigated, situation specific support comes into focus: obtaining medical treatment, decreasing the domestic violence or receiving assistance for studies in school.

7. Result synthesis and discussion

Our study assessed the psychosocial impact of parental loss on children in the North West Region of Cameroon. We compared groups of orphans, children having lost a mother, children having lost a father and non-orphans regarding diverse social and psychological factors determining the mental health status of children. The conclusions and recommendations of the study are meant to inform and to improve programs and policies for psychosocial support of children in the North West Region of Cameroon.

Orphans and children having lost one parent were represented in strong proportions in the research area. Nonetheless, HIV was only one of many causes contributing to the high orphan rate.

7.1 Differences between orphans, children having lost one parent and non-orphans in terms of social support and mental health

Comparing the groups of children categorized by their parents' survival status revealed few differences between the groups. Neither orphan status nor the loss of one parent seemed to have a negative impact on the education level of children in our study. An analysis of individual factors determining the *resilience*, namely emotional well-being, pro-social skills and self-esteem, also did not reveal noteworthy differences between the groups.

The risk of suicide was higher among orphaned boys than among non-orphaned boys. In general, suicidality was low for children having lost a father, but high for orphans and girls having lost a mother. The experience of losing both parents, and for girls the experience of losing their mother, appears to increase the risk of suicide in children. Our hypothesis is that children exposed to the death of a beloved person at a young age are forced to integrate the concept of dying very early: they observe that parents and caregivers die after suffering and draw the conclusion that death is a way of disappearing, a way out of affliction. As a consequence, they, themselves, start thinking about committing suicide to end their suffering when life becomes unbearable. However, we also observed high suicidality among non-orphan girls, indicating that parental loss is only one of many risk factors determining the suicidality of a child.

A comparison of exposures to different types of traumatic life events and, in particular to domestic violence, did not reveal notable differences between the groups. Orphans and children in single parent households were neither more exposed to domestic violence in life-time nor to ongoing abuse. An exception was the result of life-time exposure to verbal violence among boys. All boys were commonly subjected to verbal abuse, but non-orphaned boys suffered significantly less than boys who had lost one or both parents,

Finally, group comparisons of the prevalence of mental disorders showed that certain mental disorders, such as post traumatic stress disorder and depression were common among almost all groups except among non-orphaned boys. However, we found few significant differences between orphans, children in single headed households and non-orphans. Boys who had lost their father or both parents had considerably higher rates of conduct disorders than boys who had lost their mother or whose parents were alive. Most of the boys with conduct disorders were living with their mother or with other female relatives without a father or a male relative who could provide a role model. Our interpretation is that the father (or a father substitute) is important for the development of boys. If boys do not have a male role model in their household, they are more likely to construct their identity by testing limits through delinquent and antisocial behavior.

7.2 How distressing is parental loss and orphanhood?

As outlined in the section above, the findings of the group comparisons indicated little differences between orphans, children living in single parent households and non-orphans. This does not mean that parental loss and orphanhood have not been distressing experiences for the children in our study. It simply means that children who are not orphaned are also exposed to numerous distressing conditions and events that affect their development and their mental health. These are discussed in section 7.3. The study found that parental death *is* a source of serious distress. It is a common source of anxiety and it was named by a number of children as the most distressing life experience. It often brings about negative changes in the life of a child. We identified several factors associated with the death of a parent that are potential sources of trauma and suffering:

- to be witness to the process of dying;
- loss of love, affection and material support;
- an impoverished household situation if the primary breadwinner dies;
- difficulties in satisfying basic needs;
- changing of household, moving to a different village/ town;
- adaptation to new family structures and to a new caregiver;
- discriminative treatment and exploitation in foster families.

The above listed factors do not apply to all orphans, but represent a list of risk factors that may be associated with parental loss. Although the majority of children who had lost a parent stated that they were affected by the loss, less than one third described the event of parental loss as a particularly distressing life experience. The children who developed post traumatic stress and unremitting grief after the death of their parents had in common that the event of parental death in *itself* represented a terrifying experience. This is the case, for instant,

- if the parental death was sudden and occurred unexpectedly,
- if there was a direct exposure to the process of prostration and death or

- if the child discovered the body or was confronted with the body without preparation

Under these circumstances, children were often emotionally destabilized for longer periods of time. At the time of the interview, however, most children were *not* very preoccupied with the death of their parent(s). Their center of attention was not the loss, but the uncertainty on how to *normalize* their life now, and on how to open perspectives for the future. They struggle to ensured their basic livelihood, worried about how to cover their school related fees, and about how to find a place in a new foster family. They did not linger in grieving processes, but undertook all sorts of initiatives to continue their life. This high degree of resilience in children to overcome the loss of a parent is indeed amazing. Our hypothesis is that children in this community were quite resilient to witnessing death because it was omnipresent in their life. Hearing about people dying was nothing unusual for them: they observed sick people, participated in funeral ceremonies and witnessed other children loosing their relatives. The loss of a parent was not an extraordinary event, but a common experience in the community, making it less traumatic. The children in our study may dispose of a certain degree of mental preparation for losing a parent, as they have grown accustomed to witnessing death since early childhood. Such psychological preparation represents a protective factor against trauma: if you anticipate things to happen, they are less difficult to cope with once they occur (Paton 1994; Zeidner and Endler 1996; Basoglu, Mineka et al. 1997). The fact that parental death is more an *ordinary* than an *extraordinary* event for children in North West Cameroon, and that children are likely to be mentally prepared for the death of a parent are two possible explanations for the high level of resilience among children to overcome parental loss.

The results also suggest that the death of their mother is more upsetting to children than the death of their father. The loss of the mother usually means changing home and getting used to a new guardian. When the father dies the children usually stay in the same household. Furthermore, the boys and girls in our study appeared to be emotionally closer to their mother's who take care of daily needs and share important experiences. Fathers were often absent for long periods due to a high level of mobility required by their work.

7.3 Do orphans need specific support?

Although orphans report that they experience shortcomings in affective and material support compared to their step-brothers and step-sisters, they are still just as or even more supported than many non-orphans in the community. These findings question the rationale for projects that target support to children on the basis of their orphan status. If there are many children in a community that suffer just as much as the orphans, is it ethically justifiable to support only orphans? Clearly, they are a visible group, while other children affected by less visible risk factors may be more difficult to identify.

The study also indicated that orphans were not the only children suffering from discrimination. Whereas orphans suffered mainly from discrimination within their households

as compared to other household members, other groups of children suffered from stigmatization and even exclusion at community level. These included children without a known father, children with mentally ill caregivers and children whose mother was involved in the sex trade. These children were often victims of mockeries and marginalization.

7.4 Factors other than parental death endangering the mental health of children

7.4.1 Domestic Violence

The high levels of domestic violence recounted by all children in our study have undoubtedly been the most devastating impact on mental health. Many children in all groups reported physical abuse, verbal violence, and neglect. Sexual abuse was considerably less common, but still represents a serious menace for more than 10% of the girls in the study. The high prevalence of domestic violence is reason for concern. In addition, the severity of the inflicted abuse is simply dangerous. Children report broken limbs, burns and deliberate cuts. The children's narratives were confirmed by observations of the field team who noted injuries and observed refusals by parents to treat seriously injured children. The different types of domestic violence represent crucial determinants of mental health outcome. The findings indicate that they impede emotional wellbeing and self-esteem, increase suicidality and are closely related to certain mental disorders such as major depressive and post traumatic stress disorder. Community members usually do not interfere when witnessing cases of domestic violence. Physical punishment of children for the purpose of education is tolerated and considered normal. People do not interfere in "family matters". Even the most severe cases of domestic violence are not referred to the traditional nor to the governmental justice system. Hence, measures from community leaders or government representatives are inefficient for protecting children from domestic violence.

Of the 100 girls in our study, 15 reported that they had been raped, most of them by community members, some by members of their family. These numbers merit attention: more than one girl out of ten has experience coerced sex, in some cases before the age of ten. Taking into consideration the high HIV prevalence of the region and the elevated infection probability in coerced sex (see for example Kalichman and Simbayi 2004), these girls have a high probability of being infected with HIV. Girls who spoke out about what happened to them were usually disbelieved, accused of being guilty for the incidence and even punished. Some girls never told anyone, too ashamed about what they had experienced or too frightened about how family members might react to the disclosure of the information. As a consequence, none of the raped girls have received medical assistance after the incidence. This is an issue that should be taken up more vigorously by the many HIV awareness programs in the region. There meeds to be more discussion in the community about the high

vulnerability of young girls to rape, about effective protection, and about steps to take after a rape has been reported.

7.4.2 Other common traumatic life experiences

All groups of children in our study were exposed to a large number of potentially traumatic life experiences. Serious road accidents, tribal wars, beating up and assassinations of thieves or encounters with snakes or with supernatural powers were further frequent experiences that deeply upset children and could result in long lasting emotional harm.

7.4.3 Building block effect

The analysis of the impact of traumatic life experience also shows that the quantity and the intensity of exposure to adversity play a role. No matter how strong the resilience of a child is, if distressing events keep accumulating, the defense mechanisms will break and the child will develop severe mental disorders. This conclusion is in line with previous research results and is known under the term of "building block effect": the higher the number of traumatic life event, the higher the probability of an individual to be severely mentally ill (Schauer, Neuner et al. 2003).

7.4.4 Vulnerable caretakers and caretakers breaching social norms

Our study uncovered multiple examples of children living with vulnerable or "abnormal" caretakers who were exposed to high degrees of domestic violence and to marginalization by the community. These children are at high risk for mental health disorders. They include

- children living with mentally ill caretakers;
- children living with caretakers involved in transactional sex;
- children without known father;
- children with very old and impoverished caretakers
- children living with a caretaker who is himself or herself physically and verbally abused by a more powerful person.

The last group in this list includes many non-orphans who suffered a lot from the fact that their caregiver could not protect them from violence. A mother financially depended on a violent husband and deprived of all decision making has little control over her own life, let alone the lives of her children. She confers the feeling of helplessness to the children who have no choice but to get drawn into the hierarchy abided by violence. The constant submission to unjust circumstances creates feelings of helplessness, fear and frustration leading in the long run to maladaptive behavior, suicide risk and low self esteem.

7.4.5 Isolation from peers

The focus group discussions and the assessments of emotional well being illustrated the importance of peer groups for the resilience of children. Children that are kept in isolation by their caretakers and that are not allowed to join others for group activities have little possibility to develop their social skills and are vulnerable to depression. Restricted access to peers and protracted periods of isolation were key features among severely affected children. A *selective* isolation on the other hand may also be a sign of a serious disturbance. Children with weakened defense mechanisms prefer often to stay by themselves. They feel that they cannot tolerate more negative experiences and therefore stay alone to protect themselves from further harm.

7.5 What factors enhance the resilience of children to cope with adversity?

The discussion of risk factors indicates, of course, that their absence serves to enhance the resilience of children: protection from violence and traumatic experiences, a mentally healthy and privileged care taker, etc. But protection and resilience requires more than the mere absence of increased risk. We observed various internal (individual) and external protective factors that are often closely intertwined. The most important ones are discussed in the following paragraphs.

7.5.1 Internal/ individual protective factors:

- Self esteem: Children with self esteem are less vulnerable to mental illness. They don't feel inferior to other children and trust themselves that they can achieve their objectives just as well as anybody else. Their self confidence helps them to deal with hardship and react with creativity to problems they encounter.
- Feeling in control: This factor is linked to a self-confident attitude. Children who, despite adversity, feel that they have a level of control over their lives and their actions are more resilient than children who feel helpless.
- A sense of belonging: In order to develop resilience, children need a niche in a family in which they can shape their identity. A sense of belonging is not linked to living with biological parents. If children develop an attachment to their guardian, if they feel accepted and grounded in their household, they are able to construct a sense of belonging that enables them to deal with hardship.
- Faith and connection to community values: Belief and value systems enhance identity and a sense of belonging and protect from depression.
- Dreams and hope for the future: Resilience in children is linked to hope and a focus on the future and not a focus on troubles in the past past.

7.5.2 External protective factor:

- Solid relationship with a caregiver: Children need a supportive caregiver for growing up mentally healthy. As discussed earlier, this caregiver does not have to be a parent. It can be any relative providing affective and material support to the child.
- Peer relationships;
- Sufficient access food, shelter, clothing and medical services;
- Access to education;
- Close link to the culture and participation in traditional rituals such as described in section 6.3.

7.6 Parents as principle caregivers of children: a methodological concept with limited reach?

We observed that children in the participating communities often have several caretakers. Even among the children whose parents were alive, 25% did not live with them but resided with members of the extended family. Fostering children in larger families in order to provide them with as much support as possible has been part of African tradition for a long time (see for example Isiugo-Abanihe 1985; Verhoef 1999) and certainly long before the existence of HIV. According to the traditional concepts in many African societies, a child does not "belong" to its biological parents. A child belongs to its family and this family is large, including uncles, aunts, cousins etc. The "motherhood role" is not necessarily taken up by the birth mother; on the contrary, the concept of motherhood allows various relatives to be involved in nurturing, socializing and educating children (Harkness and Super 1995; Lloyd and Blanc 1996). Very often an uncle or an aunt takes up principal tasks of caretaking and becomes a more important attachment figure in the life of the child than the parents. It appears that our practice of classifying children into groups according to their parental status is of limited use in West African communities: a child –though a "non-orphan" according to the applied categories, can be deeply affected by the loss of an aunt who acted as the main caretaker. This loss is not taken into account in the applied category system, although it may be even more devastating than the loss of a mother. Rather then categorizing children on the basis of parental survival or death, it may be more useful to trace the importance of different adult relatives in a child's life and to assess if one of the main caregivers has died recently. Moreover, the high level of distress we observed among the group of non-orphan girls may be linked to the fact that they were taking care of an ill parent, including a parent who may be living with HIV. This "AIDS related impact" is not visible if children are categorized into orphans and non-orphans. In reality, several non-orphans might soon change their group status. Cross-sectional studies are unable to analyze the dynamic transformation of families and of the changing situation of children within these families.

8. Conclusion et recommendations

For several decades African societies have been confronted with multiple crises. Cameroon has not been an exception. Economic depressions and the epidemic of HIV are just two examples that have unsettled social structures of communities in the country. As a consequence, organization modes, solidarity and protective systems are in a process of transition and less effective than in former times. In order to adjust to new realities, roles and status of community members changed within short periods of time. Communities with a high HIV prevalence all over Africa have reacted in order to provide support to orphaned children. Their coping mechanisms and strategies differ from one region to another. Many development assistance projects ignore the community resources to deal with adversity and apply standardized unilinear responses to complex, multiple and constantly changing realities. The identification and material assistance to orphans are often focal points of these programs. In the North West Region of Cameroon, however, orphan assistance programs are likely to undermine positive community responses.

Our study shows that, in general, communities in this region have regulation mechanisms and social structures that allow a well-organized indigenous response to orphaned children. None of the children participating in our study, for example, was deprived of shelter, abandoned by the family or engaged in commercial sex work in order to survive. Although the foster families were not always able to meet all needs of the children, they provided a large amount of support to them. The study revealed that children have strong coping capacities to overcome the loss of a parent as long as they are confided to a new caretaker who is willing and capable of giving affection, food, clothes and access to education.

Our study indicated that the investigated groups - orphans, children living in single parent households and children with two parents – were practically on equal terms regarding emotional well-being, resilience and mental health. Children who had lost one parent and those who still had both parents were just as affected by adversity as orphans. We could also describe it the other way around: orphans and children having lost one parent were just as resilient and protected as non-orphans.

As we described in detail in previous sections, children in North West Region of Cameroon are exposed to multiple adversities, some of them related to HIV. Numerous children in this region of high HIV prevalence are temporarily affected by parental loss, but this is just one of many factors putting their healthy development at stake. A particular risk factor for the mental health outcome of children is the high prevalence of domestic violence in the region. Based on our findings, we recommend developing a holistic and integrated approach to support vulnerable children, rather than an HIV or orphan specific response. There are three main

components for this approach: (1) Strengthen family and community coping mechanisms, (2) Social support to all children in need regardless of their status, (3) Protecting children from violence and building up their resilience.

8.1 Strengthen community and family coping mechanisms

Communities and families in North West Cameroon have efficient mechanisms to ensure the care and support of orphaned children. It is therefore important that all development and assistance projects aim to strengthen these mechanisms. Taking children away from their families, providing institutional care, overtaking the role of the guardian by paying for basic needs and school fees for long periods are strategies that destabilize family responses for orphaned children. Assistance programs should not try to replace parents, but to help the parents and guardians to fulfill their responsibilities. As children's difficulties are intertwined with the difficulties and coping capacity of their caregivers, we recommend focusing assistance activities on caregivers and not directly to children. By accompanying guardians in their daily educative and caregiving tasks, the well-being of the children can be significantly improved. We propose creating dialogue spaces for parents and guardians at community level where information on child care can be delivered and discussed. Guardians can exchange about problems, identify solutions together and construct solidarity systems. For the creation of these exchange spaces, we recommend training and supporting local NGOs, present and appreciated at community level, to organize and facilitate meetings with guardians and to make use of this space to provide psycho-education to parents about the needs of children. Important aspects to address with guardians/ parents will be, for example,

- how to help and talk to a child reporting sexual abuse and what measures to take;
- the devastating impact of neglect and other severe forms of domestic violence;
- discrimination of children due to their non-afiliation with the breadwinner of the family;
- symptoms of neurological and other severe illnesses;
- socio-professional reintegration of school drop outs.

It is important that parents in general – and not only fostering families - should receive and discuss information on how to respond to the psychosocial needs of children in different age groups.

8.2 Social support to all children in need regardless of their status

Many children drop out of school for longer periods of time due to a lack of support for school related costs. Many children have health problems that often remain untreated. These experiences are not unique to orphans, but are observed among all children. We suggest developing a strategy with communities and relevant governmental institutions to assure universal access to school and health care for *all* children.

8.3 Building up the resilience of children and protecting them from violence

8.3.1 Building up resilience of children

In order to reach large numbers of children, we recommend collective activities targeting groups of children in different communities. The goal of the strategy is, as a first step, to identify and to create protective spaces where children can express themselves and are listened to and, as a second step, to organize and facilitate activities in these spaces. The following sites are examples for potential protective spaces where children can meet without creating stigmatization.

- Childrens clubs and networks;
- Small and large group games as well as sport events (soccer games etc.);
- Theater and drawing sessions;
- Child radio programs;
- Religious group gatherings.

Once an adequate framework for protective spaces is identified, key actors for child protection, namely local NGOs and community based organizations, are suggested to be trained on how to provide collective psychosocial support in the scope of these protective spaces. Recommended activities could be, for instance,

- games stimulating expression and listening to each other,
- Fairy tale sessions for encouragement and transmission of values,
- Group reflexions for identifying solutions for common problems in order to reinforce peer support mechanisms (difficulties in school performances, household chores etc.),
- Exercises in building up self confidence,
- Role plays about difficult situations for comprehending the distress of peers,
- Social games for decreasing stigmatization associated with certain types of illnesses (like epilepsy, HIV) or with the family status (e.g. a mentally ill mother).

It is important to encourage in the scope of these different activities different modes of expression, such as singing, dancing, praying or organization of traditional rituals. The community members should be involved as much as possible in the implementation of these activities. Recurrent collective activities with children will allow the facilitators to identify severely affected children who need more specific and intense support than the majority of their peers. They can be referred, as outlined in the next section, to psychosocial mobile units for severely affected children.

8.3.2 Protecting children from violence

Key actors to involve are community based organizations and development committees, teachers and religious leaders. We propose the elaboration of a training module to enable the above named actors to

- raise awareness about the devastating consequences of domestic violence;
- recognize signs of distress and abuse in children;
- set up and accompany family mediations;
- address sensitive issues with children and know how to formulate questions;
- refer the child to an adequate assistance institution;
- follow-up on the well-being of referred children (home visits) on a regular basis.

It is important to mobilize a combination of actors associated with modern and traditional institutions in order reach a large number of children. In Bamenda province, the church has a very strong capacity for youth and adult mobilization. We suggest assisting pastors and other church actors to transfer key messages about child protection. Another powerful tool for transmitting messages on psychosocial needs of children is the community radio.

Alongside an operational network for child protection at community level, we propose setting up psychosocial mobile units. As soon as a severely affected child is identified at community level, the actors of the operational network need to be able to refer it to a member of the psychosocial mobile units. These units are made up of professional or paraprofessionals trained for assisting children and families in very difficult situations. The mobile units should be permanently available. Their training level and commitment is a key factor for the success of these units. It is recommended that the members are either clinical psychologists or specially trained social workers. The specific objectives for assisting particularly affected children are to:

- Ease the emotional suffering of the identified children;
- Take appropriate action to reduce danger and harm that the identified children are exposed to;
- Empower the children to develop new perspectives;
- Build up livelihood perspectives for these children;
- Identify, collaborate and give technical and financial support to Plan's local child protections partners for ensuring medical, judicial and social support to the identified children.

The following actions will be needed in order to provide psychosocial support:

- Counseling, trauma healing and crisis intervention;

- Family mediations and regular home visits in case of conflict and ongoing domestic violence;
- Identification of family members or other care givers that are disposed to ensure the protection of the children and to work out supporting strategies for the best interest of the child;
- Relocation of children to a safer environment in case that this represents the only solution to protecting a child's life;
- Enhancing of livelihood perspectives for the child;
- Facilitating and following up on social, judicial and medical assistance

Finally, we stress the importance of regular monitoring and evaluation. Ongoing monitoring and assessment of program effectiveness is essential for making necessary adaptations in implementation strategies. It is indispensable to support frontline workers, to supervise and provide regular training for all partners. Programs should not be limited to short time slots, but at least be conceptualized for ten years.

Apart from programmatic recommendations, we also highlight the importance of more research. Even though our study makes available precious information for project development, we have to take into consideration that the small sample size represents a limitation for the reliability of the findings. Further studies investigating larger samples with a longitudinal approach are recommended to explore further the psychosocial impact of orphanhood and parental loss on children in Cameroon.

9. Annex

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