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INTERNATIONAL

**WE KNOW WHAT  
WE NEED**

**PROGRAMME DESIGN CONSULTATIONS  
WITH ADOLESCENTS IN THE FAR  
NORTH REGION OF CAMEROON**

**September 2022**

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# CONSULTING WITH ADOLESCENTS IN CAMEROON: SUMMARY OF FINDINGS AND RECOMMENDATIONS

## INNOVATIVE ADOLESCENT-CENTRED METHODOLOGY

The consultations in Tokombere and Makary communities and Minawao Refugee Camp in the Far North Region of Cameroon took place in April 2022. Plan International's [Adolescent Programming Toolkit](#) was used to guide consultations and programme design with a **total of 96 adolescents and 48 married and pregnant girls** from Minawao Refugee Camp, Tokombere host community and Makary Centre (internally displaced population and host community). The participants included 48 adolescents aged 10 to 14 years (24 female, 24 male) and 48 adolescents aged 15 to 19 years (24 female, 24 male); 24 married and pregnant girls and young mothers below the age of 18 years; and 24 married and pregnant girls and young mothers between the ages of 18 and 24 years old. Additionally, 24 spouses of married girls were consulted along with 24 parents and caregivers of adolescents (12 female, 12 male) and 24 key informants across the three locations.

The toolkit offers a range of adolescent-responsive tools that support participatory consultations with adolescents and young people, including girls and young women. For the consultation in Cameroon, participatory tools were used including an activity called **H-assessment** where adolescents explored the services and programmes in their community and identified aspects they liked and disliked, as well as areas for improvement or suggestions for future programming. Following this activity, adolescents looked at **barriers and enablers** that support or challenge young people's ability to access services. With parents, caregivers and spouses, **focus group discussions** were used to understand better their perspectives and suggestions for supporting adolescents and young people's concerns. Key informants were interviewed using a **key informant interview**.

The consultations focused primarily on **sexual and reproductive health and rights** and **protection from violence** including child protection and gender-based violence. The methodology also included questions around preferences and potential risks relating to the use of **cash and voucher assistance (CVA)**.

This initiative was part of a global adolescent consultation process initiated by Plan International in the Lake Chad basin, covering Cameroon, Niger and Nigeria, in East Africa, covering Ethiopia and South Sudan, and in the Venezuela response, covering Colombia, Peru and Ecuador.

# KEY FINDINGS: WHAT WE LEARNED FROM ADOLESCENTS IN THE FAR NORTH REGION OF CAMEROON

During the consultations, adolescents, including married girls and young mothers, and youth highlighted the following concerns:

## ADOLESCENTS HAVE LIMITED ACCESS TO SRHR INFORMATION AND SERVICES

Adolescents in Minawao Refugee Camp, Tokombere community and Makary have **limited access to SRHR information**, partly due to the strict social norms and **taboos** surrounding the reproductive health and sexuality of adolescents, particularly girls.

**Child marriage** is a traditional practice enforced by parents and caregivers to avoid informal sexual relationships between adolescents and to prevent pregnancy outside marriage.

Adolescents, particularly young pregnant girls and survivors of violence, face major barriers to services as the **availability and quality of SRH services** are limited and are often situated far from where adolescents live.

Access is further constrained by **financial and cultural barriers**. The **lack of staff, limited confidentiality** of services and **negative attitudes** of the community and service providers towards adolescents seeking care (especially girls who are unmarried) form major barriers for girls and survivors of violence seeking to access SRH services and information.

## PROTECTION CONCERNS ARE WIDESPREAD AND GIRLS FACE SIGNIFICANT RISKS OF CHILD MARRIAGE

Adolescents in the consulted communities face **numerous protection risks**, connected to armed conflict, floods, droughts and food insecurity. Adolescents have been separated from their families and lack access to education, increasing risks of **child labour** and **exploitation**.

**Child marriage** is a significant protection concern for girls with devastating consequences including emotional abuse, physical and sexual assault and rape.

Survivors of violence fear reporting concerns or seeking support due to the risk of **stigma and rejection** by their community and **discrimination** by service providers.

Adolescents highlight that there are not enough case workers or functioning community-based protection mechanisms in the community to whom they can safely report concerns.

Preventive child protection and GBV activities are limited, such as safe spaces, psychosocial support, life skills and economic empowerment opportunities for adolescent girls.

## CASH AND VOUCHER ASSISTANCE CAN SUPPORT ADOLESCENT HEALTH, PROTECTION AND WELLBEING

Adolescents think that **cash and voucher assistance** (CVA) can help them **access protection and SRH** services by using it to cover costs of transportation, services and supplies.

Adolescents do not feel confident that their parents and caregivers will spend CVA on them, while **caregivers do not trust adolescents** to spend CVA in a responsible manner. Similarly, married girls and their spouses thought that CVA could cause conflict between spouses. Across all groups, there was a slight **preference for vouchers** as a modality less likely to cause tension about how the money would be spent.

In Minawao and Makary, older adolescents and young mothers also highlighted gaps in **basic needs** such as food assistance, water and sanitation, and youth livelihoods opportunities.

While CVA was seen as an important modality to meet urgent needs, older adolescents, married girls and young women expressed a clear desire for **skill-building opportunities** such as business and life skills training, and sustainable **income-generating opportunities**.

# RECOMMENDATIONS

During the consultations, adolescents, including married girls and young mothers, developed programming priorities and shared solutions for the specific barriers they face in accessing services and support. This has resulted in the following recommendations:

## SUPPORT US WITH INFORMATION AND SKILLS-BUILDING OPPORTUNITIES

### Increase adolescents' access to information and education

- Provide information and education to adolescents to stay safe and promote sexual and reproductive health including menstrual health and hygiene (MHH)
- Provide safe spaces
- Run peer group activities for adolescent wellbeing
- Conduct community outreach activities
- Offer dignity kits, family MHH supplies and mother-child kits

### Increase the social assets of girls

- Offer education and skill-building opportunities
- Offer life skills
- Provide income-generating opportunities
- Provide psychosocial support
- Run leadership training
- Create dedicated spaces for girls
- Promote girls' participation in design, implementation and feedback activities

### Promote youth economic empowerment

- Provide cash and voucher support
- Create economic empowerment opportunities for older adolescents and young caregivers
- Run vocational training and business and economic skill training

## ENGAGE WITH OUR FAMILIES AND COMMUNITIES TO TRANSFORM HARMFUL NORMS

### Support parents, caregivers and families

- Hold parenting sessions to share information and promote positive parenting skills
- Build parents' confidence to share SRHR information with adolescents
- Run parenting groups to address negative social norms
- Provide CVA for families

### Engage with communities to address stigma and harmful social norms

- Raise community awareness about available services
- Engage with traditional and religious leaders to promote SRH and protection rights of adolescents and promote girls' access to services
- Engage with boys and men to ease restrictions for girls and promote positive masculinities

### Invest in community-level services and capacities

- Support community-level protection networks and organisations, including those led by girls and women (such as gender clubs, women's and girls' networks) to lead prevention activities and to facilitate referrals for survivors or at-risk adolescents
- Promote coordination between actors at local level

## IMPROVE THE QUALITY AND AVAILABILITY OF SERVICES IN AFFECTED COMMUNITIES

### Increase services at local level

- Establish (mobile) clinics and safe spaces at local level including in remote areas
- Establish safe houses for adolescent survivors of violence
- Provide health and protection facilities with equipment and supplies
- Hire additional health staff and case workers

### Promote adolescent-friendly services for adolescents

- Train service providers to deliver adolescent-friendly services and reduce barriers for girls when accessing health and protection services including case management
- Promote quality response services for (child) survivors of violence by ensuring that child protection and GBV case management and comprehensive response services meet minimum standards
- Support youth-led initiatives and services to promote SRHR and protection of adolescents



# CONTEXT: FAR NORTH REGION OF CAMEROON

Since 2009, armed conflict in the Lake Chad basin has displaced more than 3 million people across the Far North Region of Cameroon, and also northeast Nigeria, the Diffa region in Niger and Chad. As of 31 October 2022, the Far North region hosts an estimated 138,000 refugees from Nigeria and nearly 378,000 internally displaced Cameroonians. In September 2022, 1.2 million people require humanitarian assistance in the Far North Region of Cameroon, as a result of the compounding impacts of insecurity, flooding, drought, food insecurity and epidemics including COVID-19 and cholera outbreaks. It is estimated that 900,000 people are food-insecure.<sup>1</sup>

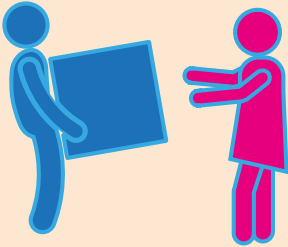
Children and adolescents represent about 62 per cent of the displaced population in the Far North Region. UNHCR protection monitoring data shows that girls form 53.9 per cent of all children involved in protection incidents, and 74.5 per cent of all child survivors of gender-based violence. Unaccompanied and separated children, children without parental care and children who are out of school, children with (chronic) health problems and children with impairments are among those young people most at risk of protection concerns.<sup>2</sup>

In 2020, the UN registered 161 grave violations against children in the Far North Region of Cameroon. Some children experienced more than one grave violation. Violations included: killing and maiming, abduction of children, recruitment and use of children by Boko Haram and splinter groups, military use of schools, attacks on schools and detention by armed forces.<sup>3</sup>

Adolescents are regularly exposed to risks of violence, abuse, neglect and exploitation as a result of income poverty, aid dependency and limited opportunities for development and participation. They have limited access to education and face increased risks of involvement in child labour, sexual exploitation and child marriage used as financial coping mechanisms by families who are food-insecure. Subjected to gender inequality and harmful social norms, many adolescent girls are vulnerable to child marriage and early pregnancy.<sup>4</sup>

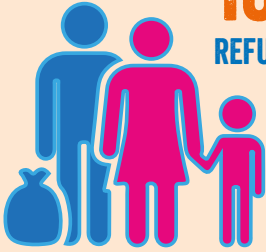
# CRISIS IN THE FAR NORTH REGION OF CAMEROON

ALMOST  
**1.2M**  
PEOPLE NEED HUMANITARIAN ASSISTANCE <sup>5</sup>

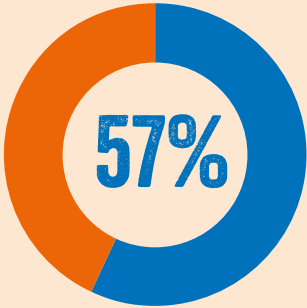


**378,000**  
INTERNALLY DISPLACED PEOPLE IN THE  
FAR NORTH REGION <sup>6</sup>

**138,000**  
REFUGEES FROM NIGERIA <sup>7</sup>



**900,000**  
FOOD-INSECURE  
PEOPLE <sup>8</sup>



OF THE PEOPLE IN NEED  
OF ASSISTANCE  
ARE CHILDREN <sup>9</sup>

DISPLACED  
ADOLESCENTS ARE  
AT HIGH RISK OF  
CHILD LABOUR  
AND EXPLOITATION<sup>10</sup>



161 GRAVE VIOLATIONS RECORDED  
AGAINST CHILDREN <sup>11</sup>

# THE ADOLESCENT PROGRAMMING TOOLKIT

The [Adolescent Programming Toolkit](#) builds upon the great motivation, energy, innovation and capacity of adolescents and the agency and potential of girls. The toolkit offers guidance and tools that support adolescents to learn, lead, decide and thrive in crisis settings.

The toolkit promotes adolescent-responsive programming, through the intentional design and implementation of actions that meet the gender, age-specific and diverse needs, priorities and capacities of adolescents, with special attention to girls and at-risk adolescents.

The toolkit contains four parts:

1. **Rationale – why** we should invest in adolescents in crisis settings
2. **Theory of change** to support adolescents to learn, lead, decide and thrive in crisis settings
3. **Programmatic framework**, presenting our results framework and key interventions
4. **Step-by-step guide** for programming with and for adolescents in crisis settings throughout the humanitarian programme cycle, including 13 practical tools and key considerations for reaching and supporting adolescent girls.

In April 2022, the Adolescent Programming Toolkit was used to hold consultations with adolescents, married girls and young mothers from Tokombere and Makary communities and Minawao Refugee Camp in the departments of Mayo Sava, Logone-et-Chari and Mayo Tsanaga in the Far North Region of Cameroon, with the specific purpose to inform the design of a new adolescent-responsive project.



## Plan International's commitments with and for adolescents in crisis settings

The toolkit was developed based on numerous recommendations of adolescents and girls in crisis settings, as well as evidence that suggests that humanitarian actors should do the following:

- **Place adolescents and girls at the centre of action**, address them as drivers of their own actions, and promote their participation and leadership.
- **Address specific risks and barriers for girls** and engage with boys and men to tackle gender inequality, discrimination and violence against girls and women.
- **Work at all levels** and engage with families and communities, local power holders, service providers, duty bearers and humanitarian actors to improve action for adolescents.
- **Deliver intentional, multi-sectoral programmes** covering protection, education, sexual and reproductive health and rights, and economic empowerment interventions, tailored to the needs and capacities of adolescents and girls in context.



# CONSULTATIONS WITH ADOLESCENTS, MARRIED GIRLS AND YOUNG MOTHERS

Consultations were held with adolescents aged 10 to 19 years, married girls and young mothers, and representatives of youth groups aged 15 to 29 years. The aim was to design a comprehensive project with and for adolescents and young people in Borno and Adamawa. The adolescent and youth consultations each had specific consultation questions.

## ADOLESCENT CONSULTATION

The consultations explored how younger and older adolescent girls and boys, married and pregnant girls, young mothers and youth groups understand the unique impact that conflict and displacement have upon them. The consultations enabled adolescents and young people to raise their voices about their immediate needs and future priorities, with a specific focus on protection, sexual and reproductive health and rights (SRHR), and youth engagement.

## THE CONSULTATIONS WERE DRIVEN BY THE FOLLOWING QUESTIONS:

- **What actions, activities and services do adolescents, particularly married, pregnant and caregiving girls, prioritise to improve their wellbeing, protection and sexual and reproductive health?**
- **What are the main (gendered) barriers and enablers for adolescent girls to access services and support?**
- **How can cash and voucher assistance support adolescent health, protection and wellbeing outcomes?**

## METHODOLOGY

The consultations in Tokombere and Makary communities and Minawao Refugee Camp in the Far North Region of Cameroon took place in April 2022.

### Adolescent Assessment Framework

This framework presents the pieces of information that we need to know about the situation of adolescents in crisis. This tool was used to conduct a desk review prior to the consultations.

### H-Assessment

This activity helps adolescents to identify existing activities and services in their community, reflect on their strengths and weaknesses, develop recommendations for improvement and share new ideas.

### Barriers and enablers

Following the H-assessment, adolescents ranked the most important activities or services for young people, discussed the possible challenges (barriers) and identified solutions (enablers) to these barriers, including social and gender norms.

For more information about the tools and methodology, see: [Adolescent Programming Toolkit](#).

The adolescent consultations focused on qualitative data collection. The consultations were held using the **H-Assessment** tool with single-sex groups of eight participants each where adolescents explored the services and programmes in their community and identified aspects that they liked and disliked, as well as areas for improvement or suggestions for future programming. Following this activity, adolescents looked at **barriers and enablers** that support or challenge young people’s ability to access services.

The adolescent groups were split according to age and gender: adolescent girls and boys aged 10 to 14 years; adolescent girls and boys aged 15 to 19 years. Married and pregnant girls and young mothers were consulted separately, to allow their unique perspective and experience to be at the centre of the consultation.

Spouses of married girls and parents and caregivers of adolescents were consulted through **focus group discussions**. Key informants were consulted through a structured **key informant interview**.

The consultations focused primarily on **sexual and reproductive health and rights** and **protection from violence**, including child protection and gender-based violence, and the use of **cash and voucher assistance (CVA)**.

## CONSULTATION PARTICIPANTS

The consultation process involved a total of 216 community members. A total of 96 adolescents were consulted, including 48 younger adolescents aged 10 to 14 years (24 female, 24 male) and 48 older adolescents aged 15 to 19 years (24 female, 24 male). In addition, married and pregnant girls and young mothers were consulted in separate groups: 24 girls below 18 years and 24 girls aged between 18 and 24 years. Additionally, 24 male spouses of married girls and 24 parents and caregivers of adolescents (12 female, 12 male) were consulted. A total of 24 key informants were consulted across the three locations, including community and religious leaders, women leaders and representatives from local community organisations and local service providers.

## OVERVIEW OF CONSULTATION PARTICIPANTS IN TOKOMBERE AND MAKARY COMMUNITIES AND MINAWAO REFUGEE CAMP

DEPT	COMMUNITY	FEMALE 10-14	MALE 10-14	FEMALE 15-19	MALE 15-19	MARRIED GIRLS	FEMALE ADULTS	MALE ADULTS	TOTAL
MAYO SAVA	TOKOMBERE (HOST)	8	8	8	8	16	4	12	64
MAYO TSANAGA	MINAWAO REFUGEE CAMP	8	8	8	8	16	4	12	64
LOGONE-ET-CHARI	MAKARY CENTRE (IDP AND HOST)	8	8	8	8	16	4	12	64

## SAFEGUARDING AND ETHICS

The participatory consultation methodology places the voices of adolescent girls and young women at the centre of needs assessment and programme design. Data collectors and Plan International staff from the same communities were trained as data collectors to conduct the consultations. The safeguarding and ethics protocols included conducting a safeguarding risk assessment during the planning phase; safeguarding policies and code of conduct signed by all staff and associates involved; informed consent obtained from both adolescents and their parents/caregivers; referral mechanisms in place for potential protection or safeguarding concerns; local safeguarding focal points in place during the consultations; design of adolescent-friendly consultation tools; and training of data collectors on safeguarding, reporting and referral procedures.





# FINDINGS: THE PRIORITIES OF ADOLESCENTS IN CAMEROON

The consultations showed how multiple humanitarian crises in the region are compounding the impact on the health and protection of adolescents, married girls and young mothers. Armed conflict, floods and food security seriously affect adolescents' ability to meet basic needs and access protection and healthcare, while also increasing negative coping mechanisms. Pervasive gender inequality and traditional practices increase the risks of child marriage and further restrict girls' access to services.

During the consultations adolescents demonstrated great concern about the issues affecting their communities and tremendous capacity to improve their lives. Despite often being denied the opportunity to do so, adolescent girls offered concrete ideas on how to engage with their families and communities to overcome the gendered risks and barriers that affect their daily lives and potential.

## FINDING 1: ADOLESCENTS HAVE LIMITED ACCESS TO SRHR INFORMATION AND SERVICES

### SRHR: Main concerns

Adolescents and married girls across all three locations highlighted **major gaps in sexual and reproductive health (SRH) information and services** with main barriers being the limited availability of services, far distances to reach services, costs of transportation and supplies, and social norms and taboos that hamper access to information and services for adolescent girls.

Younger and older adolescents indicated that most adolescents have **limited knowledge** about SRH-related topics such as puberty, menstruation and pregnancy. They also have limited information about the availability and importance of existing SRH services. Adolescent girls, parents and caregivers explained that **strict social norms and taboos surrounding sexual and reproductive health and rights (SRHR)** form a major barrier to accessing information and services in their communities. As a result, information is not easily shared within families and communities, and adolescents are left to their own devices. Some adolescent mothers highlighted that they got pregnant because they and their spouses did not have information on how to prevent pregnancy. **Parents and caregivers do not know how to share SRHR-related information** with their children, citing that they themselves lack an understanding of SRHR.

Parents and caregivers highlighted that they find it difficult to deal with the curiosity and emerging sexuality of adolescents. To avoid "hidden" sexual relationships and unintended pregnancy, many parents and caregivers encourage their girls to get married, so as not to "tarnish the family's image". As a result, **child marriage** is a common practice in the consulted communities. Once married, girls have limited information and access to SRH services, and are often forced to bear children at a young age, especially when they are married to older men.

Girls who get pregnant outside marriage face significant **stigma, rejection and discrimination** by both their relatives and community members, as this is seen as “dishonouring the family”. Many girls are too ashamed about their pregnancy to seek health services and resort to **unsafe abortions**, often with the help of their parents.

Adolescents, married girls and their parents and caregivers all highlighted that SRH services such as medical centres, gynaecologists, midwives, family planning services and gender-based violence (GBV) response services are often limited at **local level** and **far away** from their communities, especially in Makary, Logon-et-Chari and Tokombere. Where services do exist, they lack personnel and equipment. Adolescents do not always receive information about these services and their importance. They also face security risks when travelling to services and they feel that the existing services are **not adolescent-friendly and confidential**. Adolescents expressed concern over health staff displaying a negative attitude, disclosing confidential information and not always being trained to provide services to children and adolescents. Adolescents reported that due to the lack of professionalism of service providers they feel uncomfortable speaking about **sexually transmitted infections (STIs)** or obtaining contraceptives.

Many pregnant girls and young women give birth at home. Giving birth in the hospital goes against this traditional practice and is often discouraged by spouses who do not want anyone to see their wife’s body. The **lack of medical care during childbirth** poses health risks to adolescent girls, especially very young girls, who have a higher risk of complications during child birth.

Finally, adolescents of all ages as well as parents and caregivers cited **financial barriers** as a major reason why they struggle to access SRH supplies and services. This manifests itself both in challenges to pay for **access to health facilities**, as well as **payment for essential supplies** such as soap, sanitary pads and SRH items such as contraceptives. Adolescents and their parents and caregivers drew the connection between lack of financial means and risks of unintended pregnancy and the related negative health consequences for young adolescent girls.

## Recommendations from adolescents, married girls and young mothers relating to their sexual and reproductive health and rights (SRHR)

Adolescents of all ages and married girls want to receive **sexuality and health education** to learn about their bodies, their rights, safer sex and **menstrual health and hygiene (MHH)**, and to know how and where to access SRH services and support. Married girls recommended organising information and educational activities specifically for married girls and young mothers in a trusted environment such as a safe space. Similarly, spouses and key informants suggested organising sessions for adolescents, married girls and husbands on “taboo” topics such as consensual sex, contraceptives, family planning and the importance of access to SRH services for adolescent girls.

Adolescent girls recommended **distributing SRH supplies** such as soap, sanitary pads and mother-child kits, while respecting confidentiality of recipients. Married girls recommended **consulting with girls** and distributing items directly to them instead of handing items to their husbands.

All consultation groups prioritised **scaling up awareness raising** in families and communities about the availability and importance of SRH services for adolescents. Suggested modalities for awareness raising included radio broadcasting, one-on-one information sharing, educational talks, workshops and activities in safe spaces. Adolescents and married girls across all locations recommended organising **parenting sessions** to enhance parents’ and caregivers’ understanding of adolescent development, SRHR and how to facilitate access to services for girls.

To address existing social norms that prevent adolescents from accessing SRHR information and supplies, community members and key informants felt that it was critical to **engage with community leaders, imams and gatekeepers**. It was suggested to raise awareness with them on the importance of sexuality education and about available SRH services, but also to involve them in sharing key information with the community and developing strategies to address harmful social norms.

To **improve the quality of services**, adolescents recommended supplying health facilities with adequate equipment, such as delivery kits and family planning kits (condoms, pills, picture boxes for non-literate community members). They also suggested hiring more staff and delivering training to existing staff to enhance their professional skills and improve confidentiality.

Key informants recommended **creating more community-based services** to make it easier for girls and young women to access information and services, and to strengthen coordination between different community-level actors and service providers. Key informants suggested creating mobile health clinics that can travel to far-flung areas, such as the community of Makary.

To **address financial barriers** to accessing services, adolescents identified cash and voucher assistance as a possible solution but they prioritised **income-generating activities** for young people as a more sustainable way to meet their needs including access to healthcare.



## FINDING 2: PROTECTION CONCERNS ARE WIDESPREAD AND GIRLS FACE SIGNIFICANT RISKS OF CHILD MARRIAGE

### CHILD PROTECTION AND GENDER-BASED VIOLENCE: MAIN CONCERNS

In the Far North Region of Cameroon, children and adolescents represent about 62 per cent of the displaced population. Due to ongoing insecurity, thousands of adolescents have been forced to flee their homes and villages. They have witnessed violence and have been forcibly separated from their families. The presence of non-state armed groups increases risks for adolescents such as **kidnapping, abduction, physical and sexual violence** and **killing**. Recurring climate-related disasters such as floods and droughts further increase protection risks as families become financially desperate and compete for limited resources. **Food insecurity** and **lack of access to education**, particularly secondary education, forces many adolescents into child labour and exploitation.

Adolescents and their parents and caregivers both report that **corporal punishment** is a common parenting practice. While adolescents and some parents saw this as a major concern, some parents described it as an “effective means of educating children”.

Adolescent girls face high risks of gender-based violence (GBV). **Child marriage** – both a traditional practice and an economic coping mechanism – is a major protection concern for girls. Cameroonian law accepts marriage of children as young as 15 years under certain conditions. In the Far North Region, as well as among Nigerian refugees, child marriage is very common and is driven by strict social norms. Girls of an early age are often affected. Adolescents highlighted that girls who marry later are often stigmatised and rejected by their community.

**Domestic and intimate partner violence** risks are high for married adolescent girls and young women. GBV data shows that more than 70 per cent of all GBV cases against girls and women take place at home and in 90 per cent of these situations, the perpetrator is the husband. Types of GBV include physical assault, emotional abuse, sexual assault, rape and denial of resources.

While protection concerns are significant, adolescents highlighted **gaps in specialised child protection and GBV response services** such as case management, counselling, and multi-sectoral support (legal, medical, psychosocial security, economic) and shelters for survivors of violence. In many communities, adolescents cannot easily access case workers and existing personnel are not always trained to respond to (child) survivors of GBV. Adolescent girls and spouses highlighted that there are no marital conflict management committees that can help to prevent intimate partner violence. Finally, there is limited accountability for perpetrators of violence, and limited chances of justice for survivors.

Across all three communities, participants reported a lack of community-level protection services and mechanisms such as local community groups, youth groups and safe spaces. These initiatives can play a critical role in outreach to vulnerable adolescents and in engaging girls in activities that improve their wellbeing and protection. Community-based protection mechanisms can also play a vital role in identifying, reporting, referring and monitoring protection concerns in the community. They can also remove barriers to services

and offer entry points for adolescents and girls to report concerns; their absence makes it more difficult for survivors to seek justice and access support.

Adolescents reported a lack of **safe spaces** and playgrounds are available for young people. In addition, adolescents felt that there are not enough safe spaces and activities for them such as recreational activities, psychosocial group activities, and information provision about protection risks and child marriage.

**Married girls face significant, gendered barriers** to accessing services. Once married, girls have considerable domestic duties and they are subject to strict control by their husbands. Many girls suffer from **low self-esteem** and find it difficult to access the same activities and spaces as their peers who are not married. They find that there are no activities specifically for them. Girls have **no trusted adults and role models** who can accompany them and their spouses in aspects of their lives such as managing healthy relationships, consensual sex, family planning, access to education and equal opportunities within their marriage. While child marriage is a social norm, it is not uncommon that **married girls get abandoned** by their husband, leaving them in a difficult position, both financially and socially. Across the consulted communities there is limited support available for young, single adolescent caregivers.



## Recommendations from adolescents, married girls and young mothers relating to their protection from violence (child protection and gender-based violence)

Younger and older adolescents in all communities prioritised the construction of **safe spaces** with playgrounds and tailored activities for them, including **psychosocial support activities** and **information** that helps them to **prevent violence**, seek support or access services.

Married girls recommended creating **dedicated spaces and activities specifically designed for girls** – whether married or unmarried – where they can safely participate in activities, share concerns, receive advice and access services. Activities could include life skills, leadership, play and creative activities, information about protection and SRHR, and counselling.

Married girls also prioritised **vocational training** and **income-generating activities**, including non-formal education, social-economic reintegration activities, small businesses, training in business skills and life skills. They highlighted the importance of empowering girls and young women economically to prevent risks such as sexual exploitation and to support survivors of GBV and single mothers.

Adolescents, parents, caregivers and spouses recommended **addressing harmful social and gender norms** through community-wide awareness raising, sensitisation and dialogues with gatekeepers to influence and reduce harmful practices such as child marriage.

Adolescents suggested **educating parents** about adolescent development and sensitising them about violence and abuse including corporal punishment and child marriage, and their harmful impact on adolescents. They also recommended raising awareness of parents about available services in the community and emphasising the importance of these for adolescents. Furthermore, adolescents recommended **engaging community and religious leaders in community sensitisation** to address traditional practices such as child marriage and other forms of GBV. They highlight that religious leaders who support Qu'ranic teaching are particularly relevant as they reinforce gender norms that underpin harmful traditional practices that affect girls.

To **improve access to and quality of services**, adolescents recommended delivering training to case management staff to develop their professional skills and enhance confidentiality of services. Key informants recommended **supporting youth-led initiatives** with logistical, material and financial resources and bringing youth-related services closer to communities. Finally, they recommended **strengthening coordination** between the different actors that work with and for adolescents and youth.

## FINDING 3: CASH AND VOUCHER ASSISTANCE CAN SUPPORT ADOLESCENT HEALTH, PROTECTION AND WELLBEING

### HOW CVA CAN SUPPORT THE HEALTH, PROTECTION AND WELLBEING OF ADOLESCENTS

Where lack of financial means was identified as a barrier to accessing services or as a risk to their overall wellbeing, adolescents were asked about the role that cash and voucher assistance (CVA) could play in addressing this barrier.

Adolescents would use CVA to pay for **transportation** to access services such as **healthcare services**, to get **supplies** such as contraceptives or sanitary pads, or to pay for the fees of the service. Married girls said that CVA could help pregnant girls to access **maternity care**.

Older adolescents, married girls and spouses indicated that they would use CVA as an investment for income-generating activities. They indicated that economic self-reliance would help to improve their living conditions in a sustainable manner and increase their overall access to basic needs and services.

During the consultations, young mothers in the Minawao Refugee Camp also highlighted gaps in basic needs such as daily food rations, water supply and sanitation facilities. Older adolescents in Minawao and Makary also highlighted that there are insufficient income-generating activities, leadership and skill-building activities for young people available.

### MODALITIES, RECIPIENTS AND RISKS

**Preferences for cash and voucher modalities differed among communities and groups**, with a slight majority preferring vouchers. In the host community of Tokombere most adolescents preferred vouchers, while married girls and young mothers preferred cash. In the Minawao camp, cash was preferred by younger adolescent boys aged 10 to 14 years and married girls while the other groups preferred vouchers. In Makary, all groups preferred vouchers. Married girls recommended that girls' needs should be identified prior to CVA programming.

The most common **reason for choosing vouchers** was that it reduces the risk of the CVA being used for other purposes or unnecessary expenses. The most common **reason for choosing cash**, was that it enables families to buy items of their choice and to resell them on the market as a livelihood.

Overall, **vouchers were more accepted by spouses, parents and caregivers**.

Adolescents felt that they should receive CVA directly as they were concerned that their caregivers, especially their fathers, would use it for their own purposes such as marrying other women or drinking alcohol. Similarly, married girls recommended that CVA should be distributed directly to them, not to their husbands who would control the money and use it for something else. Some married girls felt that CVA might cause their husbands to leave them and marry other women who receive cash.

However, parents and caregivers worried that if adolescents receive CVA directly, they would no longer respect their parents and would leave home. Similarly, some spouses felt that providing CVA directly to girls



could create conflict between married couples, and that girls would no longer respect their husbands. They highlighted that vouchers for specific services for adolescents were more straightforward and caused less tension in households.

Although most adolescents welcomed the idea of CVA, many girls and boys said that they preferred **income-generating activities**, highlighting that it was a more sustainable way to meet their own needs, prevent risks and support survivors of violence.



# CONCLUSION AND RECOMMENDATIONS

In the Far North Region of Cameroon **adolescents, particularly girls, face many challenges in accessing information and services** related to their sexual and reproductive health, protection, and wellbeing. Adolescents have limited access to comprehensive sexual and reproductive health and protection information, supplies and services, due to armed conflict, poverty, poor infrastructure and restrictive social norms.

**Adolescent girls and young mothers are affected by pervasive gender and power inequality and harmful gender norms** that restrict their mobility, decision-making power and ability to access their basic needs and rights. Gender-based violence and child marriage risks are significant for girls, while prevention and response services are extremely limited at community level. Stigma and discrimination prevent many adolescents, especially girls, from accessing the services they need.

Despite these challenges, **adolescents, including girls, are determined to make changes in their lives and participate in humanitarian action**. During the consultations they highlighted their desire to speak for themselves and be consulted regularly about programmes aimed at them. They prioritised actions that they themselves, the people around them and humanitarian actors should take to make these changes happen.

The following recommendations reflect the programmatic priorities shared by adolescents during the consultations as well as their suggested actions to break down barriers and improve access to services for girls:

## 1. SUPPORT US TO PROTECT OURSELVES FROM VIOLENCE, TO STAY HEALTHY AND TO ACCESS ECONOMIC OPPORTUNITIES

### INCREASE ADOLESCENTS' ACCESS TO INFORMATION AND EDUCATION

Adolescent girls and boys of all ages need **information and education** about health, sexuality and protection including information about how and where to seek support or access services. **Safe spaces**, including **girl-only spaces**, peer group activities and community-level outreach activities are important ways for adolescents to access information. To practise positive health behaviours, adolescents require **health and hygiene supplies** such as soap, dignity kits, MHH supplies, contraceptives and supplies for young mothers and their babies.

### INCREASE SOCIAL ASSETS FOR GIRLS

Girls need to be empowered to overcome feelings of shame, stigma and low self-esteem through **income-generating** and **skill-building opportunities for girls** such as life skills sessions, leadership training, vocational training and psychosocial support activities specifically designed for them. **Safe spaces** with tailored activities for girls, particularly married girls and young mothers, are needed where they can discuss issues, receive support, report concerns and access services. To overcome gendered barriers to humanitarian services, adolescent girls should be supported to **participate** in planning, implementing and **providing feedback** on programme activities.

## ENHANCE YOUTH ECONOMIC EMPOWERMENT

To address short-term financial barriers to health and protection services **cash and voucher support** can be an effective modality, particularly for at-risk families, single mothers and survivors of violence. However, to prevent violence and promote long-term health outcomes, adolescents prefer **income-generating opportunities** alongside vocational training and business skill training.

## 2. ENGAGE WITH OUR FAMILIES AND COMMUNITIES TO TRANSFORM HARMFUL NORMS

### SUPPORT PARENTS, CAREGIVERS AND FAMILIES

**Parenting sessions** provide information about adolescent development and wellbeing and promote positive parenting skills to prevent harmful disciplining. Parenting education can give parents the knowledge and confidence to share SRHR information with their adolescents and to provide them with age-appropriate care, protection and guidance throughout adolescence. **Parenting groups** can also provide a platform for parents and caregivers to discuss and challenge the strict social norms and taboos surrounding the SRHR and protection of adolescents, particularly girls. **CVA and income-generating activities for families** can ease financial pressure on families and help to facilitate access to services for adolescents.

### ENGAGE WITH COMMUNITIES TO ADDRESS STIGMA AND HARMFUL SOCIAL NORMS

Social taboos can be addressed and access to services increased for adolescents through large-scale **community awareness raising** activities including radio, one-on-one sessions, and communal activities. Communities should be informed about the availability and importance of SRHR, psychosocial and protection services for all adolescents and to address the stigma associated with these services. It is important to **engage with traditional and religious leaders** to promote the SRH and protection rights of all adolescents and to promote girls' access to services and support. Programmes should **engage with boys and men** including adolescent boys, male caregivers and husbands to promote positive masculinities and address gender-based violence risks for girls.

### INVEST IN COMMUNITY-LEVEL CAPACITIES

**The presence of health and protection services at community level should be increased**, by establishing mobile clinics, safe spaces, listening points and community-level child protection mechanisms. **Community-level networks and organisations should be supported** to lead prevention activities and to identify, monitor and respond to health and protection risks for adolescents, particularly girls. **Coordination** must be promoted between formal and informal services providers at local level.

## 3. IMPROVE THE QUALITY AND AVAILABILITY OF SERVICES IN REMOTE AREAS

### EXPAND THE AVAILABILITY OF SERVICES

**Services in remote areas** should be scaled up by establishing health services at local level, and by providing existing facilities with equipment and supplies such as delivery kits and family planning kits (condoms, pills, picture boxes for non-literate community members). Additional staff such as health workers



and case workers should be hired. Where required, **mobile teams should be set up** to provide roving health and protection support. Coordination between service providers and community actors needs strengthening to ensure that adolescents in remote communities have access to comprehensive services.

**PROMOTE ADOLESCENT-FRIENDLY SERVICES FOR ADOLESCENTS**

Programmes should work with service providers to deliver **adolescent-friendly services** and reduce barriers for adolescent girls including unmarried girls. Health and protection workers should be trained to deliver services to adolescents including comprehensive, adolescent-friendly case management services for (child) survivors of gender-based violence. **Youth-led initiatives must be supported** to improve services for adolescents, particularly girls and young mothers.









# ENDNOTES

1. UN OCHA (2022). [“Humanitarian Needs Overview 2022 Cameroon”](#), [accessed 6 October 2022]
2. Ibid.
3. UNHCR (2021). “Protection Monitoring. UNHCR Multi-year and multi-partner Strategic Plan 2022-2026”
4. United Nations (2021). “Children and Armed Conflict – [Report of the Secretary-General, A/75/873-S/2021/437](#)”, 6 May 2021.
5. UN OCHA (2022). [“Humanitarian Needs Overview 2022 Cameroon”](#), [accessed 6 October 2022]
6. UNHCR (2022). [UNHCR Data Portal for Cameroon](#). [accessed 9 November 2022].
7. UNHCR (2022). [UNHCR Data Portal for Cameroon](#). [accessed 9 November 2022].
8. UN OCHA (2022). [“Humanitarian Needs Overview 2022 Cameroon”](#), [accessed 6 October 2022]
9. UN OCHA (2022). [“Humanitarian Needs Overview 2022 Cameroon”](#), [accessed 6 October 2022]
10. Ibid.
11. United Nations (2021). “Children and Armed Conflict – [Report of the Secretary-General, A/75/873-S/2021/437](#)”, 6 May 2021.
12. UN OCHA (2022). [“Humanitarian Needs Overview 2022 Cameroon”](#), [accessed 6 October 2022]
13. Protection Monitoring data, UNHCR 2022.



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