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PSYCHOSOCIAL SUPPORT AND QUALITY OF LIFE OF REFUGEES: THE CASE OF CENTRAL AFRICA REPUBLIC REFUGEES IN THE UNHCR CAMP AT GADO BADZERE IN THE EAST REGION OF CAMEROON.

A dissertation Submitted in Partial Fulfilment of the Requirements for the Award of a Master's Degree in Specialised Education
Option: Social Handicap

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CERTIFICATION

We hereby certify that this work entitled **“**Psychosocial support and the quality of life of refugees: the case of central Africa republic refugees in the UNHCR camp at Gado Badzere in the east region of Cameroon” was carried out by MEME Vivian NTOROMI of the University of Yaoundé 1, Faculty of Education, Department of Specialized Education, Option Fundamental Research.

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Date ……...

My Lovely Mother,

MEME Magdaline VOWA

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LIST OF ABBREVIATIONS

UNHCR	**:**	United Nations higher commission for refugees.
UN	**:**	United Nations
CAR	**:**	Central African Republic
QOL	**:**	Quality of life
PSS	**:**	Psychosocial Support
PSCs	**:**	Psychosocial Counselors
UNICEF	**:**	United Nations Children's fund
WFP	**:**	World food program
UNDP	**:**	United Nations development Program
NGOs	**:**	Non-governmental organizations
REAP	**:**	Refugee empowerment and advocacy program
GRC	**:**	Government risk and compliance
ECD	**:**	Early child development
IDPs	**:**	Internally displaced persons
IASC	**:**	Inter agency standing committee for psychosocial support
CVT	**:**	Center for victims of torture
SEL	**:**	Social emotional learning
WHO	**:**	World health organization
OAU	**:**	Organization of African Unity
DRC	**:**	Democratic republic of Congo
INEE	**:**	Interagency network for education in emergency

ABSTRACT

The aim of this study is to investigate the influence of psychosocial support on the quality of life of CAR refugees in the UNHCR camp in Gado Badzere in the East region of Cameroon. It originates from an empirical observation, which shows that refugees in this camp, and Camps around Cameroon have a poor quality of life. Many studies have tried explaining this concept of poor quality of life in other camps around Cameroon and a few authors have brought out factors that can explain it, such as lack of social support or mental health. In this study we have chosen psychosocial support as the main factor that can predict quality of life. This permitted us to come out with the following research questions: RQ: Does the psychosocial support provided by UNHCR and its partners predicts the quality of life of CAR refugees living in Gado Badzere Camp in the East Region of Cameroon. To answer this question of research, psychosocial support has been operationalized into three hypothesis, which are as follows: RH1: Affective psychosocial support dimension predicts the quality of life of CAR refugees in Gado Badzere Camp, RH2: Cognitive Psychosocial Support dimension predicts the quality of life of CAR refugees living in Gado Badzere Camp. RH3: Social Psychosocial support dimension impact the quality of life of CAR refugees living in Gado Badzere Camp. To verify these hypothesis, we have chosen a sample of 155 refugees through the inclusive and exclusive criteria. This study is correlational and regression in nature, Data was collected using questionnaire. The spearman ranked correlation with the help of SPSS version 21 was used to test the research hypotheses. Four relevant theories guided this work: The Ecology, the human ecology, quality of life theories (Bigelow et al 1982 & Dijkers 1997) theory that helped to expose the importance of the study. Findings revealed that Psychosocial support predicts the quality of life of refugees in the camps as follows: RH1: Cognitive psychosocial support predicts quality of life (F=30.399; p=0.000). RH2: Affective support is predicting quality of life. This predication is moderate and positive (F=24.376; p=0.001). RH3: Social support is significantly predicting quality of life (F=22.596; p=0.000). Given that all three specific hypotheses were confirmed, the RH was therefore confirmed. Which shows that refugees in Camps around Cameroon have a poor quality of life irrespective of the psychosocial support they receive. This means that the Psychosocial support given to the refugees at the UNHCR camp in Gado Badzere in the east region of Cameroon is limited in certain aspects to meet up with refugees' quality of life. Review of the psychosocial support in the said camp is strongly recommended and addressed to stakeholders involved in the psychosocial support, implementation and evaluation process.

Key words: Psychosocial support, Refugees, quality of life, Camp.

RESUME

L'objectif de cette étude est d'examiner l'influence du soutien psychosocial sur la qualité de vie des réfugiés Centrafricains dans le camp du HCR de Gado Badzere, dans la région de l'Est du Cameroun. Elle part d'une observation empirique, qui montre que les réfugiés dans ce camp, et dans les camps autour du Cameroun, ont une mauvaise qualité de vie. De nombreuses études ont tenté d'expliquer ce concept de mauvaise qualité de vie dans d'autres camps autour du Cameroun et quelques auteurs ont mis en évidence des facteurs pouvant l'expliquer, tels que le manque de soutien social ou de santé mentale. Dans cette étude, nous avons choisi le soutien psychosocial comme principal facteur prédictif de la qualité de vie. Cela nous a permis de formuler les questions de recherche suivantes : QR : Le soutien psychosocial fourni par le HCR et ses partenaires prédit-il la qualité de vie des réfugiés Centrafricains vivant dans le camp de Gado Badzere, dans la région de l'Est du Cameroun ? Pour répondre à cette question de recherche, le soutien psychosocial a été opérationnalisé en trois hypothèses, qui sont les suivantes : RH1: La dimension du soutien psychosocial affectif prédit la qualité de vie des réfugiés Centrafricains dans le camp de Gado Badzere, RH2 : La dimension du soutien psychosocial cognitif prédit la qualité de vie des réfugiés centrafricains vivant dans le camp de Gado Badzere. RH3: La dimension du soutien psychosocial social a un impact sur la qualité de vie des réfugiés centrafricains vivant dans le camp de Gado Badzere. Pour verifier ces hypothèses, nous avons choisi un échantillon de 155 réfugiés à travers des critères inclusifs et exclusifs. Cette étude est de nature corrélationnelle et régressive. Les données ont été collectées à l'aide d'un questionnaire. La corrélation de rang de Spearman avec l'aide de SPSS version 21 a été utilisée pour tester les hypothèses de recherche. Quatre théories pertinentes ont guidé ce travail : L'écologie, l'écologie humaine, les théories de la qualité de vie (Bigelow et al 1982 & Dijkers 1997) qui ont contribué à exposer l'importance de l'étude. Les résultats ont révélé que le soutien psychosocial prédit la qualité de vie des réfugiés dans les camps comme suit : RH1: le soutien psychosocial cognitif prédit la qualité de vie (F=30,399 ; p=0,000). RH2: Le soutien affectif prédit la qualité de vie. Cette prédiction est modérée et positive (F=24.376 ; p=0.001). RH3: Le soutien social prédit de manière significative la qualité de vie (F=22.596 ; p=0.000). Étant donné que les trois hypothèses spécifiques ont été confirmées, la RH a donc été confirmée. Ce qui montre que les réfugiés dans les camps autour du Cameroun ont une mauvaise qualité de vie indépendamment du soutien psychosocial qu'ils reçoivent. Cela signifie que le soutien psychosocial apporté aux réfugiés du camp du HCR de Gado Badzere, dans la région de l'Est du Cameroun, est limité dans certains aspects pour répondre à la qualité de vie des réfugiés. La révision du soutien psychosocial dans ledit camp est fortement recommandée et adressée aux parties prenantes impliquées dans le soutien psychosocial, la mise en œuvre et le processus d'évaluation.

Mots clés: Soutien psychosocial, Réfugiés, qualité de vie, Camp.

GENERAL INTRODUCTION

The magnitude of refugee influx in some African countries such as Cameroon in recent years has generated concern throughout the world. Widely perceived as an unprecedented crisis, these flows have produced a mixture of humanitarian concerns, of the millions of people forced into exile and fear for the potential threat to the social, economic and political stability of host states caused by streams of unwanted newcomers. The host states are therefore struggling to strike a proper balance between the need to maintain control over their borders and the need to protect refugees who seek refuge within their borders. Cameroon has been recognized safe haven for refugees today UNHCR (2012). In recent years, this country, which is already home to hundreds of thousands of refugees, has been experiencing a steady rise in the influx of such populations from neighboring countries, because of the numerous conflicts affecting this part of the world. Most refugees from the Central African Republic (CAR) and Nigeria have settled in the Northern and East Region of Cameroon UNHCR (2012). The government of Cameroon and its stakeholders have established camps in the different regions Cameroon to welcome and accommodate these refugees be it in the North, East or far north. These camps mostly host refugees from Chad, Equatorial Guinea, Gabon, Nigeria and Central African Republic, The quality of life in these camps indicates that refugees live in deplorable conditions as the lack food, good toilets and live in tents. (Tayimlong 2013)

According to Basheti et al (2015), People who have fled their home and taken refuge in camps in East Africa are far worse off when it comes to their quality of life. They lack food, good toilets, portable water and health facilities. The poor housing condition in camps around East Africa is deplorable as a majority of them live in makeshift shelters (tents). In Kenya's Dadaad camp 70% of the refugee population live in terrible housing conditions and have difficulties feeding, as they do not have food to eat. They also lack good toilets and live in terrible hygienic conditions, which makes them more vulnerable to infections and diseases (IIED 2022). The situation in Aysaita camp in Ethiopia is not any better as refugees living in this camp are still faced with poor housing conditions, no food and deplorable toilets (IIED 2022).

In the case of the CAR refugees in the Gado Badzere Camp in Cameroon, these difficulties are not overlooked as it goes even further to affect refugees' quality of life. Dealing with such problems in a foreign country is often difficult due to a plethora of reasons, worse for refugees

with traumatic pasts. Refugees in the Gado Badzere live in abject poverty, they lack food, good toilets, and good housing conditions as they live in tents (Marksheet shelters), which are a headache during the rainy season because they lick, this in total contributes to their poor quality of life. The living conditions for refugees, either in self-chosen settlements or in refugee camps, are also often less than ideal, with each type of settlement posing unique additional barriers to psychosocial wellbeing (Connor, 1989). In several situations, the circumstances in which refugees live in their host countries fail to encourage an environment promoting optimal quality of life. Those living in refugee camps, which are defined as "human settlements which may vary enormously in size, socio-economic structure and political character," are often deprived of basic freedoms and provided with inadequate living spaces, due to the poorly planned infrastructure of many camps (Crisp & Jacobsen, 1998, Cuny, 1977).

Refugees living in self-settlements, where housing structures are still inadequate most of the time, often face xenophobia and discrimination in their new communities (Connor, 1989). Still, there is much more autonomy than for those living in camps. These living conditions each foster a new set of threats to the quality of life of refugees. Furthermore, refugees have a universally high risk of developing depression, anxiety and post-traumatic stress disorder, hereafter referred to as PTSD, with varying incidences due to a range of factors, and poor quality of life as a significant predictor of the problems (Silove, 2004, Gorst-Unsworth & Goldenberg, 1998). Particular events or circumstances that have occurred throughout the lives of refugees, including poverty, loneliness, and conflicts with immigration officials, have been found to have strong link with the development of these disorders and social problems. Evidently, accurate diagnosis of refugees' psychosocial support poses a problem to psychologists and other social scientists.

According to UNHCR 2021 report, the population of Gado camp has risen to 29,164 Central African refugees with 57.80% of the population being less than 18 years and women/girls representing 53.23%. The main priority of the Gado Camp is focused on the monitoring of children up to secondary school level, response to non-scholarised adolescents between 14-17 years, the promotion of self-reliance initiatives, promotion of hygiene and sanitation, access to fertile cultivable land, and pasture spaces for agro pastoral refugees, shelters and reinforcement of security in the camp. Given that so many refugees arrive at their final destination with some psychosocial problems, research and innovation is valid, culturally sensitive quality of life improvement methods is urgent, especially because life in such host country can so easily spur new problems (Carballo, 2011).

Unfortunately, there also lack significant research regarding differences among poor quality of life problems faced by refugees at different stages in the asylum-seeking process and their different living conditions. Appropriate psychosocial support designed by professional partners is not adequately structured to take into consideration the psychosocial backgrounds of refugees, along with the realities of their everyday lives and quality of life situations. This research is aimed at assessing if psychosocial support by development organizations predicts the quality of life of Central African Refugees living in Gado Badzere Camp of the East Region of Cameroon.

CHAPTER ONE:
THE PROBLEMATIC OF THE STUDY

In this part of the study, we shall elaborate the problem by looking at the context and justification; formulate the problem, research questions, hypothesis, and objectives. We shall also look at the scope of the study and define some main terms.

1.1. CONTEXT AND JUSTIFICATION

1.1.1. Context

Our world has experienced political, social, and cultural upheaval unmatched by any other period in our history. Continuous conflict compounded with the economic impacts of coronavirus has forced hundreds of millions out of their homes and into a world without healthcare or social support systems. After more than a year of struggle through COVID-19, refugees and displaced people are facing more challenges than ever especially women and girls. Ethnic tensions, political strife, famine, climate change, and terrorism continue to uproot lives.

According to the United Nation High Commission for Refugees -UNHR (2021), at least 82.4 million people around the world have been forced to flee their homes. Among them are nearly 26.4 million refugees, around half of whom are under the age of 18yeras. There are also millions of stateless people, who have been denied a nationality and lack access to basic rights such as education, health care, employment and freedom of movement. At a time when 1 in every 95 people on earth has fled their home as a result of conflict or persecution, the task is much challenging for humanitarian workers, UNHCR and other Non-Governmental organizations (NGO) to ensure that the psychosocial needs of these refugees are made in other to guarantee them a good quality of life (Barbelet 2017).

Around half of the world's 26 million refugees and 85% of the world's refugees are accommodated in developing countries (UNHCR, 2021). The UK received 3,775 asylum applications from separated children in 2019. In proportion to its population, the UK ranks 16th in Europe for asylum applications. In 2019, 68% of the world's refugees came from just five countries: Syria, Venezuela, Afghanistan, South Sudan and Myanmar 45% of separated children applying for asylum in the UK in the year up to June 2020 were from Iran, Vietnam and Afghanistan. There were 676,300 first-time asylum applications in the EU in 2019, with Germany and France receiving the most.

The number of refugees globally has steadily increased since 2012 but within Europe, the number of asylum-seeker applications has significantly decreased from 1.3m in 2016 to 676,300 in 2019. In the last decade 400,000 unaccompanied and separated children have lodged asylum applications throughout the world. The number of separated children internationally has decreased since 2015 with numbers in Europe following a similar pattern, dropping from 95,205 to 17,890 in 2019 (UNHCR 2020).

Africa continues to experience expanding and record levels of forced displacement as a result of predatory governments, political fragmentation, and violent extremist groups (UNHCR, 2021). Africa is experiencing another record of forced displacement, this has been at a steady upward trend seen since 2011. More than 32 million Africans are either internally displaced, refugees, or asylum seekers as regard to 29 million some years ago. The sources of Africa's population displacement are highly concentrated, ten African countries account for 88 percent (28 million) of all forcibly displaced people on the continent (UNHCR 2021). Each of these top 10 countries of origin are in conflict. These conflicts represent a combination of government repression against citizens, extremist group violence, and the militarization of politics. Seven of the ten have governments that are autocratically leaning.

Of these 32 million forcibly displaced, three-quarters are internally displaced (24 million IDPs). This means that most displaced Africans have fled to the first safe refuge. Sometimes this involves crossing a border; Most of the time it does not. This detail matters because additional international laws of protection are activated once a forcibly displaced person is outside their country of origin (such as the 1951 UN Refugee Convention and its 1967 Protocol or the 1969 OAU Refugee Convention). While they are within their own country, their rights to protection are ultimately decided by their government, which may or may not adhere to its international vows of protection (such as the Kampala Declaration). With over 6 million forcibly displaced people, the Democratic Republic of Congo (DRC) has at least a third more displacement than any other country in Africa (UNHCR 2019).

South Sudan has nearly 4 million people forcibly displaced out of a total population of 11 million, making it the African country with the highest proportion of its population displaced. South Sudan is also distinctive in that the majority of its forcibly displaced are refugees and asylum seekers, living mostly in Uganda, Sudan, and Ethiopia according to the UNHCR (2019). Ethiopia saw the largest jump in size of its forcibly displaced population in the past year with an estimated 1.8 million people dislocated due to the conflict in Tigray.

Ethiopia simultaneously hosts over 800,000 refugees from surrounding countries. Nigeria faces a range of destabilizing security threats. In the North East region, violent attacks by Boko Haram and the Islamic State in West Africa have resulted in the displacement of 2.5 million Nigerians. Kidnappings, extortion, and organized criminal attacks in the North West have displaced an additional 800,000 people.

Sudan, with 2.5 million of its own internally displaced, is also hosting 1.1 million refugees, mostly from South Sudan and Eritrea. Burkina Faso has experienced an explosion in its forced displacement crisis as a result of a militant Islamist group violence originating in Mali. Its 1.2 million displaced population represents a nine-fold increase from 2019. Mozambique, the only southern African country facing a major displacement crisis, saw a tripling in its displaced population. A violent insurgency in the north by Ahlu Sunnah wa Jama'a (ASWJ) has resulted in the number of displaced increasing from 21100 to 668,000 people in the past year

For several years now, the Republic of Cameroon has been a safe home for refugees from neighboring countries faced with different forms of crises. In 2013, hundreds of thousands of men, women and children fled their homes in Central African Republic (CAR) in desperation, many seeking refuge in neighboring Cameroon, Democratic Republic of Congo and Chad. They arrived in terrible circumstances, some having trekked for days without water or food. Many refugees showed signs of brutal attacks and extreme malnutrition (UNHCR 2018).

Possibly, Cameroon as a chosen destination for refugees is preferred by its attractive legal and institutional system. This is because, Cameroon as a signatory to all major legal instruments on refugees, including the 1951 Refugee Convention and the 1969 Organization for African Unity (OAU) Refugee Convention has the mandate to receiving refugees from other countries. In addition, Cameroon adopted a Law Defining the Legal Framework for Refugee Protection in July 2005, which went into force in November 2011 (Law No. 2005/006 of 27 July 2005 relating to the Status of Refugees in Cameroon). However, for some years now, Cameroon has been facing a complex and unprecedented humanitarian crisis resolving in both increasing numbers of refugees and IDPs (Buchenrieder, Mack & Balgah, 2017).

In the past, Cameroon has always been a “safe” place for African refugees such as refugees from Ghana and Equatorial Guinea in the late 80s. According to World refugee report of June 1992, 5000 Chadians were received in northern Cameroon. As of 2018 Cameroon

hosted 659,807 people of concern. This figure includes 249,053 Central African refugees and 89,543 Nigerian refugees totalling 338,596 refugees (UNHCR 2018). Refugees from the CAR represent 73.55% of the total number of refugees from these two countries. They are hosted mainly in the Eastern part of Cameroon UNHCR (2014).

The extensive Cameroonian border with the CAR, in the East Region provides an important reason for receiving the largest number of refugees. According to UNHCR (2014), the number of border entry points identified by the Cameroonian Government increased from 24 official entry points to several non-official points along the Cameroon border stretch as the war increased. However, major entry points of the refugees into the East region are Gbiti, Kentzou and Garoua Boulai. Nevertheless, there are 24 official entry points and non-official points along the 50kms border stretch Agwa (2021). With the open-border policy, refugees may sometimes cross the borders without being registered by UNHCR. These influxes have produced a mixture of humanitarian concerns of the thousands of people forced into exile and fear for the potential threat to the stability of host communities. This work is focus on CAR refugees in the Gado Camp in the Eastern Region of Cameroon which is the largest of the five camps that host refugees in the region. The situation in CAR that forced refugees to seek refuge in Cameroon since 2006 remains unstable as almost every ruler of CAR since independence either came to power or was ultimately overthrown in a military coup. CAR has witnessed more than 10 military coup attempts and army riots, and an almost constant state of rebellion (Fiona & Malan 1998).

As UNHCR tried to design programs to assist theses hundreds of thousands of refugees in the East Region of Cameroon, the situation was further compounded by COVID-19 pandemic causing reduced assistance for CAR refugees especially those in Gado Badzere camp. This pandemic being far more than a health crisis, affected societies including CAR refugees and host communities in Cameroon and economies at their core, destroying lives and livelihoods and undermining the basis for ending poverty and achieving the Sustainable Development Goals thus playing on their quality of life. According to OCHA (2020) as of June 2020, the Cameroon Government's response plan covered essentially the medical aspects while a strategy to respond to the social and economic impact was still being prepared, thus increasing the vulnerability of Central African refugees in the East Region and influencing their quality of life negatively. These displaced populations frequently face difficulties in accessing essential services, including health and food that are otherwise available to the general population. In addition, they have limited capacity to social distance due to

overcrowding in often temporary shelters. Hygiene conditions for most of these displaced persons are usually low with a lack of access to clean water, soap and masks. Socio-cultural norms, coupled with limited access to services and information, thus placing women, girls and children at added risk.

1.1.2. Justification

The choice of this research is motivated by three reasons which are; social, personal and scientific.

1.1.2.1. Social Reason

In essence the plight of refugees and internally displaced persons is unnecessary. The problem results from intolerant governments, environmental disasters, weak economic conditions, armed conflict and other causes. Once they are forced to flee from their homes or across boarders', refugee's face challenges as to the countries or areas to which they flee. The international community must develop more effective approaches to assist refugees, indeed they must prevent them from occurring in the first place. Refugees are prime indicators for social, political and economic instability for human atrocities and great human suffering. They signal our failure to provide basic human security for all, and the call upon the assistance of a few who are able to challenge head on the forces of injustice, poverty and suffering. International bodies who have resources to preserve the dispossessed must address the causes of forced migration at their roots, by promoting good environmental economic, political and cultural governance.

The insecurity that refugees and internally displaced people (IDPs) face extends far beyond the guns and blasts of the war. It includes lack of access to food, health care, housing, employment, and clean water and sanitation, as well as loss of community and homes. For war refugees, these problems are exacerbated in the face of exile. A good number of CAR refugees have been displaced, either abroad or within their own countries, and are living in grossly inadequate conditions. Refugees also face difficulties in renewing visas, the denial of civil rights and services, the fear of deportation, and anxiety about the future which automatically affects their quality of life negatively.

A developing country like Cameroon is faced with the challenges of a fast-growing population. Influx of refugees from neighboring countries such as CAR can be detrimental to such a growing population especially in the case where it out numbers that of the host

community. The level of unemployment is fast growing, underemployment is at its peak and poverty, frustration is so much of a concern not only among refugees but also host communities who before the advent of refugees have been living a sub-standard live characterized by abject poverty, malnutrition, poor housing, insufficient infrastructure and public services. These situations are influential enough to raise eye brows amongst humanitarian bodies and refugees in Cameroon. There is an urgent need to redress such situations on time so as to stamp out the frustration among refugees and their host communities.

Leaving everything behind in one's life and beginning, another in a different country with different laws, different educational system, different languages and different cultural situation requires a period of adjustment. For people who seek refuge this process is much difficult due to the amount of psychosocial support they receive in their country of refuge. Refugees remain unemployed, financially unstable and have mental health issues due to lack of sustainable and livelihood projects to boast their quality of life.

Psychosocial support is not a one-man-show. It involves the state, humanitarian bodies, social workers, individuals and the society. This study will examine the supposed cooperation that exists between partners providing, the type of psychosocial support provided and the impact such as assistant has on refugees' quality of life. This study is timely and contextually relevant as it seeks to ascertain if psychosocial support predicts quality of life. Reason being that the living conditions of refugees remain very low in the Gado Badzere refugee camp despite the psychosocial support they receive, the effort made by humanitarian bodies is laudable but the impact is not felt.

1.1.2.2. Personal Reason

As a student, specialized educator and counsellor, I have this strong desire to work with refugees and help them to be able to regain their stability holistically in the refugee camp. Facilitate or bring programs that can help improve their livelihood and consequently quality of life.

1.1.2.3. Scientific Reason

The urge to contribute to existing knowledge in the area of improving the quality of life of refugees motivated me to conduct this study. Many studies have been carried out concerning refugees and their plight. Such as ‘’exploring the psychosocial needs of Syrian refugees in the UK: account of community service providers. (Sabouni 2019). However, there are still a lot of difficulties integrating psychosocial support provided by intervening partners and assessing the

quality of life of refugees. This motivated me to embark on this study. The findings of this study will also stimulate discussions and learning in both development and political arenas for improved decision making in the domain of the quality of life of refugees especially those in camps.

1.2. OBSERVATION AND PROBLEM OF THE STUDY

In this segment we will be presenting the empirical observation that is what we observed on the field and the theoretical observation what other writers have written about the topic in question.

1.2.1. Emperical observation

Leaving everything behind in one's life and beginning another new life in a different country with different laws, different education and health systems, different languages and different cultural expectations requires a period of adjustment. Alfadhli & Drury (2016) in their study on social support mechanisms, psychosocial needs and stressor among refugees, did a systematic literature search of peer reviewed journal articles. They discovered that as refugees move towards a prolonged urban displacement phase their needs and stressor became different than those of the acute phase. They also discovered that while many of the psychosocial interventions focus only on Post traumatic stress disorder, daily stressor affected far more the quality of life of refugees of conflict in developing countries than the former. They therefore stated that for the psychosocial approach to be effective, there is need for a social identity approach to help understand the emergence of a common refugee identity, and its role in empowerment of refugees through the activation of social support networks. Alfadhli and Drury's work raises another aspect of daily stressors in refugee camps which the researcher will definitely take into consideration.

Basheti et al (2015**)** in their study on Syrian refugees at Alzatary camp discovered that the refugees under study suffered from numerous quality of life problems that required urgent attention by the responsible authorities. According to them half of the refugees reported dissatisfaction with the care provided to them and to their family members at the camp. Basheti et al added that the refugees staying in tents reported greater dissatisfaction compared to refugees staying in caravans. The result of their study necessitated the establishment of dedicated psychosocial team to access and coordinate the care delivered by the different international field hospitals available at the camp, with a special focus on the refugee's quality

of life. Mattingly on his part found some interventions aimed at promoting quality of life hardly reach all the targeted audience. This to him necessitates the need for specific or targeted support programs that will reach out traditionally marginalized groups and refugees: an approach which he says should vary from one context to another. Citing other studies such as that of Punamaki et al. (2014) and Burden (2015). Mattingly argues that within the target support programs and variety in population, results reveal mixed, weak, or even negative effect of psychosocial support intervention for women and girls refugees. Given that this studies handles the plight of refugees in relation to quality of life, Mattingly's study cautions the research towards expected results when dealing with female refugees as oppose to their male counterparts.

According to Connor 2010 refugees living in camps have specific problems related to their quality of life. Some of these challenges include: finding good housing, finding employment, language and communication barriers, discrimination, community attitudes, financial difficulties. Comparative studies have been carried out to understand refugees living in and out of camps and their quality of life, (IIED 2010) but this is still a course for concern giving that irrespective of the efforts put in by NGOs, refugees in camps around Cameroon specifically the Gado camp still have a poor quality of life. Young refugees face particular challenges because of their age, as they are deprived of their childhood experiences and rights, most of them do not go to school as their care takes or parents cannot afford to send them to school. Sometimes they are forced to work as labourers and perform other task around the Gado community that are not feet for children of their age just to be able to afford their daily bread as food is a major concern at the camp. Worst of all are the ones that end up becoming road bandits, just as a means of survival. Although children are very resilient they are still the most affected by the poor quality of life in camps. (Carballo 2010) A deeper or a logical reflection on all these challenges and how refugees in camps (specifically Gado Badzere) cope in relation to their quality of life is a major motivation for this study.

The UNHCR Gado Badzere camp in the East region of Cameroon is the largest refugee camp in Cameroon, due to its large nature, it has been stratified into 12 quarters. This camp harbors specifically CAR refugees, these refugees face numerous challenges in relation to their quality of life, and they live in poor housing conditions, lack food, good toilets, security and electricity. According to the camp officials, with the insecurity at the camp, they have been a number of registered rape cases perpetrated by some unapprehend individuals. It should be noted that most of the refugees in this camp lived in tents and dread the rainy season due to

leakages they experienced as a result of the worn out nature of these tents. They can barely afford a meal a day and lack affordable medical facilities reason they rely mostly on local herbalist at the camp for their health challenges. The women, men and children share a common latrine in every household and a single tent, this makes them more vulnerable to diseases and infections. The hygienic conditions in the camp is not also the best irrespective of the effort put in by the camp officials to ensure the cleanliness of the camp, children are seen defecating in open areas due to lack of toilets. Also, with the lack of sustainable development projects for these refugees, a few of them rely on farming and cattle raring for survival, while a larger number wallow around with not doing, reason being that they are no specific farm lands allocated to these refugees and the few who are lucky to find favor with a member of the Gado community may get a farm land to use. All of these add up to the poor nature of their quality of life as a majority of the refugees have no source of income or means of survival.

Moreover, refugees living with infections gotten through rape or other unfortunate circumstances, live in self isolation. According to the camp officials their quality of life is greatly affected as they do not receive any specialized care and are not open to the idea of interacting with other refugees and the entire Gado community. They are skeptical about everyone who comes around and feels they are associating with them out of pity because of their condition. They have difficulties buying and selling from their local market and keep to themselves most of the time as they do not have any friends but just their family members to rely on. One of them confirms to have attempted suicide a couple of times as her health keeps deteriorating and it has only been by God's grace she has been surviving.

Given that there is free entry and exit of both the host community and the refugees in to and out of the camp, they are frequent cases of sexual abuse and theft in the Gado Bazere camp; camp officials has it that these acts are perpetrated by the refugees themselves and partly by the host community. Irrespective of whom the perpetrators are, this act is savage and should be decried as it plays on the quality of life of these refugees. Anxiety, depression and other stress-related problems threaten their ability to live healthy and happy. Violence can take a lifelong toll on quality of life if not addressed properly.

The term Quality of life can also be said to be the degree to which an individual is healthy, comfortable, and able to participate in or enjoy life events. Quality of life is inherently ambiguous, as it can refer both to the experience an individual has of his or her own life and to the living conditions in which individuals find themselves. Psychosocial support on the other

hand refers to the close relationship between the individual and the collective aspects of any social entity. Psychosocial support can be adapted in particular situations to respond to the quality of life needs of the people concerned, by helping them to be comfortable and able to participate in or enjoy life events. The above-mentioned refugee challenges have prompted the researcher to find out if psychosocial support predicts quality of life. The question is does psychosocial support predict the quality of life of refugees? The researcher therefore is of the opinion that if psychosocial support is adequately implemented, there is a probability that most of these challenges faced by refugees will be eradicated thereby, positively impacting refugees' quality of life. This stimulated the researcher to conduct a study on this topic.

1.2.2. Theoretical observation

Various theories are stipulated which backs the influence of psychosocial support on quality of life. The researcher made use of 4 theories which guided this study. The theories consist of: the ecological approach of Richard et al. (1996) model, the human ecological theory of Bubolz et col. (1980), quality of life theory by Bigelow et al. (1982) and the Dijkers (1997) quality of life model

1.2.2.1. Richard et al. (1996) model

It takes as focus the actions taken by professionals within ecosystems, referred to as interventions to affect the quality of life of populations and groups of individuals. Such a conceptualization can help construct and deconstruct the actions taken by professionals. This model is largely inspired by the writings of Stokolsc (1992), for whom health promotion interventions are situated on a continuum ranging from the intervention provided in a microenvironment (an organization, for example) to those offered in larger environmental contexts such as large geographical units (a society, an entity at the supranational level), via communities. Each of these levels is a place to implement strategies for both the individual and the environment. It is clear that, for Stokols (1992), an ecological program includes actions aimed at several targets (individuals and different facets of the environment) in multiple intervention sites. Environments and targets thus constitute the key dimensions of the integration of the ecological approach in health promotion programs. Let us look more specifically, at how these concepts are defined and articulated in the Richard et al. model (1996).

The target of a program or intervention is the ecological unit(s) it is intended to address. The ecological model of Richard et al. is based on the framework developed by McLeroy et al (1998) and defines five classes of health determinants and related behaviors. Each of these classes can be conceptualized as targets for intervention:

The individual-client, that is, the individual whose quality of life we ultimately want to maintain or improve. We are referring here to the refugees; the individual's interpersonal environment. This is the informal social network of which the individual is a member. In the case of refugees, for example, we often refer to the family, psychosocial support agents, community and friends; the organizations in which the individual lives. This may involve targeting organizational dimensions or key players in the organizations (psychosocial support agents, social workers etc.); the community in which the individual lives. This could include dimensions of the physical environment (type of houses) as well as community representatives; the political subsystem and its representatives, for a territorial entity in which the individual lives. In this model, individuals are the ultimate target of psychosocial support and quality of life programs, and the other four types of targets can be seen as intermediate targets for action. In its simplest form, the initiative is aimed directly at the individual without the use of an intermediate target.

The ecological systems theory is conceptualized in terms of systems ranging from micro to macro, comprising the microsystems, mesosystems, exosystems and the macrosystems. The theory posits that human development/behaviour is determined by these four levels of systems, to which he adds the chronosystem - which includes the concept of individuals as constantly changing over their lifespan and how the time period in which they live influences their approach to their environment. This new concept adds the influence of time period to expectations and assumptions during development and it reflects the non-static nature of influences around refugees which may influence the psychosocial support they receive vis-à-vis their quality of life. For instance, over time there may be an increase in the cost of living, rarity of good food resources, conflicts in the family, drop in motivation, which may in turn influence behavior and choices.

1.2.2.2. Bubolz et col. (1980) Model

They developed a quality of life model based on the human ecological model (Bubolz, Eicher & Sontag, 1979) to assess the quality of life of a group of individuals in relation to their environment. Four concepts are central to this model: Individuals represent a single individual

(biophysical, psychological and social dimensions) or several individuals who have a sense of belonging, use common resources, have common goals, values or interests and share a sense of common identity. The environment is the sum of the physical, chemical, biological, social, economic, political and aesthetic structure surrounding the individuals. The total environment includes three dimensions. The natural environment (space-time, physical, biological), the environment modified or constructed by humans (sociobiological, sociocultural, sociophysical), and human behaviors (biophysical, psychological and social). Interaction is defined as the influence of the reciprocal relationships between the components of individuals and environments.

This model considers quality of life in its broadest sense, and refers to the well-being or discomfort of individuals and/or the environments in which they live. From an individual perspective, quality of life consists of the satisfaction of physical, biological, psychological, economic and social needs. Environmental resources are used to meet these needs. From an environmental perspective, quality of life represents the environmental capacity to produce the resources needed to meet these needs. Quality of life is assessed by compiling the needs that are required and met. The model is based on the assumption that needs must be met and represent the desired state or ultimate goal. The overall perception of satisfaction with life is considered an indicator of the overall quality of life.

The conceptual framework presented by Bubolz et al. (1980) is largely based on the main principles of urban ecology. In their view, quality of life is considered in a very general sense to describe the well-being or ill-being of people and/or the environment in which they live. From the perspective of the individual, quality of life consists of the degree to which their basic physical, biological, psychological, economic and social needs are met. These needs are met by the resources of the environment. Quality of life is the degree to which the environment has the capacity to provide the resources necessary to satisfy needs. The level of quality of life is assessed in a normative way, either in relation to a standard, from which needs should be satisfied, or in relation to a standard concerning the required resources.

1.2.2.3. The Bigelow et al. model (1982)

The development of the Bigelow et al. (1982) model is based on two theoretical positions: a quality of life theory (Bigelow et al., 1982) and a role theory (Sarbin and Allen, 1986). The quality of an individual's life is based on two elements: the general feeling of well-being (satisfaction of needs) and performance (actualization of skills). The needs considered

are taken from Maslow (1943): basic needs (physiological and safety), needs for affiliation, esteem, autonomy and self-actualization. The environment offers opportunities to satisfy these needs, both material (food, housing, etc.) and social (friends, spouse, work, etc.). However, the opportunities offered by the environment are associated with expectations or performance requirements.

The individual must respond to the demands of society using his or her cognitive, affective, behavioral and perceptual skills. To the extent that the individual experiences adequate satisfaction of his or her needs and achieves a certain performance in the accomplishment of his or her roles, he or she is adapted to his or her environment and enjoys a good quality of life.

1.2.2.4. The Dijkers (1997) quality of life model

Dijkers' (1997a) quality of life model is based on the World Health Organization (WHO) model published by the International Classification of Impairments, Disabilities and Handicaps (ICIDH; WHO, 1980). It includes both objective and subjective quality of life. Impairments, producing disabilities, create a cascade and affect several spheres of quality of life, due to: the link between impairments, disabilities and handicap (or participation), the social process of discrimination towards people with disabilities and economic realities.

Dijkers' (1997a) model highlights the influence of disability situations on, among other things, leisure, family and social interactions. It also demonstrates the direct and indirect consequences of illnesses and traumas that result in permanent and significant disabilities, thus affecting physical health and life expectancy. Disabilities are conducive to creating a situation of discrimination and devaluation, thus increasing the risk of developing disability situations. Disabilities affect the quality of life, either because a family member has to stop working to take care of the person, or because of the expenses associated with disabilities that affect income and reduce material comfort.

1.2.3. Formulation and position of the problem of the study

Armed conflicts and natural disasters cause significant psychological and social suffering to affected populations. The psychological and social impacts of emergency may be acute in the short term, but they can also undermine the long-term quality of life and psychosocial wellbeing of the affected population 47). The emotional wounds may be less visible than the destruction of homes, but it often takes far longer to recover from emotional

impact than to overcome material losses. These impacts may threaten peace, human rights and development. The ways in which people respond to the stress of armed conflict will depend on their own particular circumstances and characteristics. These include individual factors such as age, sex, and personality type, personal and cultural background. Other factors are linked to the nature of the support they receive, including frequency and the length of the support.

Poverty destitution and joblessness are all detrimental to quality of life; the wellbeing of refugees is particularly vulnerable. Newly arrived refugees deal with a range of issues which include uncertainty and concerns about being removed from the country, worries about the where about of their family members and issues relating to adapting to a different culture and language. The experience of homelessness, poverty, ensuring basic necessities such as accommodation, meals and health care can be extremely difficult. Living with this uncertainty and knowing there is a risk of being removed is likely to be detrimental to quality of life, often made worse by the lack of family or community support. The government's policy, whereby refugees are hosted in a different area (refugee camp) away from developing community supports is an additional challenge.

According to the human ecology model of **Bubolz et col. (1980)** the quality of life of humans and the quality of their environment are interdependent. The relationships between refugees and their social and physical environment cannot be overlooked, how does these refugees interact with and adapt to their environment in relation to the support they receive and how does it affect their quality of life? This model considers quality of life in its broadest sense, and refers to the well-being or discomfort of individuals and/or the environments in which they live. From an individual perspective, quality of life consists of the satisfaction of physical, biological, psychological, economic and social needs. Environmental resources are used to meet these needs. From an environmental perspective, quality of life represents the environmental capacity to produce the resources needed to meet these needs. Quality of life is assessed by compiling the needs that are required and met. The model is based on the assumption that needs must be met and represent the desired state or ultimate goal. The overall perception of satisfaction with life is considered an indicator of the overall quality of life. From the perspective of the individual, quality of life consists of the degree to which their basic physical, biological, psychological, economic and social needs are met. These needs are met by the resources of the environment. Quality of life is the degree to which the environment has the capacity to provide the resources necessary to satisfy needs. The level of quality of life is

assessed in a normative way, either in relation to a standard, from which needs should be satisfied, or in relation to a standard concerning the required resources.

The above stakes of conflicts paint a glaring picture of the plight of refugees with regards to quality of life. The year 2013 on its part equally the start of the most recent arm conflicts in the Central African Republic (sharing border with the east region of Cameroon) which has led to an influx of refugees to the East region Refugee camp. Given that early and adequate psychosocial support can prevent distress and also help refugees Cope better and become reconciled to everyday lives challenges without attributing it to their past negative experiences they by improving their quality of life; the goal of this works therefore is to find out if the psychosocial support provided by UNHCR and its partners predicts the quality of life of refugees.

1.3. RESEARCH QUESTIONS

Here, the principal or general research question, thematic analysis and the specific or secondary research questions are examined. This question is: "Does cognitive, affective and social support approaches predict the quality of life of CAR refugees in the Gado Badzere camp in the east region of Cameroon?"

1.3.1. Principal research question

Does the psychosocial support provided by UNHCR and its partners predict the quality of life of CAR refugees living in Gado Badzere Camp in the East Region of Cameroon?

Table *1*

The main and specific factors of this research

Psychosocial support	**No**	**Specific Factors**	**% of Yes**	**% of No**
Does psychosocial support have a link with the following specific factors?	1	Cognitive dimension	80	20
	2	Affective dimension	60	10
	3	Social dimension	90	10
Quality of life Does quality of life have a link with the following variables?	1	Individual	75	20
	2	Environment	85	10
	3	Social Network	70	15

1.3.2. Secondary research questions

This study is guided by the following specific question:

- Does cognitive dimension predict the quality of life of CAR refugees living in Gado Badzere Camp?
- Does affective dimension predict the quality of life of CAR refugees in Gado Badzere camp?
- Does social support dimension predict the quality of life of CAR refugees living in Gado Badzere Camp?

1.4. CONCEPTUAL HYPOTHESIS

A hypothesis is an educated prediction or guess that can be tested. It is a tentative statement about the relationship between two or more variables. According to Cambridge Advanced Learner's Dictionary (Third Edition), a hypothesis is an idea or explanation for something that is based on known facts but has not yet been proven. This work is guided by the general and specific research hypotheses as stated below.

1.4.1. General hypothesis

The general hypothesis of this study is as follows:

The psychosocial support provided by UNHCR and its partners predicts the quality of life of CAR refugees living in Gado Badzere Camp in the East Region of Cameroon.

1.4.2. Specific hypothesis

The following specific hypothesis came out of the main hypothesis:

- Affective Psychosocial Support dimension predicts the quality of life of CAR refugees living in Gado Badzere Camp.
- Cognitive Psychosocial support dimension predicts the quality of life of CAR refugees living in Gado Badzere Camp.
- Social Psychosocial Support dimension predicts the quality of life of CAR refugees in Gado Badzere Camp.

1.5. RRESEARCH OBJECTIVES

This study is being guided by a general objective and specific objectives as stated bellow.

1.5.1. General objective

The role of UNHCR and its partner's performance on providing psychosocial support to CAR refugees living in the East Region of Cameroon has not been widely reported. The main purpose of this study is to find out if the psychosocial support provided by UNHCR and its partners predicts the quality of life of Central African Refugees living in the Gado Badzere Camp of the East Region of Cameroon.

1.5.2. Specific objectives

The specific objectives of this study include the following:

- To find out if there is a link between psychosocial support and the quality of life of refugees.
- To find out if psychosocial support predicts Quality of life.
- To know the dimension of psychosocial support that most predicts quality of life
- To find out what percentage of the variance of psychosocial support explains quality of life.

1.6. SIGNIFICANCE OF THE STUDY

The focus of this study is to bring out contributions that will be used to enhance the quality of life of refugees and make psychosocial support more qualitative for refugees to meet their needs. The study will assist International and regional stakeholders to make an in-depth analysis of the strengths and weaknesses of the actual measures and how they can explore and improve on these measures to enhance refugees quality of life. This study is therefore significant to the following group of persons:

1.6.1. To the government and public stakeholders

Government serving as host countries to refugees 'seldom operate without partners. Though refugee-oriented policies are internationally binding, they greatly affect national policies especially those which concern the psychosocial aspects. Interventions that are Education, recreational and sport based will require the government to make provision of human resources who can adequately and effectively serve the needs of the refugees. Better still the family and community involvement of approach of psycho-social support greatly require the effort of host communities as well to facilitate the tasks.

Knowledge of the different psychosocial support policies applied by non-state partners in the Gado Badzere refugee camp will help the Government with information on what contributions to make and the types of non-state partners it should convene or work with. The

awareness of the impact or outcome of the psychosocial approaches will also help the Government streamline its sensitization campaigns to host communities of Refugees.

1.6.2. To Refugees

It will help refugees understand the different psychosocial approaches that can best help them as well as the stake holders involved. The success stories of those already benefiting from the psychosocial interventions will motivate many other refugees who might have been timid in their participation. Those who are going through specific challenges might be encouraged to find out that they are not alone especially during focused group discussions.

1.6.3. To International and regional stakeholders

The study will assist international and regional stakeholders such as the UNHCR to make an in depth analysis of the strength and weaknesses of the present psychosocial measures and how they can better improve on these measures to enhance the wellbeing of refugees. It will also serve as a fact book for other NGOs who may want to intervene in the area.

1.7. LIMITATIONS OF THE STUDY

The limits or boundaries of this study will be set in geographical and the thematical perspective as seen below;

1.7.1. Geographical scope

The East region occupies the South-eastern portion of the Republic of Cameroon. It is boarded to the east by Central Africa Republic (CAR), to the South by Congo, to the north by the Adamawa region and to the West by the Centre and South Regions (appendix 1). It is the largest region in Cameroon with 109,002km^2 of land and a population of 771,755 inhabitants in 2005 according to the National Institute of Statistics (2011) but the most sparsely populated region. This work concentrates on the population of refugees from Central African Republic seeking refuge at the UNHCR camp in Gado-Badzere, a village within the Garoua Bulai subdivision 30km from Cameroon eastern border with the Central African Republic in the Lom and Djerem Division of the East region of Cameroon. Gado Badzere camp is the biggest out of the five camps in the East region of Cameroon. According to UNHCR 2021 report, the population of Gado camp has risen to 29,164 Central African refugees with 57, 80% of the population being less than 18 years and women/girls representing 53, and 23% being the main vulnerable group of persons in the society. The same report states that the main priority of the Gado Camp is focused on the monitoring of children up to secondary school level, respond to

non scholarised adolescents between 14-17 years, the promotion of self-reliance initiatives, promotion of hygiene and sanitation, access to fertile cultivable land, and pasture spaces for agro pastoral refugees, shelters and reinforcement of security in the camp.

1.7.2. Thematic scope

This work is within the sphere of psychosocial support (health, nutrition, shelter, education, hospitality, legislation, livelihoods and protection) in relation to the quality of life of refugees in Gado Badzere camp. This study focuses on the psychosocial support which helps to enhance their quality of life and facilitate reintegration How psychosocial support has contributed in empowering these refugees by enhancing their quality of life and facilitating their struggle to get reintegrated into the society and how the society treats them, do they interact with the society or become victims of psychological trauma, societal discrimination, financial instability or social phobia. The study looks at the relevance of the psychosocial support given to their quality of life and if psychotherapy, capacity building, guidance and counselling contributes to improve the wellbeing of these refugees and not just leave them vulnerable to the society. Therefore, considering that this camp is the biggest in the East region, the results of this research will be generalize to other refugee camps or different areas across the country and the findings will inform future investigations of this nature.

1.8. TYPE OF RESEARCH

The researcher chose the quantitative research method so as to reach a large number of refugees and allow them freely express their opinion without fear due to its anonymity. This is in relation to applied research which according to Mahabat (2018), applied research is designed to solve practical problems of the modern world, rather than to acquire knowledge for knowledge's sake. For example, applied researchers may investigate ways to: improve on the general health conditions, treat or cure a specific disease, improve the energy efficiency of homes, offices, or modes of transportation.

1.9. DEFINITION OF TERMS

In a research study like this one, a better understanding of key terms is very important in the research process. It is in this line that the definition of key terms is obliged to be part of this research work. The key terms under study include:

1.9.1. Psychosocial Support

The term ‘psychosocial’ refers to the dynamic relationship between the psychological dimension of a person and the social dimension of a person. The psychological dimension includes the internal, emotional and thought processes, feelings and reactions, and the social dimension includes relationships, family and community network, social values and cultural practices. ‘Psychosocial support’ refers to the actions that address both psychological and social needs of individuals, families and communities. (Psychosocial interventions. A Handbook, page 25.)

Psychosocial support can be both preventive and curative. It is preventive when it decreases the risk of developing mental health problems. It is curative when it helps individuals and communities to overcome and deal with psychosocial problems that may have arisen from the shock and effects of crises. These two aspects of psychosocial support contribute to the building of resilience in the face of new crises or other challenging life circumstances.

PSS refers to the processes and actions that promote the holistic wellbeing of people in their social world. It includes support provided by family and friends. PSS can also be described as a process of facilitating resilience within individuals, families and communities. PSS aims to help individuals recover after a crisis has disrupted their lives and to enhance their ability to return to normality after experiencing adverse events.

1.9.2. Refugee

According to the UN Refugee Agency, A Refugee is someone who has been forced to flee his or her country because of persecution war or violence. A refugee has a well-founded fear of persecution for reason of religion, nationality, political opinion or membership in particular social group. Most likely they cannot return home or are afraid to do so. War and ethnic tribal and religious violence are leading causes of refugee fleeing their country.

1.9.3. Refugee Camp

A refugee camp is a temporary settlement built to receive refugees and people in refugee-like situations. Refugee camps usually accommodate displaced people who have fled their home country, but camps are also made for internally displaced people. Usually, refugees seek asylum after they have escaped war in their home countries, but some camps also house environmental and economic migrants. Camps with over a hundred thousand people are common, but as of 2012, the average-sized camp housed around 11,400. They are usually built

and run by a government, the United Nations, international organizations (such as the International Committee of the Red Cross), or non-governmental organization.

1.9.4. Quality of life

WHO defines quality of life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals standards and concerns. Health care professionals regard quality of life as a reflection of an individual's health, comprising their physical, psychological and social wellbeing.

Quality of life can also be said to be the degree to which an individual is healthy, comfortable, and able to participate in or enjoy life events. The term quality of life is inherently ambiguous, as it can refer both to the experience an individual has of his or her own life and to the living conditions in which individuals find themselves. Hence, quality of life is highly subjective. Whereas one person may define quality of life according to wealth or satisfaction with life, another person may define it in terms of capabilities (e.g., having the ability to live a good life in terms of emotional and physical well-being). A disabled person may report a high quality of life, whereas a healthy person who recently lost a job may report a low quality of life. Within the arena of health care, quality of life is viewed as multidimensional, encompassing emotional, physical, material, and social well-being.

1.9.5. Wellbeing

Wellbeing is defined as a condition of holistic health and the process of achieving this condition. It refers to physical, emotional, social, and cognitive health. Wellbeing includes what is good for a person: having a meaningful social role; feeling happy and hopeful; living according to good values, as locally defined; having positive social relations and a supportive environment; coping with challenges through positive life skills; and having security, protection, and access to quality services.

1.9.6. Resilience

Another concept related to an overlapping with PSS is resilience. Often referred to as an outcome, resilience refers to a process by which individuals in adverse contexts recover and even thrive. It is the capacity of a system, community, or individual potentially exposed to hazards to adapt. This adaptation means resisting or changing in order to reach and maintain an acceptable level of functioning and structure. Resilience depends on coping mechanisms and life skills, such as problem-solving, the ability to seek support, motivation, optimism, faith,

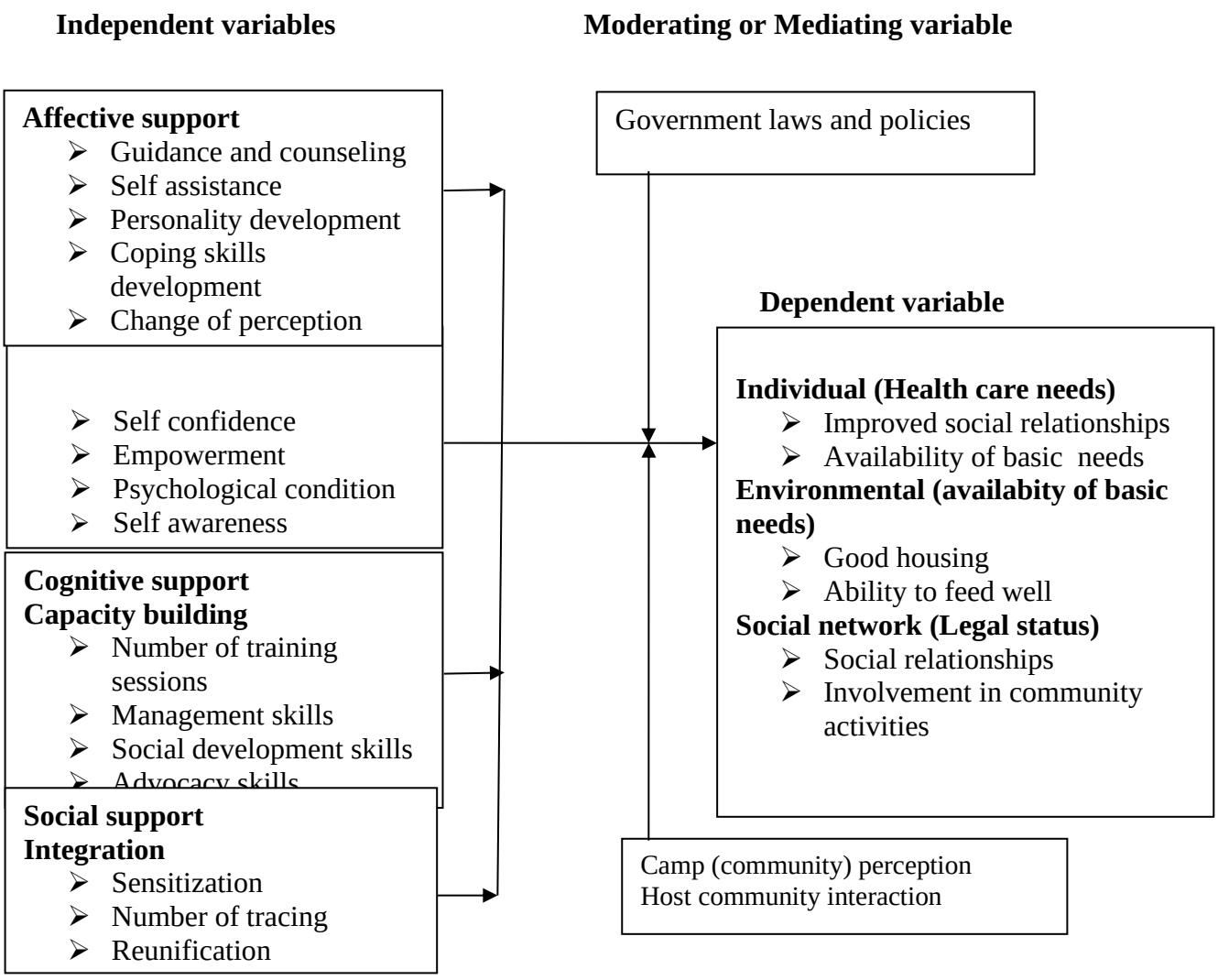
perseverance, and resourcefulness. Resilience occurs when protective factors that support wellbeing are stronger than risk factors that cause harm. Activities that promote PSS and SEL can contribute to resilience by promoting the core competencies that support wellbeing and learning outcomes (i.e., skills, attitudes, behaviours, and relationships), and which in turn allow children and youth and the education systems they are part of to manage and overcome adversity. It is also important to note that individual resilience is often boosted by community support, including interactions with peers, family, teachers, community leaders, and so on (Diaz-Varela, Kelcey, Reyes et al., 2013).

CHAPTER TWO
PSYCHOSOCIAL SUPPORT AND THE QUALITY OF LIFE OF REFUGEES

This chapter necessitates the review of literature on quality of life and the psychosocial support of refugees. It brings out what other researchers have written which is related to this study. It is a review of their works and from the review synthetic statements are made to give a better understanding of this piece of work. It further discusses quality of life in terms of psychosocial support as perceived by many scholars around the world. This chapter is subdivided into two parts. These subsections include: quality of life variables and dimension and Psychosocial support approaches for refugees.

2.1. CONCEPTUAL FRAMEWORK

Figure 1: Review of research concepts.



Extraneous variables

In the figure above, it can see on the figure above, the provision of Cognitive, Affective and social support via counselling, education, health facilities, financial support and sensitization has a direct impact on the quality of life of refugees.

2.2. QUALITY OF LIFE

WHO(World health organization) defines quality of life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals standards and concerns. Health care professionals regard quality of life as a reflection of an individual's health, comprising their physical, psychological and social wellbeing.

Quality of life can also be said to be the degree to which an individual is healthy, comfortable, and able to participate in or enjoy life events. The term quality of life is inherently ambiguous, as it can refer both to the experience an individual has of his or her own life and to the living conditions in which individuals find themselves. Hence, quality of life is highly subjective. Whereas one person may define quality of life according to wealth or satisfaction with life, another person may define it in terms of capabilities (e.g., having the ability to live a good life in terms of emotional and physical well-being). A disabled person may report a high quality of life, whereas a healthy person who recently lost a job may report a low quality of life. Within the arena of health care, quality of life is viewed as multidimensional, encompassing emotional, physical, material, and social well-being.

2.2.1. Objective and Subjective Quality of life

Various fields of research such as economics, social sciences, political sciences and health, both clinical and administrative, use the term "quality of life", but use their own definition. Quality of life is frequently used as a proxy for well-being, enjoyment of life and satisfaction with life (Noreau & Shephard, 1995) and is thought to be dependent on the balance between body, mind and spirit (Albercht & Devlieger, 1999). It would also depend on the establishment and maintenance of harmonious interpersonal relationships (Albercht & Devlieger, 1999). According to Vlek et al (1998), the most important attributes of quality of life are health, family, a quality environment and safety. Two approaches have been established to define quality of life: the objective approach (U.S. Departrnent of Health, Education and Welfare 1969) and the subjective approach Albrecht & Devlieger (1999), Dijkers (1997),

Osberg et al (1987), Kirchrnan & Schulte (1989), Lawton et al (1999), Lucas et al (1996), Zhan (1992).

The objective quality of life measure takes into account several variables: socioeconomic level, years of education, marital status, living situation, work, physical health, number of televisions in the home, and municipal services (Dijkers, 1997). The objective approach also encompasses the concept of health-related quality of life (Fitzpatrick et al., 1992; McHomey et al (1994). The variables of interest are signs and symptoms, treatment side effects, physical, cognitive, emotional and social functioning, functional autonomy, fatigue, pain, social and physical activities and restricted days at home or in bed. Dijkers (1997), Fitzpatrick et al (1992), McHomey et al. (1994). The more positive these variables are, the better the so-called objective quality of life.

Subjective quality of life, on the other hand, takes into account the person's cognitive and emotional perception. Cognitive perception emphasizes the components of satisfaction with life. Andrews & Withey, (1976), Campbell et al (1976), Osberg et al 1987), while emotional perception emphasizes mood, Kirchman & Schulte (1989), Zhan (1992) and affects. Bradbum (1969). The elements measured are coping strategies and adjustment to functional disabilities, morale and acceptance of disability. Dijkers, (1997), aspirations versus achievements. (Campbell et al, 1976), Robnett & Gliner (1995), mood (Kirchman, 1986), sense of control, physical, psychological and spiritual health, Robnett & Gliner, (Personal pathways (Mayers, 1995), family and intimate relationships (Campbell et al 1976), Albercht & Devlieger (1999), home environment, Bubolz et al (1980), Chapman & Beaudet (1983), Lawton et al (1978), Lawton & Cohen (1974), social life, and recreational activities Kirchman (1986), Mayers (1995) are also taken into consideration. Pearlman and Uhlmann (1991) have shown that objective indicators of quality of life are weakly correlated with the subjective dimension of quality of life. Kirchman (1986) first defines quality of life as the fulfillment of one's basic needs, that is, food, shelter and material possessions.

He then explains that other factors are involved, such as self-fulfillment in work, appreciation of the beauty of nature and the arts, a sense of identification with one's community, and a feeling of having given maximum effort. The person's aspirations are his or her feelings or perception of his or her life that is, his or her goals, and values, standards of comparison, desires or life plans. Achievements are defined by what the person currently has, is, owns or controls in relation to his or her life standards. The bridge between aspirations and

achievements is experienced by the individual in perspective of time. Their congruence generates a cognitive reaction of satisfaction or an emotional reaction of happiness. Conversely, their non-congruence produces a reaction of dissatisfaction or depression. Time is a significant element since the duration of a particular status or the expected time before the achievement of a certain accomplishment plays a major role in the subjective reactions resulting from the bridge between desires and reality.

2.2.2. Multidimensional quality of life

"Quality of life" (QOL) refers to an individual's general well-being, including positive and negative everyday life experiences. It is a broader metric than economic participation and living standards, including various factors that influence human capabilities and functioning. Most previous studies have measured QOL narrowly by focusing on income, an approach that researchers have often criticized. Diener & Suh (1997) elaborate on the limitations of the income-only QOL approach; include the failure of increased income to guarantee happiness or to reduce several deprivations experienced by the poor. These criticisms paved the way for broader multidimensional QOL assessments Alkire & Foster (2011), Nussbaum & Sen (1993).

Multidimensional QOL assessment is critical in a situation of forced displacement. Refugees may be economically engaged yet have low life satisfaction due to exploitation or multidimensional deprivations in nutrition, health, education, employment, and shelter (Becchetti & Rossetti, 2009; Sand & Gruber, 2018). These deprivations disproportionally affect refugees' QOL compared to the host population. The level at which these issues affect refugees living in camps may also differ from how they affect refugees living out of camps. Another issue is that the income indicator alone may not provide reliable information about refugee welfare. For example, refugees may not be truthful about their earnings if they conceive that the purpose of the survey is to plan for refugee assistance or resettlement. Therefore, for policy consideration and proper targeting, the multidimensional QOL indicator is appropriate in understanding refugees' deprivations, whether they live in or out of camps.

Generally, multidimensional measures encompass several indicators, such as income, health, education, living standards, empowerment, quality of work, threat of violence, and housing conditions (OPHI, 2016). However, as a framework for poverty measurement, researchers can measure a person's or a group's QOL using any combination of the indicators that reflect policy needs and priorities (Alkire & Foster, 2011; Robeyns, 2005). As such, different research groups have adopted different sets of indicators. For instance, the Oxford

Poverty and Human Development Initiative (OPHI) and the United Nations Development Programme (UNDP) adopted a measure of 10 indicators categorized under the three dimensions of poverty: health, education, and living standards (Alkire et al., 2020). Stiglitz, Sen, & Fitoussi (2009) also provided nine QOL dimensions including material living condition; productive or other main activity; health; education; leisure and social interactions; economic security and physical safety; governance and basic rights; natural and living environments; and overall experience of life. Following the recommendation of Stiglitz et al (2009) that QOL should be measured comprehensively, linking both subjective and objective conditions, this researcher adopted two dimensions to measure refugee QOL. The first dimension is the overall experience of life, or "life satisfaction"(improvement of quality of life), and the second is the material living conditions.

The "life satisfaction" indicator assesses people's subjective well-being. It is purposefully used in this study of refugees because it requires respondents to reflect on, and make an overall assessment of their life happiness, including wealth, security, and hopes for the future. "Material living condition" captures households' objective living conditions and opportunities, including material deprivations and housing conditions that directly affect their QOL. Material deprivations refer to the level at which households are able to have the consumption goods and services needed in a society at a given time. Several indicators could measure material deprivations. One typical indicator is the ability or inability for households to meet basic food needs at above the national abject poverty level.

In the eastern regions, basic social services do not have the capacity to meet the demand of the entire population, including that of Central African refugees. Since the beginning of the crisis the limited existing health centers have been overcrowded and have faced insufficient human and material resources. Extreme poverty prevents vulnerable people from paying the costs necessary for health care. Apart from this, 70 per cent of health facilities do not have the necessary medical equipment and sufficient staff to ensure quality health care. Especially children under five, pregnant and lactating women, persons with disabilities, older people and those with chronic diseases face difficulties in accessing health care (OCHA, 2021). Other measures of deprivations may include counting the number of household assets, such as beds, air conditioners, and cooking utensils. The availability of housing and housing conditions can also be captured by calculating overcrowding and satisfaction with accommodation services, such as water and electricity.

2.2.3. Individual (Health Care Needs of Refugees)

As people flee from war and persecution, they are at great risk of injury, or of contracting potentially fatal diseases. Emergencies lead to extensive loss of life and increased incidence of disease, especially in the early phases of crisis. The main 'killers' in refugee situations are measles, diarrhoeal diseases (including cholera), acute respiratory infections (pneumonia), malnutrition and malaria (where prevalent). Other health problems include tuberculosis, meningitis, vector-borne diseases, HIV/AIDS and other sexually transmitted diseases, pregnancy and obstetric complications as well as vaccine-preventable childhood diseases (UNHCR 2002). The surge of such relatively easy-to-prevent conditions in times of emergency is due to the drastic deterioration of people's living conditions.

Moreover, the volatile situation in which many displaced persons find themselves tends to place them at greater risk of sexual violence, resulting in the accelerated spread of sexually transmitted diseases and unwanted pregnancies, which place on their quality of life. In the immediate aftermath of their flight, many displaced people are exposed to insecurity and physical violence; lack adequate shelter and sanitation facilities; are packed into overcrowded camps or makeshift settlements; have insufficient access to appropriate food, clean water and basic supplies for personal hygiene; have no immunity to the local diseases of their new environment; and Suffer considerable emotional stress as a result of traumatic experiences and the uncertainty of their situation.

One of the greatest challenges is to ensure that the most vulnerable patients are rapidly identified and treated. As the sick and the elderly are often unable to travel, they may have no way to contact the relevant health services themselves without the help of concerned relatives or neighbours. Others may be unaware that any help is avail-able. It is therefore crucial that health care is brought to communities and that those in need of assistance are actively sought out. Refugees have the same right to quality medical attention as resident communities.

How this is pursued depends on certain conditions on the ground: are the refugees living in a remote and enclosed camp situation or are they spread out and integrated into various local communities? Are national health services available to them or do they depend on aid agencies for medical care? What are the most pressing health problems and to what extent can the refugees themselves contribute to their resolution? Hence, a thorough assessment of the needs and available resources must be the first step in any situation. In most cases, needs will be identified at several levels, including: basic primary health care needs that can be dealt with at

the community level; Needs for in-/outpatient care provided by health centres; and needs for more sophisticated treatment at a referral hospital.

Another concept related to an overlapping with PSS is “resilience”. Often referred to as an outcome, resilience refers to a process by which individuals in adverse contexts recover and even thrive. It is the capacity of a system, community, or individual potentially exposed to hazards to adapt. This adaptation means resisting or changing in order to reach and maintain an acceptable level of functioning and structure. Resilience depends on coping mechanisms and life skills, such as problem-solving, the ability to seek support, motivation, optimism, faith, perseverance, and resourcefulness. Resilience occurs when protective factors that support wellbeing are stronger than risk factors that cause harm. Activities that promote PSS and SEL can contribute to resilience by promoting the core competencies that support wellbeing and learning outcomes (i.e., skills, attitudes, behaviours, and relationships), and which in turn allow children and youth and the education systems they are part of to manage and overcome adversity. It is also important to note that individual resilience is often boosted by community support, including interactions with peers, family, teachers, community leaders, and so on (Diaz-Varela, Kelcey, Reyes et al., 2013).

2.2.4. Environment (availability of basic needs)

According to American University of Beirut final report (2018), majority of CAR refugees in Cameroon live in extreme poverty in the least developed regions of the country. In reality, refugees struggle to meet their most basic daily needs, such as food, water, shelter or healthcare, and suffer from high levels of chronic malnutrition. Results from vulnerability analyses reveal alarming levels of extreme poverty amongst the refugee population, showing that over 80% are considered ‘extremely vulnerable’ and in need of assistance, yet current levels of aid fall well below this level. Without covering the basic needs of CAR refugees and supporting them to move beyond daily survival, refugees are unable to develop meaningful livelihoods, reduce their dependency on aid and become self-sufficient. In this context, transitioning from humanitarian assistance delivered by international humanitarian actors to government and development actor-led systems is highly challenging, as families living below the extreme poverty line will likely use any assistance they receive to meet their immediate needs rather than being able to develop longer-term income generating activities (UNHCR, 2018).

Many refugees settle in urban areas based on the assessment that this will make them relatively better off. A central factor to this decision appears to be the greater ability to earn a living. In some cases, refugees living in urban settings who do not do well economically return or migrate to camps. For urban refugees, employment in the informal sector is particularly common. In countries that have not ratified the 1951 Convention or that have not afforded refugees the right to employment, many refugees seek work informally to keep their refugee status hidden. Often, employers exploit refugee workers' dire situation and pay unfair wages, demand long working hours, or expose refugees to dangerous working conditions. This goes unreported because refugees fear identification and possible detention or deportation. Due to the lack of regulations in the informal economy and lower wages, refugees struggle to support themselves and their families (Alexander 2008; Campbell 2006; Crisp et al., 2009; Jaranson 2004). To avoid exploitation, a number of refugee groups have procured fake documents and/or pursued entrepreneurship.

Many who pursue business in their asylum countries bring relevant expertise from their country of origin. Self-sufficient refugees are not an economic strain on the host country, and in many cases, authorities ignore refugees' informal work, tacitly acknowledging their contribution. In fact, they make economic and social contributions to their host cities: rejuvenating communities, expanding markets, importing new skills, and creating transnational linkages. In some cases, such as that of Somali refugees in Nairobi, refugee-run businesses have become integral to the informal markets (Alexander 2008; Campbell 2006; Crisp et al., 2009; Jaranson 2004).

A majority of in-camp refugees in most countries leave camps. These camps are under joint administration of the government of the host countries and UNHCR. Although the camps differ in terms of location, time of establishment, capacity, and administration, their inhabitants broadly share the same characteristics. The UNHCR and other NGOs support camp residents through provision of targeted assistance in the form of cash and sometimes "in-kind" core through the World Food Programme's (WFP) block chain system to cover food needs. Schools and health centers around the camps benefit the refugees as well as neighboring communities.

Despite these benefits, CAR refugees like any other humans are rational and continuously seek to reside in places where they perceive more freedom and better livelihood opportunities. Most CAR refugees in the East Region have opted to live outside camps because

it may improve their ability to search for jobs (World Bank, 2020). According to the UNHCR (2020), the greatest share of camped refugees to the total population of registered CAR refugees in the East Region decreased from 55 percent in 2013 to 19 percent in 2020. This reduction is the result of both new arrivals preferring to reside outside the camps, as well as the departure of refugees after some years in the camps.

However, several reports have shown that out-of-camp refugees often live in bad living conditions, work in informal jobs, and pay high rent (World Bank, 2020). Considering that they maintain lower contact with officials, they may lack access to information and may not be fully informed about their rights. These issues can put out-of-camp refugees at a disadvantage compared to camp residents, affecting their QOL (Verme et al., 2016). Another challenge faced by refugees is that of resettlement and pathway to citizenship. It has not been an easy task to Central African Refugees in Cameroon. According to the 2005 refugee law, naturalization is possible. However, it is well beyond the means of refugees to pay for permanent residency, which costs approximately US$500. After holding permanent residency for ten years, refugees over the age of 18 are eligible for naturalization. For the time being, the GRC (Governance risk and compliance) is not willing to reduce the price or to facilitate a mass application process. This is likely to remain the case while an indefinite number of CAR refugees continue to cross the border.

The GRC wishes to follow the law precisely and indicates that previous efforts to get a reduction in the price failed. Furthermore, the preference is to grant citizenship to those who add value to the country. Unfortunately, refugees are not in a position to contribute to the national economy because they are living as subsistence farmers and did not come with any formal education. There are also political issues involved. If the over 270,000 refugees currently in the country were to become citizens, the politics of the East and Adamawa regions could shift dramatically. In the East region, the refugees make up an estimated 10 percent of the population and so with the right to vote, the refugees could influence elections. Increase in the number of citizens in the region could also shift the balance in parliament. At this point, refugees know nothing about the process of becoming a citizen nor do they think it is important. They already feel like they are Cameroonians, having moved back- and-forth across the border for many years as nomadic pastoralists living among fellow Mbororos and Mbaya. They did not have documentation in CAR and they do not believe they need it in Cameroon. One of the most important statements on the subject of resettlement as it pertains to urban refugees is UNHCR’s acknowledgment that a refugee in an urban area should have neither more nor less

chance of resettlement than he or she would have had in a refugee camp (UNHCR 1997, Buscher 2003).

Resettlement programs serve as a substantive and symbolic gesture of support for host government efforts to contend with mass flows of refugees (Crisp et al 2009). However, resettlement is clearly established within the literature as a limited option which can only offer a durable solution to a small proportion of the refugee population (Alexander 2008, Asylum Access 2009, Crisp 2009, and UNHCR EPAU 2000). Resettlement, despite its limited potential, is front of mind for a majority of refugees. Landau and Jacobsen (2004) posit that refugees may sometimes select a country or city to settle in based on the possibility of entering a resettlement program. In some cases, refugees have opted not to accept residence permits or seek legal status in their present country of asylum for fear that it might jeopardize their chance at qualifying for resettlement (Grabska 2006).

Access to basic services is limited, rates of documentation are lower than national averages and this region is largely isolated from the rest of the country in terms of their economic integration. The presence of large numbers of refugees is exacerbating such pre-existing structural challenges, resulting in increased fragility and potential risk to social cohesion in the affected areas, a risk amplified by increasing pressure on the natural environment and scarce natural resources. The protracted refugee situation in the East with limited return opportunities, diminishing humanitarian assistance, potential intercommunity tension, continuing pressure on weak government services and limited natural resources are factors plaguing refugees. Furthermore, in the Eastern border regions the general perception often seems to be that crime rates have risen in some areas with the arrival of CAR refugees. There seems to be a looming risk of radicalization of the largely unemployed and disenfranchised refugee youth.

The prospects for return and other durable solutions are limited, in particular for CAR refugees. The long-term presence of CAR-refugees has further exacerbated the lack in sustainable development of the host communities in border areas, which have been neglected not only by international partners, but also been traditionally marginalized areas within Cameroon. There is an increased perception in some quarters of Government that Cameroon has reached its absorption capacity, due to the financial burden, the gradual withdrawal of humanitarian assistance from CAR-refugee hosting areas due to donor fatigue and the insufficient engagement of development actors in refugee-hosting areas (UNHCR, 2018-2020).

Furthermore, there is the fear that the drastic reduction of food rations and overall humanitarian assistance may have paved the way for some refugees to explore alternative means of survival causing further estrangement between them and the local populations.

The main barrier for full integration is an inadequate pathway to citizenship. While legal integration is allowed by law, it is not accessible to the vast majority of refugees because the costs, lack of information about the process, and bias against uneducated subsistence farmers. So far, the Government of the Republic of Cameroon has not indicated any interest in facilitating the process, reducing the fees, or changing their expectations about the potential contributions of rural refugees. The refugees have not yet expressed a desire to be naturalized, but the issue may surface if they become more interested in enjoying the same rights as their Cameroonian neighbors, such as unrestricted freedom of movement, holding civil service jobs, obtaining titles for land, or voting. It could also become an issue if the Cessation Clause is invoked. In this case they would lose their refugee status and be asked to repatriate, something most do not want to do. If they choose to stay, which may increase in likelihood the more settled they become in Cameroon, they will lose their UNHCR identification documents, protection, and the right to stay in Cameroon.

2.2.5. Social network (Legal Status)

The right to freedom of movement is enshrined in international refugee legislation as well as the Universal Declaration of Human Rights, yet governments hosting refugees (Hovil 2007) often disregard it. Governments hosting significant numbers of refugees often try to keep refugees segregated from the local population, forbidding them from leaving camps or settlements and branding those who self-settle in urban settings illegal. While the majority of refugees living in urban centers do so illegally, much has been written about Egypt and South Africa, where refugees are legally allowed to settle amongst the urban population. Refugees with legal status in Johannesburg and Cairo have prompted studies into the effect of legal status on urban refugees' livelihoods and security. It has been argued that legal status is insufficient to protect urban refugees.

By itself, legal recognition does not necessarily provide access to the rights guaranteed in the international treaties or to socio-economic opportunities. The constraints applicable to all refugees by virtue of their flight and importantly, the economic climate of host countries, may negate the importance of legal access to employment and identity documents

(Bailey 2004). Since 2002 populations facing recurrent socio-political unrest in the Central African Republic (CAR) have sought refuge in neighboring countries, including Cameroon. This peaked in 2014, with the registration of almost 120,000 Central African refugees in the eastern part of Cameroon (East, Adamawa and North administrative regions). In this part of the country, recognition of refugee status and registration is the sole responsibility of UNHCR since, apart from in the capital city of Yaoundé; the State is yet to set up the required mechanisms to carry out refugee status determination.

Faced with very large numbers of arrivals, it was necessary to take a *prima facie* approach (implying group recognition of refugee status) to Central African refugees, on the basis of the 1969 OAU Convention. Before registering refugees UNHCR officers must first make sure that the applicants are indeed of Central African nationality or, if it is not possible to do so, must gather evidence that they were habitually resident in CAR. The difficulties that staff encountered in establishing and evidencing this link highlight the fact that among these populations are people who are at risk of statelessness. Group recognition under the *prima facie* approach is generally done in "situations in which entire groups have been displaced under circumstances indicating that members of the group could be considered individually as refugees" (UNHCR, 2015). There are two principal elements to note here. Firstly, it must be established that there are objective circumstances that justify flight, such as conflict, occupation, massive human rights violations, widespread violence or events seriously disturbing public order. Secondly, there must be a massive influx of people, making it almost impossible to conduct a thorough analysis of individual cases.

The situation of generalized conflict and violence in CAR was widely known, providing objective reasons for flight. Given the large number of arrivals, plus the urgent need to provide international protection and UNHCR's shortfall in resources, it was not possible to apply formal refugee status procedures. UNHCR staffs in the field were therefore called upon to conduct concise, semi-structured interviews with applicants, the objective being to establish that they belong to the identified group, namely nationals or residents of CAR who had fled because of the prevailing circumstances. The task was even more complex because the border is relatively porous; communities, which belong to the same tribes and which share cultures and religion, live on both sides. The work of identifying newly arrived people was therefore done in collaboration with border law enforcement authorities, with village chiefs and with leaders of already-settled refugee communities; monitoring of these identification mechanisms took place to limit the risks of abuse or fraud.

2.3. PSYCHOSOCIAL SUPPORT DIMENSIONS FOR REFUGEES

After looking at the dependent variable quality of life and its indicators, we are going to look at the independent variable psychosocial support. Bearing in mind that the term psychosocial refers to the close relationship between an individual and the collective aspect of any social entity. Psychosocial support in relation to refugees can therefore be adapted to respond to their psychological and physical needs. Psychosocial strategies or approaches are interventions that focus on psychology and social elements. The approaches shall be discussed in three dimension. The first dimension will handle affective approaches specific to psychological or mental health while the second will handle cognitive approaches and the third, social support for refugees.

2.3.1. Affective psychosocial support dimensions

This section seeks to present the different ways through which refugees oriented actors provide affective (psychological) assistance to refugees. Among the most common psychosocial sequence of mental health among refugees are feeling of isolation, insomnia, relieving of painful experiences and stigmatization. Adequate psychosocial support can therefore prevent distress and suffering among refugees from developing in to something more severe, help refugees cope better and become reconciled to everyday life (Sannoh &Alieu).

2.3.1.1. Community sensitization approach to promote quality of life

Community sensitization can also be called community awareness, community education or community outreach. The idea behind community sensitization is to provide education and/or information to a group of people which in this context is the hosting communities of Refugee camps. The goal of community sensitization is to give community members and opportunity to learn and discover for themselves valuable information about an issue with which they are already struggling. (Herman (1992) It is important to engage in community education about mental health, psychosocial promotion of mental health experiences, and the kind of services that actors can provide to the general population in the refugee camp. Community sensitization can be very beneficial and empowering.

In the Refugee camps, the NGOs and government actors conduct community sensitization in many ways, including large group activities such as events marking December 10(international Human Rights Day) and June 26 (the UN international day in support of victims of torture); door-to-door visit; speeches made at schools and other gathering places;

and introductory trainings for community leaders. Research shows that the number of regular community events, usually relate to sensitization or socialization activities like sport tournaments, purification ceremonies and mass celebrations.(Herman 1992 Ibid) In the context of Refugee camps in Cameroon, community sensitization work can be done through psycho-educational messages are disseminated through songs, dances and drama to participant in wider community events such as school celebrations, art and craft shows and international Refugee day.

Besides the benefits of community sensitization, there are equally challenges. One such challenges have to do with the language context that western and African affiliations, so far western mental health and treatment are still new concepts. In Somalia and many other African cultures, concepts of western Sense are not well developed: one is crazy or one is not crazy. There is no conceptual framework work that includes a spectrum of health and diseases, mental health and mental illnesses (Stark &Trisha 2003). Depression, for example, has no direct translation in many African languages. Instead, it is described: refers to the feeling of sadness (kroll & Jerome 2003) to describe the illness through its recognized symptoms rather than by category or label, such as depression for Psychosocial support to be effective, it must be understood by the client from a personal, religious and cultural perspective. Significant stigma shrouding mental health issues prevents many Refugees in the Refugee camp from seeking treatment or assistance.

If a treatment is recommended that has negative cultural associations the client will not accept it (Kara & Meade 2004). If on the other hand, the treatment is consistent with cultural and religious beliefs, the client will more likely be an active participant and the treatment will be more successful. Refugees can be with others who have experienced similar histories to accept and ask for help (Berger & Weiss, 2002). Refugees experience support and guidance from peers and group leaders, and develop healthy relationships within the group. In effect, this helps to re-establish the Refugee family and clan support system.

Outside language shortcomings, Africans eagerly believe that wars crisis, disasters and mental illnesses are predominantly spiritual or metaphysical that is from a supreme being such as God or evil spirits. Sometimes these illnesses are also allegedly associated to other persons or oneself through curses, bad behavior or witchcraft. Many Africans traditionally explain behavioral problems as an expected result of spiritual causes or possession by an evil spirit. Healing for these problems is provided by religious leaders or by traditional healers.

Community sensitization in this light are very essential in raising awareness on the actual situation, prevalence and effects of mental health. It helps community members such as teachers, religious and local leaders know what they can do to help others, and to help identify potential victims.

2.3.1.2. Local advocacy strategy in promoting mental health/ Quality of life among refugees.

In recent years, advocacy for mental health promotion has become increasingly recognized as an important public health and humanitarian aid priority. More research has been undertaken to in to better understand the prevalence and predictors of mental health disorder among immigrants and refugees (Sannoh & Alieu, 2015). The experience of migration can negatively influence mental health (Furham & Bochner, 1986) and immigrants and refugees may have an increased risk for mental health disorder and distress when compared to non-immigrants (Breslau et al., 2007). In addition, refugees residing in refugee camps tend to have more mental health problems than do non refugees (Porter & Haslam, 2005). Some groups are more at risk of severe emotional distress than others for example separated children people with pre- existing severe neurological or mental disabilities, the elderly who have lost family members support, women heading house hold is a call for establishing priority for providing psycho-social and mental health assistance (Iglesias et al., 2003). Because of psychological and psychosocial processes that are inter- related each in turn influencing the other, acting on social factors will necessarily also impact the mental health of the Refugees (Herman, 1992). Individuals often need advocacy within their family and community in other to reduce stigma in the promotion of mental health and prevent social isolation (Berger & Weiss, 2002). Moreover, it is crucial to educate both victims and their families about mental health and mental illness.

Further, although safety and stabilization are important treatment goals , many theories and practitioners of mental illness treatment maintain that, for some people clinical significant improvement cannot occur without verbalizing the trauma or representing it in some nonverbal from through art, dance and music or music). Therefore advocating on behalf of Refugees of victims, multifaceted needs is one way of helping them achieve greater safety and stability. This then creates a need for Counselors to network with other NGOs and to make referrals as needed like liaising with health care workers, promoting reproductive health, addressing

domestic violence and other political motivated areas (Center for Victims of Torture CVT 2005).

In addition, CAR often need advocacy within their family and community in other to reduce stigma and prevent social isolation. Moreover, it is crucial to educate both victims and their families about mental health and mental illness. This is important to promote adequate monitoring of treatment compliance and side effects. Because of the strength of Refugees, connection to family, families play an important role in providing the support needed and encouragement to make treatment successful. Without this support, Refugees with mental illness may feel alone, adding to existing feelings of hopelessness and worthlessness (Lu et al, 1995).

2.3.1.3. Counseling and capacity building

Many Refugees with mental illness or mental situation are often socially isolated. The pain of this isolation is intensely (Link & Shoaee 2004). While people with mental illness may be ostracized from the community, their fear of stigma may be even more powerful. Whether the ostracism is created by the community or self-imposed due to anticipated negative responses, the social isolation creates a profound worsening of the mental health state. This social isolation can be very disorienting and can make the process of healing very difficult. In fact, even without prior mental health problems, isolation from community alone can contribute to the development of depression (Jaranson et al 2004). That is why counseling and capacity building are very important approaches to be handled as they have tremendous impact on the quality of life of refugees.

2.3.1.4. Psychosocial counseling as a strategy in promotion of quality of life.

Psychosocial counseling is a process that assists others with personal, social or psychological problems (Herman, 2001), the counselor works with the Refugees to find solutions to problems and through, empathic attitude support and care, find relief from emotional pain. The purpose of psycho-social Counseling is to help people of concern or Refugees solve their personal problems. Psychosocial counseling strategy in the promotion of mental health helps individuals and communities to heal the psychological wounds and rebuild social structures after an emergency, war, a crisis or a critical event. It can help change people into active survivors rather than passive victims (International Federation of Red Cross and Red Crescent Societies 2010).

Psychosocial counseling can be adapted in particular situations to respond to the psychological and physical needs of the people concerned , by helping them to accept the situation and cope with it (The Reference Centre for Psychosocial Support 1993). Previous epidemiological research has found that PTSD and depression are the two most prevalent mental disorders among refugees and the symptoms of these ailments are the most prevalent mental disorder among refugees and the symptoms of these ailments are identifiable cross-culturally with only some variation (Steel et al 2002). Yet prior studies have reported a wide range in the prevalence of PTSD symptoms among refugee populations varying from 3% to 86% (Carlson et al 1994, Fazel et al 2005). Rates of depression among refugee populations have also shown 12 great variations, ranging from 3% to 80% (Fazel et al. 2005)

According to Herman (Herman 2001), psychosocial Counseling in promotion of quality of life places great emphasis on the therapist's own self- analysis and care as being one of the key features of a trauma survivor succeeding in treatment once properly diagnosed. His research also showed that traumatic events have primary effects not only on the psychological structure of the self but also the systems of attachment and meaning that link individuals and communities. What grieving people need is someone who is willing to listen to and hold their full expression of shock, hopelessness, protest, fear and bottomless pain one the grief is expressed slowly the intensity of the anguishes will lessen and the clients can find interest in life once again. (Link & shoaee 2004)

2.3.1.5. Capacity building as a strategy of promotion of quality of life among refugees.

Many Refugees do not yet know which of their relatives have survived the war and which ones have died. Furthermore, for some, cultural practices related to mourning require that they reconnect with their communities at home (Kara 2004). For example in order to have a particular person or materials available for conducting a ceremony or ritual. Some Refugees do not have social support networks and institution are necessary.

Moreover, it is crucial to educate both victims and their families about mental health and mental illness. This is important to promote adequate monitoring of treatment compliance and side effects (Berger & Weiss 2002). Because of the strength of other families' connection to the individual with mental illness, families play an important role in providing the needed support and encouragement to make treatment successful. Without this support, Refugees with mental illness may feel alone, adding to existing feelings of hopelessness and worthlessness.

For capacity building to be effective in mental health promotion, it must be understood by the victim from a personal, religious and cultural perspective. If the capacity building aspect recommended has negative cultural associations, the victim will not accept it (Herman 2001).

Providing capacity building for health care Professionals, government workers, teachers, religious and community leaders will be essential for improving their ability to effectively help the population that needs mental health support.(Berger & Weiss 2002). In order to effectively carry out this task, stakeholders have to recruit local Counselors. These individuals otherwise referred to as psychosocial Counselors (PSCs), offer psycho-social support services for Refugees. Stakeholders build capacity through providing training for the professionals Counselors, community and religious leaders, health care workers, teachers and NGO's workers on war trauma and mental health issues. Capacity building as a strategy of promoting mental health emphasizes experiential training, matching that allow locally hired counselors work side by side their trainers , in addition to class room work, the intensive, hand on training gives practical to the institution whose objective is to provide high quality services to Refugees (Center for Victims of Torture 2011).

2.3.2. Cognitive psychosocial support dimensions for refugees

After looking at the different actions of stakeholders with regards to affective support, this section seeks to present the cognitive support axes. This will be carried out in two subsections: In the first section, we will present exclusively the Education based interventions while in the second section we will talk about community engagement and recreational activities. In contrast to psychological interventions that require specialist personnel, resources and training, and focus only on the minority with diagnosed conditions, this broader, preventative psychosocial approach has been found to be beneficial to the wider population, not only leading to improvement in general symptoms among refugees both with and without specific disorders, but reducing symptoms below a threshold of clinical significance for large proportion of the population.

Once psychosocial interventions are in place, those individuals whose needs are not met by these restorative community level interventions can be identified and provided a higher level of mental affective care (Nicolai 2003). This is reinforced by Jordan et al (2010) who found that although there was little uniformity in psychosocial programs, there was a strong consensus in guidelines and key publications promoting the importance of: Normalization of the Refugee's daily life, Social reconnection/ reintegration and social support mechanisms,

Utilization of individual and community coping and resilience mechanisms ,Discouraging child family separation especially the important role of caregivers, Focus on existing education and health care systems, Emphasis on their education of social discrimination and a non-clinical identification of problems, Youth participation.

An understanding of the culture within the affected country is of fundamental importance in planning psychosocial support programs. There is increasing recognition by several studies that the application of western, individualized approaches to counseling therapy and the use of clinical labels does not readily apply in many cultures, and that in many countries these specialist may not be available. In Syrian context a pre- existing regional shortage of mental health professionals has been placed under extreme pressure and even where such professionals are available, they are not trained with the required therapeutic skills (Kalksma 2007). Burde et al 2015 also stressed on the limitations of applying concepts of western psychology in non- western context. They cite a study by Wessel's (Wessells & Micheal 2009) which shows interventions had inadvertently harmful effects if they did not take local norms and customs into account. They recommend contextually relevant program design should be used as a guiding principle for emergency interventions that address children's wellbeing psychosocial approaches have been found to be more suited to strengthening resilience, using local capacities, and promoting coping and positive development. The IASC guidelines (IASC 2007) recommend psychosocial interventions ensure as safe an environment as possible and provide a return to routines, since predictability and engagement is important for promoting quality of life during complex humanitarian emergencies.

In addition to helping a refugee develop self-esteem and confidence a focus on resilience, gives the advantage of directing attention to their strengths rather than their weaknesses. Nicolai & Triplehorn (2003) also found psychosocial intervention can be an important first step in promoting mental health. This should include stabilizing routines as far as possible whilst providing opportunities to maintain or reinvigorate social connections and engagement in activities such as paid work, education, religious practices and opportunities for recreational sport or art. This is re- enforced by Betancourt 2005 who found these activities also provided a source of hope for the future, especially among youths The close link between psychosocial activities and education is highlighted by Nicolai & Triplehon (2003) who recommend that for many Refugee children or youths in conflict affected areas, schooling whether formal or non-formal is the main means through which support can be provided.

This has critical implications for teacher training to develop classroom management skills, basic knowledge of child development and child friendly pedagogic techniques, as well as providing children time and space for recreational and expensive activities. According to UNICEF (2009), applying a resilience building approach to promote psychosocial well-being focuses program on the following objectives: Reducing risk to Refugee children or youth's safety and emotional wellbeing while promoting an environment conducive to positive development, effective coping and resilience; Promoting refugee children's or youths holistic development and age - appreciate physical, cognitive and emotional competencies; Fostering a secure and stable environment; Strengthening family and community care-giving structures; Supporting children's and youths voice and Full participation in all phases of programming; trengthening local networks that enable child protection, care and wellbeing, such as women's groups or religious networks.

2.3.2.1. Cognitive based interventions

Many studies recognize the importance of education and attendance in school (both formal and non-formal) in providing the stability, structure and routine that refugees children need to cope with loss, fear, stress and violence UNICEF (2016). Wide-scale exposure of people especially children to violence and deprivation has resulted in efforts to provide psychosocial support to those who are war affected and displaced within schools. Burde et al. (2015) found evidence that providing school routines improves mental health and resilience and can help recovery for the majority of children and youths affected by disaster and conflict. They also found strong observational evidence for the importance of ensuring education opportunities are inclusive and creating school environments that reduce the stigma associated with conflict. Boothby & Melvin (2007) argued that though the type of research that would allow for comparative impact conclusion on interventions has not been undertaken, there are emerging evidence in the form of case studies, program evaluations, and other field based findings that point to promising trends and lay the foundation for subsequent research and program learning opportunities. They highlight the following: Keeping school and accessible acts as a key psychosocial response in restoring a routine and a sense of normalcy, in keeping with the inter-agency network for education in emergencies (INEE) standard on education in emergencies.

However, they recognize that, in conflict situations, both providing adequate schooling and enabling children to access school can present difficulties, and that school can also be sights of abuse and conflict. Classroom-based initiative with distinct Psychosocial components

to reduce stigmatization of mental health issues and can improve Refugees children or youths self-esteem, self-efficacy, pro-social behavior and post-traumatic stress symptoms. Providing teachers with knowledge and skills to help children in their classroom come to terms with psychological and social wounds were found to have modest effect on the psychosocial status of refugee children and youths in Bosnia, Croatia, Kosovo and Palestine, the report found the success of these efforts, however is highly dependent on the Education system ability to support its teachers. Peer to peer dialogue has been employed in schools with some success, particularly in the development of life skills. The review found the discussion leaders have too little training to be regarded as Counselors, and their role needs to be made clear. Programs to support school-based counselors' work with individuals and groups of severely affected children and youths have proven to be effective, but only when these efforts have been implemented in cultures that traditionally use these types of mental health interventions and in schools which are part of functional education systems.

2.3.2.2. Classroom Management Program (Healing classroom approach)

In the Context of sudden onset and chronic crises, as well as context of Post crisis and State fragility, the international rescue committee (IRC) Burde et al 2015 Healing classroom approach is designed to develop and strengthen the role that schools and especially teachers play in promoting the Psychosocial recovery and wellbeing of Refugee children and youths. It encourages an inclusive approach to education, in which all children and youths are welcomed-including girls, children of different ethnic origin and children with disabilities. The approach particularly focuses on expanding and supporting the positive role that teachers, parents government officials and community members play in ensuring children and youths can recover, grow and develop, with learning spaces providing safe environment for children and youths, where they are not only protected from harm but also given the skills, knowledge, voice and capacity to protect themselves.

An evaluation of the IRC healing classroom program by Winthrop & Kirk (2005) found that providing a separate session/module on Psychosocial support to teachers (who may not have had formal training as teachers) covering topics such as child development techniques for creating a supportive classroom environment, how to communicate with Refugee children how to communicate with a distressed child in the classroom, and when and how to refer a child to mental health or other professionals, was not an effective approach for implementation into practice. Even though the session/ module provided concrete tools for classroom teaching, in practice it remained separate from teachers understanding and application of general

pedagogical and classroom management skills. There is also the risk of over emphasizing the subject leading some teachers to believe that the training enables them to solve children's problems which it was not designed to do.

Winthrop & Kirk (2005) suggest a better approach would be to integrate the psychosocial concepts, without naming them as such, into pedagogy, lesson planning and classroom management training. This would also shift the emphasis away from a specific bundle of psycho-social skills towards those tools needed to be good teachers and to create healing classrooms. Also important is to build more explicitly on the cultural understandings the teachers already have of their students as members of the same community. The stand-alone session/module approach to psychosocial teacher training, however is common to many education-in-emergency programs.

2.3.2.3. Social emotional learning (SEL) Program

The INNE 2016 (inter-agency network for education in emergency) states that schools and learning spaces are natural channels for delivering social and emotional learning (SEL) programming, especially in crisis contexts The add that SEL is at the heart of most programs designed to support healing, social cohesion and resilience, and may be evidence through peace education, conflict resolution, violence prevention, life skills, character Education, or referred to as something else. This is reflected by the World Bank (World Bank and IRC 2003) which confirms that SEL competencies often serve as the core competencies outline in most programs intended to build social cohesion before, during and after crisis or conflict. The most evident based programs are designed to empower children and youths to have improved academic social and emotional learning outcomes and include conflict resolution, life skills character Education, violence prevention, civic and peace education. In context of adversity education systems are well advised to integrate SEL components and process into their academic programs.

Research suggests that this is best accomplish through integrated SEL classroom instruction, student engagement in positive activities in and out of the classroom, broad parent and community involvement in program planning, implementation and evaluation. (Weare et al 2011) In emergency settings the ties between social, emotional and academic skills grow stronger as learners of all ages struggle to cope and survive in unstable and often life-threatening environments. SEL skills are critical skills for building resilience among children and youths affected by crisis, which can make the difference between their having supportive

relationships or being socially isolated, between managing stress and turning to negative coping mechanisms and between success in school or dropping out. Education programs that incorporate SEL can play a crucial in developing protective factors in youths which mitigate the negative development and behavioral effects of exposure to conflict.

This is achieved through building intra- personal and inter-personal skills that are necessary for managing emotions and building healthy relationships. SEL strengthens the healing and coping mechanisms needed to deal with adversity, and contributes to academic success at school. One of the most important factors for most of these adolescents is the opportunity to make meaning of the adversity experienced and to find purpose in education. SEL supports this engagement process, and can also help increase students ability to focus on learning.

For children and youths, learning is a source of control in an otherwise uncontrollable context (Reyes & Joel 2013). In contexts of violence and conflict, learning can contribute to well-being, and wellbeing to learning and they are therefore inextricably linked. A three-tiered approach for promoting the social and emotional wellbeing of children and youths should focus on classroom and school climate, teaching pedagogy and school personnel support, and student skill building. SEL programs are focused on planned learning, whereas Psychosocial support programs are more oriented towards children Psychosocial and social wellbeing and the two operate simultaneously and build on each other (INEE(2016).

2.3.2.4. The training of teachers (Special need educators)

Resilience research by the World Bank with Palestine Refugees in the west bank, Gaza and Jordan reveals the critical role teachers play in providing not only academic instructions but also care, advice and emotional support.(World Bank 2013) This occurs in both direct ways (teacher visits to students homes after particular difficult moments, for example) but also through integrated social and emotional care within academic instruction, extra-curricular activities, and opportunities for students to exercise leadership and committed mutual support. Opportunities for practice and skill building enable students to demonstrate and model social and emotional competencies with their peers, teachers and parents.

Increasingly, research has shown that programming must be integrated into the long-term environment, school curriculum or system and not as temporary projects or add-on activities (IASC 2007). Things like dance or music could be introduced alongside the curriculum so that students may have the skills, creative Vision and confidence to contribute

to the cultural life of their country. The Qattan Centre for the child in Gaza, for example, has adopted an integrated pedagogical approach that utilizes literature, music, drama and cinema to support self-directed learning and encourage students to express themselves, discover different cultures and strengthen their understanding of their own cultural identity (World Bank 2013).

Studies reviewed by Burde et al (2015) found that where NGOs have implemented the practice of training teachers, which involves a short-term training of community members and teachers in the basic skills of psycho-social intervention and alleviation of distress, these helpers need ready access to professional feedback and consultation. Planning and expectations about their work should be gauged in light of the amount of training they obtain. They reflect that teachers have the important task of supporting and understanding students, can facilitate discussions about conflict situations, and have opportunities to reinforce coping skills, correct rumors, identify suffering in children and prepare children for future experiences. This studies also showed schools and other public services can monitor children adjustment and level of coping and can facilitate the provision of professional help when it is needed.

During programs in Bosnia and Kosovo, teachers were trained in subjects such as cooperating with parents, dysfunctional families, the impact of poverty, stress in children, the traumatized child, loss and grieving in children etc. As a result of its training and follow up programs they said they felt empowered and stimulated in the sense that they had more energy for coping with their job, as well as with their own difficulties but the effect on the children and their parents was not measured(Kaufmann 2006).

Through effective teaching effective teaching pedagogy and instructional practice teachers enable students to develop and practice social and emotional skills. Social administrators can offer leadership and guidance in reinforcing the use of these skills outside the classroom and in school life. When teachers work on their own social and emotional knowledge and skills their students also benefit. It is recommended that school administrators prioritize this kind of teacher professional development. The report also recommends school based educational programs should teach peace education and reconciliation, in order to promote the culture of peace in children.

In a study of an intervention in Israel conducted after the 2006 Lebanon war, Wolmer et al (2011) found that when teachers established a safe environment, children's coping skills improved. Teachers were trained to employ a supervised, structured protocol of eight, two-

hour classroom sessions over a one- month period. The session were structured around an imaginary character that writes letters to the children and invites them to share, discuss and process their experiences. Teachers used narrative techniques, play activities and diary documentation to help children process traumatic experiences. Overall the study found that participating children were more likely to maintain a healthy equilibrium and re-experience traumatic events less frequently.

2.3.2.5. Learning by playing technique

A recent innovation reported by Norad (2017) challenged game developers to create open source smartphone applications designed to build foundational literacy skills in Arabic and improve Psychosocial well-being for out-of-school Syrian refugee children aged five to 10 in Syria and neighboring countries. The two winning games are now available for free download through Google play and the app store is designed to help students learn despite being negatively affected by high stress and trauma. The report claims the games develop literacy and social emotional learning (SEL) Skills, by helping children process information without being distracted, use their working memory, control their impulses and emotions, perseverance, solve problems and get along with others. The competition took advantage of the high availability of smartphones among war-affected Syrian families and these downloadable games can potentially reach millions of out of school children. The game both have open source licenses and are designed to be easily adapted for other languages and different groups.

2.3.2.6. Community engagement and recreational activities

These include the role of creative arts, family and community involvement as well as early childhood interventions. Concerning the role of creative arts and spots, Boothby and Melvin (2007) found recreation and structured activities have helped large numbers of refugees to normalize their behavior after exposure to violence or flight studies reviewed by Burde et al. (2015) found creative arts are increasingly employed in Psychosocial interventions aimed at children affected by conflict and crises. They cite programs that include music therapy, creative play therapy and dance, drama, painting and drawing as strategies that are increasingly surrounded by neuroscientist to enable the process of traumatic experience. Robust evidence from a US - based meta- analysis specifically links play therapy programs in schools to improvement in academic out outcomes (Ray et al 2015). In both conflict and crisis affected context, creative arts and play therapies have had positive effects for participants. A systematic

review of 21 studies (14'in high income countries, 7 in refugee camps) on interventions targeting 1800 refugee children aged 2-17 found that cognitive behavioral therapy and creative arts-based programs were the most commonly employed techniques (Tyrer & Fazel 2014). Significant improvement in mental health were found from both types of interventions as well as interventions that employed multiple modalities. A quasi-experimental study centered on creative arts activities in northern Uganda indicated statistically greater improvements in wellbeing of intervention participants than those that did not participate (Ager et al 2011).

An observational evaluation of Right to play in refugee camps discovered that participation in the programs supported wellbeing through developing peer relationships, students and teacher relationships, and the increased inclusion of young girls (Lange & Haugsja 2006). The report found qualitative results in northern Uganda from a program initiated by ARC indicated a positive impact on children's wellbeing and addressed their basic psychological needs. Parents reported that their children and their own participation in the activities has resulted in a greater awareness of the specific needs of different age groups, a greater awareness of their own children's strengths and fostered more of different age groups a greater awareness of their own children's strengths and fostered more inter-generational dialogue.

Both adults and children placed the greatest value on social skills, social responsibility and social conformity as evidenced by positive social functioning behavior. Social competence is primarily shown by the willing and respectful participation in appropriate household responsibilities, livelihood support and duties. During a long-term psychosocial intervention with children in Kosovo, workshops including creative techniques and sports were offered in cooperation with local schools. The leaders of the workshops claimed that the behavior of children changed for example a timid withdrawn child started to play with the other children, the children started to work together, and that the attitude and approach of the teachers toward the children also changed (Kaufmann 2016). Child-friendly youth activities and children's clubs are recommended to encourage the development of children's pro-social behaviors, including enhanced self-esteem, hope and a sense of self-efficacy and the increased protection of children (Mattingly 2017).

Family and community involvement, in keeping with IASC guidelines, Burde et al (2015) found contextually appropriate community based and social ecology models were increasingly discussed in the alternative as alternative to trauma-centered interventions. A

qualitative evaluation of the communities, our schools intervention in Palestine indicated a positive relationship between community-supported school-based interventions students psychosocial functioning and learning outcomes (Shah 2014). The intervention sought to address immediate community needs by engaging parents and communities around school operations and education activities and promoting inclusive, student-centered teaching. Communities can be mobilized as a key resource for a range of psycho-social interventions for children, including the training of volunteers to organize activities and the promotion of education.

Observational evidence points to the potential of community negotiations to mitigate attacks on education, as demonstrated by the schools as zones of peace (SZoP) program during the conflict in Nepal in 2001. This supported dialogue between communities and local political groups to establish the neutrality of schools (Save the children 2009). Data suggests the programme has improved both the physical protection of schools and learning outcomes of students. Other observational studies suggest that a greater sense of community ownership in education serves as a protective mechanism to stave off attack and/ or make students feel safer (Burde et al 2015). This is reflected in a report for UNICEF (2009) that found high level of community and family participation were positively associated with students feeling safe and included in their child friendly school program, especially among girls.

Researchers found that caregiver's mental health was highly and significantly related to youth mental health and "family acceptance "and "community stigma" were significantly associated with youth depression and anxiety symptoms. These studies suggest that psychosocial interventions in emergency settings should include and/or directly target caregivers in their efforts to improve children's mental health. Psychosocial interventions directed solely at caregivers and children and at families are all effective at improving children's health (Siegenthaler et al 2012). Burde et al (2015). Also found some evidence of the use of community mobile phone messaging in support of the physical protection of children's activities in conflict affected areas, especially in connection with attacks on schools. A large-scale SMS alert and survey system was initiated in Gaza with message sharing across parents, school staff and other community members to provide alerts and emergency notifications of on-going military activities alongside more general school announcements.

In a study of IRC supported emergency education for Chechen displaced youth, Betancourt (2005), found a lack of formal education created additional stress among

adolescents as their priorities were for normalcy and the needs to secure a future through completing their education. They therefore wanted formal schooling situation and testing opportunities legitimized by local Education officials. This has led IRC to move more rapidly to formal education in this and other programs. This research also revealed that the more adolescents perceived their relationships with their families as close, caring and respectful the better their mental health. Organizations working in conflict and emergencies therefore need to encourage parents and extended family to participate in education through family-teacher-student discussion groups, school-based health activities or community education committees.

As for early childhood interventions**, e**arly child development (ECD) provides health, nutrition and cognitive development to 3-6 years old. The value of integrating the psychosocial components in the ECD program for conflict affected populations is that the children may have mild developmental impairments due to limited stimulation from their mothers. Due to parental stress, mothers may not interact with the children, the children may not have as much freedom to roam around, explore and play, and receive little support from older siblings who may be forced to become income-earners for the household.

UNICEF (2012) found that children in conflict zones who have attended early childhood development programs centers were better able to express themselves without fear. Family Communications and parent's attitudes were also reported to model healthy behaviors better. Burde et al (2015) found strong evidence to support the impact of interventions focused on early child development in crisis on child wellbeing. For example, a program in Bosnia provided non-formal weekly meetings promoting good mother -child interaction, peer support, increased knowledge of child development and trauma and basic health care demonstrated differences in maternal wellbeing and mental health, as well as on child Psychosocial functioning between those attending and a control group.

2.3.3. Social support dimensions for refugees

Indeed, man is the only animal that is born without the means to satisfy his needs. Thus, all the men are dependent on each other, and as the philosopher Eric Fiat (2006) underlined it, "We owe our Humanity to others". Beyond the necessary human presence for the survival at birth, it is not useless to recall and evoke the important place of the social relations in the development of the child and in particular the importance of attachment behaviors that allow the individual to develop a sense of security and self-esteem from birth (Bowlby, 1969).

(Bowlby, 1969). This author states that attachment is not automatic and that it depends on a process of reciprocal interactions between the mother and the child. At the same time, Spitz (1968) demonstrated that the "only" emotional deficiency in young children placed in the first eighteen months of life results in impaired mental and physical development physical development that can go as far as death (hospitalism).

We can also recall the work of Maslow (theory of motivation, 1943) and his "pyramid of needs". This researcher positions the social needs immediately after the physiological needs, physiological (life support) and psychological (need for security). These social needs include affectivity, esteem and recognition of others as well as the feeling of belonging. From a more pragmatic perspective, the theory of social exchange aims to study social relations in relation to their benefits (Homans, 1961; Thibaut & Kelley, 1959, cited by Vaux, 1988). Thus, individuals engage in social behaviors that are likely to satisfy them through an exchange of resources. These resources can take various forms, such as love, recognition, the exchange of information, money, goods or services (Foa, 1971, cited by Vaux, 1988). In agreement with these authors, social relations begin with the exchange of tangible and universal resources, but "close relationships" are marked by particular symbolic exchanges (e.g., signs of affection) in which the identity of the participants is of crucial importance.

In social health psychology, research on these necessary human interactions is part of the study of the concept of social support. Our interest will focus on work concerning the effects of social support in the context of health, quality of life and well-being, work that has been developed in the 1970s. In order to be able to situate ourselves in the different research currents. More than a century ago, Durkheim (1897-1951) postulated that the rupture of family, social and professional ties caused by migration to industrial areas seems to be deleterious for the psychological well-being. Durkheim (1967) also observes that suicide occurs more often in people with few social relations, the dissolution of social roles and norms leading to what he termed "the state of anomie". Social support: he considers that it acts as an information signifying to the individual that he is loved, has value, is estimated and belongs to a network of communication and mutual obligations.

This perception is protective because it is supposed to facilitate coping and adaptation. (Cobb 1976) suggests that this information has two functions: the fulfillment of social needs and protection from the negative consequences of crises and stressors. (Cobb 1976) emphasizes the moderating role of social support ("stress-buffer") and demonstrates in numerous studies

that the existence and quality of social relationships or, on the contrary, their absence, seem to be involved in the overall well-being of the individual. He concludes that adequate social support can protect individuals from a variety of physical and psychological disorders during crises, probably through the coping and adaptation strategies. Social support involves creating the conditions for supportive relationships. Indeed, social support is not a variable, it is a process that occurs during social s interactions. It is not an "item" that can be delivered outside of its relational context.

The term “social support” often appears in discussions of relationships. Social support means having friends and other people, including family, to turn to in times of need or crisis to give you a broader focus and positive self-image. Social support enhances quality of life and provides a buffer against adverse life events. Social support can take different forms: Emotional (sometimes called non-tangible) support refers to the actions people take to make someone else feel cared for. Instrumental support refers to the physical, such as money and housekeeping. Informational support means providing information to help someone. One of the earliest studies on the physical and psychological health benefits of social support was in 1905. Dr. Joseph Pratt, an internist from Boston, gathered a group of tuberculosis patients together to educate them about hygiene in relation to their illness. This “support group” provided early evidence of the power of psychological support in physical health and healing. Social support, whether from a trusted group or valued individual, has been shown to reduce the psychological and physiological consequences of stress, and may enhance immune function. Social networks, whether formal (such as a church or social club) or informal (meeting with friends) provide a sense of belonging, security, and communism.

In fact, social support is now proven to be a literal lifesaver. People that are supported by close relationships with friends, family, or fellow members of a church, work, or other support groups are less vulnerable to ill health and premature death. Individuals afflicted with leukemia or heart disease have higher survival rates if they have extensive social support. There is also a strong tie between social support and measures of wellbeing. Those who have close personal relationships cope better with various stressors, including bereavement, job loss, rape, and illness. With any social support network, make sure you feel comfortable with the group’s beliefs, practices, and expectations. While it’s unrealistic to think you’ll never experience any disagreement with your friends, family, or other social support networks, remember that spending time with them should make you feel accepted, peaceful, and energized, not coerced or anxious.

Social support is a positive resource provided by one's environment, which helps with coping with stressful situations, critical life events, and daily problems. In order to improve differentiation, a distinction is made between two types of sources of social support: On the one hand, formal social support systems include professional entities - such as governments of host societies, politics, and services. While, on the other hand, informal social support systems include help provided by ethnic communities, family members, friends, and peers. This differentiation allows a deeper understanding of ways refugees find access to social support and provides the basis for the following considerations.

2.3.3.1. The influence of formal social support on quality of life

Focusing on formal social support, research has revealed that one way to formally support refugees is to provide a sense of affiliation and opportunities to utilize their abilities in the new society. Examples of how governments can offer different kinds of services to support the settlement process include housing security, language courses, education, and employment. These services can contribute to refugees' quality of life, because they foster a sense of being socially supported. Through housing security, refugees can enter the workforce or build a social network on their own. Another key factor for successful formal social support is broader access to language schools. Through language learning offerings, the governments of immigration countries can support social integration by counteracting the habit of staying within one's own ethnic group. Underlining the importance of language acquisition, it seems that achieving an acceptable competence in the host country's language will lower the likelihood of depressive symptoms in young refugees. This is easy to imagine if people remember how difficult it can be to communicate during a holiday in a foreign country if they cannot speak the local language, which, makes them feel unfamiliar and insecure about their own abilities.

By providing formal support, however, governments can facilitate refugees' connections to social and economic resources, which is crucial as social and environmental well-being has been shown to depend on the subjective social status. According to Montgomery, community interventions should aim for a "secure, predictable, coherent and stable life context" for refugees. Furthermore, through professional treatment strategies, preventive mental health measures, and culturally competent supportive services, it can be ensured that refugees feel secure and well cared for. This can reinforce a sense of welcome and thus a sense of belonging to the new society. In this way, formal social support can contribute to refugees' well-being through the fact that they can become citizens of the new country over time. In the context of

the six-factor model of well-being, it becomes clear that formal social support can improve the dimensions of personal growth, purpose in life, autonomy, and positive relations with others.

2.3.3.2. The influence of informal social support on Quality of life

Similar effects can be observed for informal social support system: research indicates that social reinforcement provided by refugees' own ethnic community has significant positive effects on well-being. In particular, people of the same origin represent an important source of support for refugees. For example, as Sundanese cultural life is largely based on ethnic community and extended family, researches have shown that when Sudanese refugees interact with people from their own ethnic background, such interactions have a positive effect on their quality of life as this promotes a sense of togetherness and solidarity for each other. The exchange of experience and mutual support in dealing with the new challenges play an especially central role here. Even family contacts like parent-children-interactions can be of vital importance for the quality of life of refugee children and adolescents.

Against this background, the inclusion of socio-cultural background as a component of quality of life becomes clear. Particularly for refugee children and adolescents, connectedness with their peers, like close friends and classmates, is an essential factor in this context because it provides additional informal social support through interpersonal relationships, friendship, and belonging. In this context it is interesting that adolescents, who reported having close friends and being supported by them, had higher global self-worth scores and recognized themselves as being more socially acceptable. Key factors of well-being as defined by the six-factor model. Researchers also emphasize the importance of positive relationships for a higher self-esteem and social adjustment. Moreover, school belonging will have a positive impact on the refugee child's self-esteem. All these examples of informal social support have a direct impact on the quality of life of refugees but also have an indirect positive influence thro

2.3.4. Conative dimension of psycho-social support for refugees in Cameroon.

Conative support refers to assistance that promotes action, agency, and empowerment in individuals facing challenging life situations. It can take various forms, such as providing refugees with the knowledge, skills, and resources to advocate for their own needs and rights, or creating opportunities for refugees to participate in decision-making processes that affect their lives (Kippen, 2015). Conative psychosocial support can play a crucial role in promoting action, agency, and empowerment in African refugees, particularly in contexts where refugees

may have limited control over their lives and decision-making processes. For example, conative support can help refugees develop the skills and confidence to advocate for their own needs and rights, or to participate in community-level decision-making processes.

Conative support may also promote a sense of agency and self-determination in refugees, by giving them the opportunity to take an active role in shaping their own lives and futures1. This is particularly important for refugees who may have experienced significant loss and trauma, and may feel disempowered as a result, there are several examples of conative psychosocial support interventions that have been implemented in African refugee populations. One example is the Refugee Empowerment and Advocacy Programme (REAP) in Uganda, which aims to promote the empowerment and participation of refugees in decision-making processes that affect their lives (Kippen, 2015). The REAP program provides refugees with training in leadership, advocacy, and communication skills, and supports refugees in establishing community-based organizations to advocate for their rights and needs (Kippen, 2015). Another example is the "Empowerment Through Education" program in Ethiopia, but in this section, we will be looking at the conative approach in terms of the institutional and legal framework that promote the right of refugees in Cameroon.

2.3.4.1. The legal framework for refugee psychosocial support.

This section is going to handle the legal instruments beginning from the international, religion then national, which constitute the protection of refugees: notably the psychosocial protection and support of refugees. They include the following: United Nations Universal Declaration of human rights and the Geneva Convention of 1951 relating to the status of refugees and the 1967 protocol.

On October 24, 1945, in the aftermath of world war 11, the United Nations came into being as an intergovernmental organization, with the purpose of saving future generations from the devastation of international conflict. The UN charter empowered ECOSOC (the Economic and social counsel) to establish commissions in economic and social fields and for the promotion of human rights.(Bradley 2014) One of these was the united nations human rights commission, which under the chairmanship of Eleanor Roosevelt, saw to the creation of the universal declaration of human rights. The declaration was drafted by representatives of all regions of the world and encompassed all legal tradition. Formally adopted by the United Nations on December 10 1948, it is the most universal human rights documents in existence, delineating the thirty fundamental rights that form the basis for a democratic society.

Throughout the 20th century, the international community steadily assembled a set of guidelines, laws, and conventions to ensure the adequate treatment of refugees and protect their human rights. The process began under the League of Nations in 1921. In July 1951, a diplomatic conference in Geneva adopted the convention relating to the status of refugees (' 1951 convention) which was later amended by the 1967 protocol. As seen above this convention draws its inspiration from the universal declaration of human rights. These documents clearly spell out who is a refugee and the kind of legal protection, other assistance and social rights a refugee is entitled to receive. The 1951 convention brings out the psychosocial areas needing support in the field of refugees. It defines a refugee as a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail him or herself of the protection of the country, or to return there, for fear of persecution. People who fulfill this definition are entitled to the rights and bound by the duties contained in the 1951 convention. Initially, the 1951 conventions was or less limited to protecting European refugees in the aftermath of World War 11, but the 1967 Protocol expanded its scope as the problem of displacement spread round the world.

2.3.4.2. Regional instruments of psychosocial support for refugees.

The regional instruments for the psychosocial support of refugees include the convention governing the specific Aspects of Refugees Problem in Africa, the African charter on Human and people's Right (Banjul chanter) and the African charter on the rights and welfare of the child.

The convention governing the specific Aspects of Refugees Problems in Africa was adopted on the 10th of September 1969 by the Assembly of Heads of states and Governments in the city of Addis Ababa. It entry into force was on the 20th of June 1974, in accordance with its Article XI. The preamble of this convention recognized the needs for an essentially humanitarian approach towards solving the problems of refugees. Humanitarian approach, it should be noted deals a lot with psychosocial support in the area of mental health, education and more. The member states are also aware, that refugee problems are a source of friction amongst many member states, and desirous of eliminating the source of such discord, such that, it doesn't affect the treatment refugees get in host countries. The convention also makes a distinction between a refugee who seeks a peaceful and normal life and a person fleeing his country for the sole purpose of fomenting subversion from outside.

Also known as the Banjul charter, it was adopted on 27 June 1981, its entry into force was on the 21 October 1986, in accordance with its article 63. The charter which lays down the principle of human rights and their application on all lay some emphasis on the inviolability of the human being. Every human being shall be entitled to respect for his life and the integrity of his person. No one maybe arbitrarily deprived of this right. This right affects everybody, no matter the status she/he carries. Another common right that touches the psychosocial element is the right to assemble freely with others and the right to equality, nothing shall justify the domination of a people by another (even if they are refugees or asylum seekers).

The African charter on the rights and welfare of the child was adopted on the 11 of July 1990. It entered into force on the 29th of November 1999, in accordance with its article 47. Article 23 of the African charter on the rights of the refugee child. It creates the obligation on states parties to take all appreciate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law shall, whether unaccompanied or accompanied by parents, legal guardian or close relatives, receive appreciate protection and humanitarian assistance in the enjoyment of the rights set out in this charter and other international human rights and humanitarian instruments to which the states are parties.

2.3.4.3. National instrument for the psychosocial support for refugees

The government of Cameroon equally pays attention to the psychosocial plight of refugees especially those from the neighboring countries. To this effect, the government has enacted the following laws:

The constitution of Cameroon which is the supreme law of the land and which governs everybody identifies the human person as possessing inalienable and sacred rights without distinction as to race sex or belief. It equally affirms its attachment to the fundamental freedom enshrine to the universal declaration on ACHPR and all duly ratified international conventions to which the psychosocial support to refugees is included. Some psychosocial aspects in the rights of everyone refugees inclusive include education, freedom of movements, expression, association and financial support.

The government of Cameroon also enacted Law No. 2005/006 of 27th July 2005 on the status of refugees in Cameroon. This law handles a vast domain of discrimination to be shunned on refugees in Cameroon. Article 9 of this law stipulates that refugees shall also enjoy certain fundamental rights as Cameroonian citizens do. Article 10 paragraph 1 of the same lawn

handles their exercise of socioeconomic activities such as employment or self- employment without exemption form taxes. They equally enjoy all social rights linked to the exercise of all social activities in the same manner like nationals. The same article 10 in its paragraph 2 stipulates that refugees shall be accorded the same treatment as nationals in relation to access of education.

2.3.4.4. Institutional framework of psycho-social support of refugees.

The evolution of international standards in human rights and in refugee law has produced and obligation to protect individuals who are forced to seek asylum. The admission of asylum seekers, their treatment and the granting of refugee status are themselves, crucial elements of the international system of protection of human rights. The role of international organizations cannot be over emphasized in protecting, ensuring and enhancing these rights. These are at the core of UNHCR's work.

The office of the United Nations High commission for Refugees (UNHCR), also known as the UN refugee agency, this is a united nation's program with the mandate to protect refugees, forcibly displaced communities and stateless people, and assist in their voluntary repatriation, local integration or resettlement to a third country. The UNHCR was created in 1950, during the aftermaths of the World War 11. Its headquarters are in Geneva, Switzerland and it is a member of the United Nations development group 91) The UNHCR has won two Nobel peace prize, once in 1954 and again in 1981 and a prince of Asturias Awards for international cooperation in 1991. The UNHCR mandate was originally set out in its statute, annexed to resolution 428(v) of the United Nations general assembly of 1950. This mandate has been subsequently broadened by numerous resolutions of the general assembly and its Economic and social council (ECOSOC). According to the UNHCR,

Its mandate is to provide, on a non- political and humanitarian basis, international protection to refugees and to seek permanent solutions for them.

The United Nations children emergency fund, created by the general assembly of the United Nations on the 11th of December 1946, its major role was to provide emergency food and healthcare to children in countries that were deeply affected by the devastating effect of the second world war today, that role has been extended to the provision of humanitarian and developmental assistance to children and mothers in developing countries. This organization is present in about 190 countries in the world and relies mainly on government and private donors to fund it activities. UNICEF saves the lives of children, defends their rights and helps

them fulfill their potential through early childhood throughout their adolescence. Education is one of its key areas of intervention. UNICEF believes that every child has the right to education regardless of who they are, where they come from.

2.3.4.5. National Institutions concerned with the psychosocial support of refugees.

Ministry of social Affair, within the framework of the implementation of international directives in the implementation of the rights of the child, the government of Cameroon signed with UNICEF in December 1995 an agreement to this effect. This agreement piloted through a program of cooperation of the ministry of the economy, planning and regional development with the ministry of social Affair as Executor. This implementation covers children of all status including refugees.

The ministry of basic education (MINEDUB), it is Cameroon ministry responsible for the development of government basic education policy. As such, it is responsible for the organization and functioning of nursery and primary education. It designs and determines the curricular and conduct research on the most appropriate method for basic education. It develops principles of management and evaluation of institutions at this level of education. In partnership with UNICEF and the United Nations agencies as well as in civil society, the ministry of basic education supports the Education of refugee children in the East, Adamawa and Far north regions.

The commission for human rights, formally known as the national commission for human rights and freedoms (NCHRF), this is an independent institution for the promotion and protection of human rights in Cameroon. It posits its education as a human right especially for children especially refugees, is a prerequisite for development, economic growth and the eradication for poverty.

The purpose of this part was to discuss the background aspects of psychosocial support of refugees. Divided into the legal and institutional frameworks of refugees' psychosocial support; as well as the components of such support. This section has presented the legal and institutional instruments at global, regional and national levels.

2.4. REVIEW OF RELATED WORKS

The following are related works that have been carried out by previous researchers

Mouelle 1986 in his exhaustive study on refugees in Cameroon, states that by e 1960s Africa had only 200000 refugees but the situation became alarming by 1981 when the number moved to 5 million and 20 million by 1985. He traces that of Cameroon to the Biafra war between 1966 and 1970 in Nigeria which led to the influx of Nigerian refugees to Cameroon. The Equatorial Guinea and Chadian crisis according to Mouelle brought in 30,000and 266,000 refugees from the different cries respectively w a focus on two main aspects that is refugees in Cameroon alongside government and international humanitarian assistance. Mouelle states that the refugee's situation goes beyond a mere legal framework on protection to dwell on factors such as shelter, healthcare and education.

Mouelle analysis might have lasted over three decades by the challenges of the refugee situation are still glaring. The interest in refugee's health and education that existed during the time of his research has simply diversified into what is referred to today as psychosocial support. This new dynamic of refugee's mental health and social warfare is the focus of this study and the literature deduced from Mouelle work is going to be very helpful in pinpointing the evolution of past and current refugee support policies.

Tayimlong (2013) on his part takes a more current dynamic to evaluate both national and international frameworks for the social Protection of refugees. His main objective was to find out the extent to which national regulations and frameworks were in compliance with international standards. His analysis established not only the degree of conformity but equally the role played by various global, regional and national stakeholders to implement the framework of social Protection of refugees in Cameroon. Tayimlong's findings are relevant in this work as it contributes to the knowledge and awareness of framework work in the psychosocial domain which happens to play a significant role in this study.

Barbelet (2017) having carried out two studies on the wellbeing of CAR refugees in the East region of Cameroon stated that the support provided to refugees in the area cannot be over emphasized. She states that actors such as existing family networks, friends, trading partners, individual's institutions in host communities, and humanitarian agencies have provided practical psychosocial support to these refugees. After analyzing the degree and impact of the aid provided by the diverse actors to CAR refugees in East Cameroon, Barbelet concluded that one possible way forward to effectively support refugees in protracted displacement situations may be to understand how assistant can be delivered in ways that promote self-reliance and create opportunities and a conducive environment for local

integration and livelihoods support. Barbelet's recommendation towards self-reliant aid is relevant to this study as it provides the basis of analysis for the different approaches of psychosocial support implemented by stakeholders in Cameroon.

Looking at studies specific to the role of partner organizations in the psychosocial welfare of refugees in Cameroon, **Nso (2013)** carried out a study on the role of UNICEF in the Education of children in the refugee camps in the east region of Cameroon. He applied a qualitative approach of interviews to prove his results. As finding to his study Nso argued that though partner organizations such as UNICEF have done and are still carrying out enormous work in the psychosocial domain of education in the refugee camps their contributions are not without challenges. He cites examples of the hitches such as financial constraints, unstable environment due to continuous influx of central African refugees as well as limited school resources. Nso concludes his study by recommending more progress towards inclusive education, adaptation of Cameroon education system in refugee camps, sustainability of education beyond primary education and increased global partnerships.

Tsche (2018) on her part examined the refugee situation management policy in the Lolo camp in the East region by the UNHCR. With the UNHCR being the UN agency in charge of refugees. Tsche explains that the institution has carried out a lot of activities in the sector in Cameroon. These activities include the organization of trainings workshops, issuance of 6100 birth certificates, issuance of 6900 identification cards and 8300 attestation to families. In the psychosocial domain Tsche records that the UNHCR has consistently delivered medical supplies to some 50 existing health centers in the area. It has equally equipped mobile clinics and trained some 300 community workers as well as 80health personnel to support refugees through mental, health and malnutrition problems.

Tsche adds that in spite of the major hikes recorded in the Lolo camp and Cameroon as a whole, partner organizations and even the refugees face several challenges. According to her, these challenges include; bad roads, communication problems between both parties as a result of language barriers, constant influx of refugees as well as hostilities from host communities. The studies of Nso and Tsche are relevant to this work as they give the researcher a foretaste of some of the challenges encountered in the field by partner organizations. Though both studies target children as s refugee population, it is important to note that these activities are very important as they cut across the psychosocial domain and family life; complimentary aspects of this study.

To understand the quality plight of refugees in other African countries besides Cameroon, **Adaku et al (2016)** studied the armed conflict situation in South Sudan which began in December 2016 and discovered that over 2.2 million people were displaced. Amongst the displaced persons, Adaku et al found out that more than 270,000 people fled to Uganda as refugees and were hosted in its refugee camp (settlement) found all over the territory. A critical analysis and review of this situation revealed to Adaku et Al that the psychological risk of refugees had increased drastically compared to the state in which they were in their own country. Following semi- structured interviews with the victims, they ranked over thinking, ethnic conflict and child abuse as the top ranking psychosocial problems.

Other problems included family separation, drug abuse and unaccompanied minors. They concluded that even though the psychosocial damages were overwhelmed; there was limited mental health and psychological support for the refugees. The question of financial material and human resources to handle refugee's problems has been raised by almost all the authors reviewed in this study and therefore leave the researchers with the duty of brain storming on a recommendation that will solve these aspects. It equally contributes to this study in that it provokes thought towards the different approaches used by stakeholders to solve the problem; an aspect to be elaborately discussed in the first part second chapter of the work and second part first third chapter of the work.

Following a global perspective and approach specific to refugees of conflicts within developing countries, **Alfadhli & Drury ( )** in their study on social support mechanisms, psychosocial needs and stressor among refugees, did a systematic literature search of peer reviewed journal articles. They discovered that as refugees move towards a prolonged urban displacement phase their needs and stressor became different than those of the acute phase. The also discovered that while many of the psychosocial interventions focus only on Post traumatic stress disorder, daily stressor affected far more refugees of conflict in developing countries than the former. They therefore stated that for the psychosocial approach to be effective, there is need for a social identity approach to help understand the emergence of a common refugee identity, and its role in empowerment of refugees through the activation of social support networks. Alfadhli and Drury's work raises another aspect of daily stressors in refugee camps which the researcher will definitely take into consideration.

Away from the African continent, **Basheti et al (2015)** in their study on Syrian refugees at Alzatary camp discovered that the refugees under study suffered from numerous

quality of life problems that required urgent attention by the responsible authorities. According to them half of the refugees reported dissatisfaction with the care provided to them and to their family members at the camp. Basheti et al added that the refugees staying in tents reported greater dissatisfaction compared to refugees staying in caravans. The result of their study necessitated the establishment of dedicated medical team to access and coordinate the care delivered by the different international field hospitals available at the camp, with a special focus on the refugee's mental health.

Mattingly (2017) on his part found some interventions aimed at promoting quality of life hardly reach all the targeted audience. This to him necessitates the need for specific or targeted support programs that will reach out traditionally marginalized groups and refugees: an approach which he says should vary from one context to another. Citing other studies such as that of Punamaki et al. (2014) and Burden (2015). Mattingly argues that within the target support programs and variety in population, results reveal mixed, weak, or even negative effect of psychosocial support intervention for women and girls refugees. Given that this studies handles the plight of refugees in relation to quality of life, Mattingly's study cautions the research towards expected results when dealing with female refugees as oppose to their male counterparts.

According to Mattingly, many agencies involved in the humanitarian response to conflict and crises are now incorporating psychosocial and mental health support into their programs based on a pyramid - shaped framework of intervention set out in the Inter-agency standing committee (IASC) guidelines produced in 2007. These guidelines are grounded in human rights and equity, within a 'do no harm' framework aiming to build upon existing community resources and capabilities and development of integrated and multi layered support systems for affected populations. This recognized the importance of implementing psychosocial support programs through a commentary, integrated and multi sectored approach, having found stand-alone services to be unsustainable, generate stigma and further fragment what care system may exist.

Taking a stand oriented towards the methodological aspects of psychosocial interventions and impact, **Jordans et al. (2009)** argue that there is a scarcity of rigorous studies in this domain. According to them with the diversity of research interventions and the prevailing conditions in which interventions are conducted, it had become very difficult to make firm conclusions on the impact of psychosocial interventions. Jordans et Al find that

although some evaluations are promising, the effect sizes of controlled studies still pose some methodological flaws. The highlight and apparent gap between research, policy and practice with a serious lack in the literature of evidence supported interventions and the presentation of application approaches. The report considers the move from narrow to broader programming makes evaluation more challenging but considers it important to create an evidence base from which psychosocial and mental health interventions can be scaled up. The findings et al adds to the significance of this study as it is geared towards contributing literature in the domain of psychosocial support and quality of life. It also response to the challenges of providing concrete evaluation of evidence- supported interventions and the presentation and application of approaches.

According to the study by Bharadwaj & Wilkening (1977) which was conducted at the very beginning of the popularity of the concept of subjective quality of life. The results collected from 1311 people aged 18 and over show that satisfaction with life is, for the most part, derived from personal domains. Social and psychological domains have a different importance according to gender, age and income. Income, except in extreme cases, is not a salient discriminant of life satisfaction. Strong associations were observed between life satisfaction and family ($r = 0.50$), work ($r = 0.46$), health ($r = 0.41$), leisure ($r = 0.41$) and material goods ($r = 0.39$). Associations with community, housing, food, spiritual life, and education were rather moderate (0.32 to 0.36). Finally, weak associations (between 0.13 and 0.25) are found for organizational involvement, natural environment, and national government. According to these researchers, the best predictors of quality of life satisfaction are family, health, work, community, standard of living and leisure.

Another study by Kinney & Coyle (1992) was conducted using 790 participants between the ages of 18 and 55. The following variables were identified as the best predictors of quality of life: satisfaction with leisure, self-efficacy, standard of living, religious satisfaction, satisfaction with health, self-esteem and marital status. Satisfaction with leisure alone accounted for 31% of the variability in the quality of life measure.

Flanagan (1982) conducted a survey of 3,000 Americans aged 30, 50, and 70, evenly divided by gender. In this cross-sectional study, the five dimensions most frequently described as important to quality of life were: 1) being healthy and safe, 2) having and raising children, 3) understanding oneself and one's strengths and weaknesses, 4) having satisfying, rewarding, and meaningful work, and 5) having an intimate relationship with one's spouse. The results for

the senior group were similar to the overall sample, except for having material comforts, i.e., a suitable home, food, amenities, and material security, ranked second. In addition, having intimate relationships with one's spouse was replaced by relationships with friends, and work was no longer among the most important items. Government and community involvement, participation in active leisure, learning and education, creative expression, and helping others fulfilled Americans' needs and wants the least. The results were again similar for the senior group, adding in family relationships. Material comfort, work, personal health and safety, active leisure, and learning and education were the five dimensions most correlated with quality of life. This article is one of the most cited references in the quality of life literature. However, the methodology and results are not very detailed.

Lau et al (1998) also conducted an exploratory study on quality of life, this time qualitative, with six Chinese women over 65 years of age living in Hong Kong. The participants had low incomes and lived at home. According to this study, the main elements that would contribute to quality of life are: 1) physical and functional well-being (good health, participation in leisure activities), 2) social well-being (support and interactions with the social network), 3) psychological well-being (joy and satisfaction with life) and 4) economic well-being (money, housing). The authors' in-depth analysis of the results allows for the addition of the following factors: self-concept, self-esteem, functional independence, role fulfillment and coping skills. In this study, the term "quality of life" was replaced by "a good life" in order to facilitate the participants' understanding of the concept.

2.5. THEORETICAL FRAMEWORK

This section necessitates the review of theories on psychosocial support and quality of life. It presents the theoretical framework of this study. That is, bringing out theories from books that are related to the work and interpreting them to suite the context of the research work. Amin (2005) defined a theory as a generalization or a series of generalizations by which the researcher attempts to explain, understand and predict some phenomenon in a systematic manner. With respect to the above definitions, psychosocial support and quality has several theories which will enable the researcher to be guided throughout this work. For a good manipulation of the variables in the study and a good understanding of the research work, the following theories will be used.

2.5.1. REVIEW OF RELATED THEORIES

The ecological approach has inspired the development of many ecological models. To enable the identification and analysis of the complex meshwork of relationships between individuals, populations, and their environments, researchers and theorists from several disciplines first sought to model the environment in terms of its multiple levels of influence. Emerging from a variety of disciplines, early models proposed conceptualizations related to environmental influences that were subsequently widely replicated for both research purposes and intervention program design analyses (Sallis et al., 2008; Richard et al., 2011; Green et al., 1996). While continuing to focus on environmental influences, more recent models develop deeper into certain levels of influence, such as community resources in Stokols (Stokols et al., 2003), or life courses in Best (Best et al., 2003).

Given its potential and the developments it has sparked (generated), the ecological approach continues to generate enthusiasm. However, it also poses many challenges for planners and practitioners who are called upon to operationalize it in programs: the complexity of the approach, the time required to implement it and to evaluate its effects, and the ethical and political issues it raises have all been cited as barriers to its full operationalization. Given these difficulties, the general tendency with various populations is still often to target individuals to the detriment of the deleterious conditions of their environment (Richard et al., 2011; Trickett, 2009). This seems to apply equally to disease prevention and health promotion programs for refugees. Although environmental determinants are well integrated into many of the conceptual models of aging and the policy statements and action plans derived from them (Hooyman & Kiyak, 2011), disease prevention and health promotion for refugees is still often synonymous with clinical prevention education and services (Albert & Freedman, 2009).

These strategies, while having a positive impact on the targeted groups, are not sufficient to benefit the entire population. It is important to provide comprehensive approaches that address a variety of determinants, including those related to the environment, using different strategies. There is growing evidence that this type of approach is effective for the refugee population (Hooyman & Kiyak, 2011). Some models have been proposed to operationalize the ecological approach more easily. We will present here the ecological model of Richard al. (1996), which has already been used to analyze a variety of contexts including prevention and health promotion for refugees, the human ecology model by Bobulz et all, the Bigelow et al. model (1982), the Dijkers (1997) quality of life model will be our major theories for this work.

2.5.1.1. The Ecological Model of Richard et al, (1996)

Richard et al. (1996) model takes as its focus the actions taken by professionals within ecosystems, referred to as interventions to affect the health of populations and groups of individuals. Such a conceptualization can help construct and deconstruct the actions taken by professionals. This model is largely inspired by the writings of Stokols (1992), for whom health promotion interventions are situated on a continuum ranging from the intervention provided in a microenvironment (an organization, for example) to those offered in larger environmental contexts such as large geographical units (a society, an entity at the supranational level), via communities. Each of these levels is a place to implement strategies for both the individual and the environment.

It is clear that, for Stokols (1992), an ecological program includes actions aimed at several targets (individuals and different facets of the environment) in multiple intervention sites. Environments and targets thus constitute the key dimensions of the integration of the ecological approach in health promotion programs. Let us look more specifically, at how these concepts are defined and articulated in the Richard et al. model (1996).The target of a program or intervention is the ecological unit(s) it is intended to address. The ecological model of Richard et al. is based on the framework developed by McLeroy et al. (1998) and defines five classes of health determinants and related behaviours. Each of these classes can be conceptualized as targets for intervention:

The individual-client; the individual whose health we ultimately want to maintain or promote. We are referring here to refugees whose quality of life needs we want meet; the individual's interpersonal environment (INT). This is the informal social network of which the individual is a member. In seniors' health, For example, we often refer to the family, family caregivers and friends; the organizations (ORG) in which the individual lives. This may involve targeting organizational dimensions (e.g., the menus in the hospital cafeteria) or key players in the organizations (attendants, nurses, etc.); the community (COM) in which the individual lives. This could include dimensions of the physical environment (a pedestrian pathway) as well as community representatives; the political subsystem (POL) and its representatives, for a territorial entity in which the individual lives. For example, the intervention could be aimed at mayors, members of parliament or the office of a minister.

In this study we are referring to refugee families (their immediate families and communities) and the environment that surrounds them. This may involve psychosocial support agents, organizations and community agents.

In this model, individuals are the ultimate target of disease prevention and health promotion programs, and the other four types of targets can be seen as intermediate targets for action. In its simplest form, the initiative is aimed directly at the individual without the use of an intermediate target. Educational interventions

Educational interventions involving the provision of information to seniors are interventions aimed at a direct individual target. Other initiatives involve working with intermediate targets, which in turn will influence individuals. This is the case, for example, with interventions to educate the spouses of people with cardiovascular disease (work on the "interpersonal environment" target, known as INT) or interventions aimed at changing health policies (work on the "political environment" target, known as POL). The specification of the type and sequence of the different targets leads us to identify the intervention strategy.

The intervention strategy describes the program's transactions with the different systems in its environment, so as to influence the health of the people identified as clients of the program. In order to better understand strategy, it is worth recalling that there are two types of relationships between programs and its potential targets: a first type of strategy refers to the direct transformation of one or more aspects of a target. For example, a health promotion intervention using a direct, individual strategy may aim to change an individual's knowledge and attitudes (IND). It may also involve an organizational target (ORG) and attempt to change the physical structures and/or processes within the organization to make it more health-promoting.

2.5.1.2. The Human Ecological Model of Bubolz and colleagues

Bubolz and colleagues (1980) developed a quality of life model based on the human ecological model approach (Bubolz, Eicher & Sontag, 1979) to assess the quality of life of a group of individuals in relation to their environment. Four concepts are central to this model: Individuals represent a single individual (biophysical, psychological and social dimensions) or several individuals who have a sense of belonging, use common resources, have common goals, values or interests and share a sense of common identity. The environment is the sum of the physical, chemical, biological, social, economic, political and aesthetic structure

surrounding the individuals. The total environment includes three dimensions. The natural environment (space-time, physical, biological), the environment modified or constructed by humans (sociobiological, sociocultural, sociophysical), and human behaviors (biophysical, psychological and social). Interaction is defined as the influence of the reciprocal relationships between the components of individuals and environments.

This model considers quality of life in its broadest sense, and refers to the well-being or discomfort of individuals and/or the environments in which they live. From an individual perspective, quality of life consists of the satisfaction of physical, biological, psychological, economic and social needs. Environmental resources are used to meet these needs. From an environmental perspective, quality of life represents the environmental capacity to produce the resources needed to meet these needs. Quality of life is assessed by compiling the needs that are required and met. The model is based on the assumption that needs must be met and represent the desired state or ultimate goal. The overall perception of satisfaction with life is considered an indicator of the overall quality of life.

The conceptual framework presented by Bubolz et al. (1980) is largely based on the main principles of urban ecology. In their view, quality of life is considered in a very general sense to describe the well-being or ill-being of people and/or the environment in which they live. From the perspective of the individual, quality of life consists of the degree to which their basic physical, biological, psychological, economic and social needs are met. These needs are met by the resources of the environment. Quality of life is the degree to which the environment has the capacity to provide the resources necessary to satisfy needs. The level of quality of life is assessed in a normative way, either in relation to a standard, from which needs should be satisfied, or in relation to a standard concerning the required resources.

The basic components of a human ecosystem help to clarify which human phenomena should be described and which data should be chosen as indicators. Indicators can describe or measure something about the conditions or status of people (the human environment), the resources of the environment (the natural, built or behavioral environment), or the interaction of people with the environment and its resources (the use of that environment). Both objective and subjective indicators can be used to assess the quality of life in an ecosystem.

The term ecology has its origin in the ancient Greek "oikos" and "logos" and means "science of the habitat". It is generally claimed that its first use dates from 1866 and is attributed to Ernst Haeckel (1834-1919), a German zoologist (Lawrence, 2001). The word ecology refers

to the science that deals with the correlations between organisms and their environment. Since the late 19th century, the term "ecology" has given rise to many interpretations. For example, in the natural sciences, botanists and zoologists use the term "general ecology" to refer to the correlations between animals, plants and their immediate environment.

Human ecology deals explicitly with the relationship between the individual and the environment. The term provides a conceptual framework for academics and practitioners in the natural sciences (e.g., biology, chemistry, and geology) and the humanities (e.g., anthropology, epidemiology, sociology, and psychology) to accept divergent methods and concepts and to develop an integrated approach. The ecological perspective presented here considers four sets of factors of correlations: The individual, having a specific genetic code that determines his or her fragility or immunity to disease and lifestyle characteristics; The agent or vector of disease, which includes, beyond the bio-geophysical components of the environment, the social and psychological dimensions of the human being; The physical and social environment of the individual which affects the receptivity of the host, the virulence of the biophysical agents and the exposure, quantity and nature of contact between the host and the vector; The available resources used by individuals and households, including housing, food, money, information, and access to medical and health services that should be available to all population groups.

According to the model, quality of life is the person's perception of his or her position in life, in the particular context of his or her culture and values, in relation to his or her personal goals, aspirations, standards and concerns. This perception can be influenced by all aspects of the environment, the individual's experience with health care, the disability process and opportunities. Society's reactions to an individual, his or her attempts to participate optimally socially, live independently, meet needs and be equal will also influence his or her perception of quality of life. In the model, quality of life is the end result of the influence and interaction of environmental risk factors, an individual's life process, the disability process, and the opportunities available to the individual.

2.5.1.3. The Bigelow et al. model (1982)

The development of the Bigelow et al. (1982) model is based on two theoretical positions: a quality of life theory (Bigelow et al., 1982) and a role theory (Sarbin and Allen, 1986). The quality of an individual's life is based on two elements: the general feeling of well-being (satisfaction of needs) and performance (actualization of skills). The needs considered are taken from Maslow (1943): basic needs (physiological and safety), needs for affiliation,

esteem, autonomy and self-actualization. The environment offers opportunities to satisfy these needs, both material (food, housing, etc.) and social (friends, spouse, work, etc.). However, the opportunities offered by the environment are associated with expectations or performance requirements.

The individual must respond to the demands of society using his or her cognitive, affective, behavioral and perceptual skills. To the extent that the individual experiences adequate satisfaction of his or her needs and achieves a certain performance in the accomplishment of his or her roles, he or she is adapted to his or her environment and enjoys a good quality of life.

2.5.1.4. The Dijkers (1997) quality of life model

Dijkers' (1997a) quality of life model is based on the World Health Organization (WHO) model published by the International Classification of Impairments, Disabilities and Handicaps (ICIDH; WHO, 1980). It includes both objective and subjective quality of life. Impairments, producing disabilities, create a cascade and affect several spheres of quality of life, due to: the link between impairments, disabilities and handicap (or participation), the social process of discrimination towards people with disabilities and economic realities.

Dijkers' (1997a) model highlights the influence of disability situations on, among other things, leisure, family and social interactions. It also demonstrates the direct and indirect consequences of illnesses and traumas that result in permanent and significant disabilities, thus affecting physical health and life expectancy. Disabilities are conducive to creating a situation of discrimination and devaluation, thus increasing the risk of developing disability situations. Disabilities affect the quality of life, either because a family member has to stop working to take care of the person, or because of the expenses associated with disabilities that affect income and reduce material comfort.

In short, all these factors influence subjective quality of life. Consequently, disabilities and physical health affect mental health and coping strategies. Finally, these factors affect subjective quality of life, that is, sense of well-being, satisfaction with life and enjoyment of life. This model is very comprehensive and, moreover, was chosen for the present study. It responds well to the need to identify a subjective approach to quality of life and makes the link with functional disabilities. Moreover, it takes into account both cognitive and emotional perceptions of quality of life. In this research, we will focus on the human ecological model of quality of life that we chose as the basic model.

The focus of this part was to present the different quality of life and psychosocial support dimensions, review of related works and theoretical framework. These dimensions were discussed in three sections. The first two sections handled dimensions specific to quality of life and psychosocial support for Refugees. The presentation of the dimensions of psychosocial support though from a global perspective partly answers the three hypothesis of the study. They serve as an opener into chapter three, then chapter five where these approaches shall be discussed at a national level with facts from the data collected from the field.to be reviewed

CHAPTER THREE

METHODOLOGY OF RESEARCH

In this third chapter, we will present the approach we followed to collect and analyze the data from our survey. We will begin with the choice of site, participants, sampling procedures, statistical data collection and processing tools, and end with the variables that allowed us to formulate our hypotheses.

3.1. Study Site

This study is carried out in the Republic of Cameroon, more precisely in Garoua Bulai sub division in the Lom and Djerem division of the East Region. The East region has a surface area of 109,002 km^2 and has a population of 395,000 inhabitants. According to OCHA 2020, the Central African Republic refugee population stands at 272,000 inhabitants in the Region. Refugees receiving psychosocial support at the UNHCR Camp at Gado-badzere located some 246Km from Bertoua town (headquarters of the East Region). The UNHCR and the government of Cameroon (2016) report on the profile of Gado, states that the camp is 75km from Cameroon Eastern border with the Central African Republic. Created in 2014, on a 55 hectares piece of land, the camp is divided into seven sectors. The camp which had a capacity of 8,000 in 2014, received 18,783 refugee inhabitants, 23,667 inhabitants in 2016 and 29,164 inhabitants 2021 (OCHA, 2021). The refugee population more than double the host community population which in 2016 was 10,724 inhabitants. The main aims of the camp are to provide safe space and humanitarian assistance to the CAR population fleeing political conflicts in their country. This involves providing psychosocial support to these refugee population brought into the camp. This psychological and social support could be through the provision of psychotherapy and psychological counselling to traumatized, stressed and depressed refugees, provision of shelter, nutrition, health care, drinkable water, and recreational centers in the camps. All these are geared towards the provision of quality life to these refugees.

The influx of refugees into Cameroon over the years has led to the creation of refugee camps to accommodate them. By 2014, Cameron had refugee camps in Yokaduma, Lolo, Mbile, Timangolo, Gado Badzere and Gado Mborguene (now closed) in the East region, Ngam and Borgop in Adamawa and the Minawoa Camp in the Far North (UNICEF: 2014). There are presently seven operational sites in the East and Adamawa and one refugee camp in the Far North region as indicated on the map. Refugees are usually housed in camps and are discouraged from mixing with the host community for security reasons (Finnstrom 2003).

However, the situation in the East region of Cameroon seems to be different, as a good number of the CAR refugees have settled amongst the natives, inter-married with Cameroonians (Barbelet, 2017).

The integration of the CAR refugee into the community is facilitated by the cultural similarities shared by the CAR refugees and Cameroonians in the East region and also by the fact that the Central Africans are Pastoral nomadic who practice transhumance across the Cameroon/Central African Republic boarders. The refugee influx has created a noticeable pressure on the scare socio-economic resources in the region (UNHCR, 2018). This pressure is particularly felt on social facilities (like education, health and security) and on the demand for food and water in the community. The pressure created on these resources as a result of the refugee influx has often led to conflicts between the refugees and the host population. Given these facts, the refugee crisis does not only entail the issue of hosting, feeding, clothing, resettlement or educating the refugees but also their impact on the host who in most cases are left with the burden of ensuring the survival and quality of life of these refugees.

The Gado Badzere camp has been stratified into 12 quarters. Each quarter having a quarter head to whom refugees report their immediate challenges, whom in turn carries it to the camp officials during their weekly meetings. In a situation where the problem in question is an urgent one, the quarter head could report it immediately to the camp officials or send the refugee in question directly to the camp official. As concerns their civil issues UNHCR and its partners establish birth certificate for both children and adults who do not have. It should be noted that refugees are allowed to marry amongst themselves and intermarry with the Gado community. The UNHCR is as well responsible for establishing them a marriage certificate if the refuges in question so please

The camp has good portal water located in quarter eleven, which the whole camp uses. The forage is accessible to all and has a place built with cement for washing clothes. Talking about clothes, most of these refugees has issues dressing properly because they don't have any agency in the camp that takes care of that, which implies these refugees are supposed to take of their clothing independently. This is actually a problem because most of them cannot afford a meal a day talk less of sparing money to dress “properly”. This is so because the agency in charge of their feeding (WFP) gives 4400 FRS to every family head through a phone owned by every family head. This process is referred to as (cash base intervention). These phones are linked to a shop that sell at a minimum price (Cash based trade) you buy things through your

phone and the money is cut through a particular code the store keeper uses. (This means there is no exchange of physical money) As concerns their housing which is handled by CAL (community aider au logement). They provide houses only to the very old and handicaps. But for the rest of the refugees, it's a fifty fifty deal you bring the bricks and the agency the zinc (spear grass) that is if you can afford or you are given plastic sheets to build a house for yourself. It should be noted that this plastic sheets have a life span of just six months, reason most of the refugees live in horrible housing conditions because CAL is never there on time to ameliorate these housing conditions. (The show up in two years)

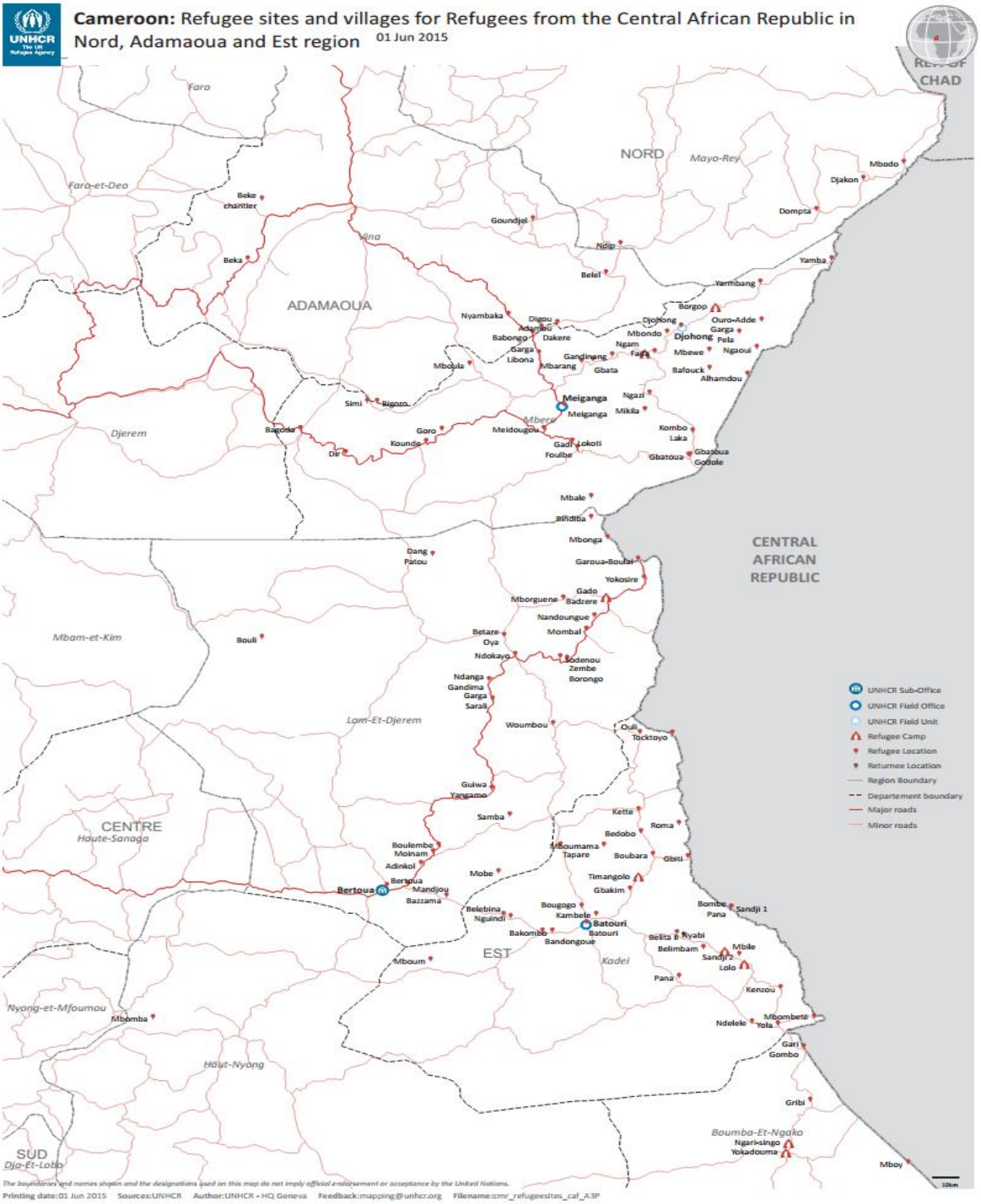
The lack of lights in the camp is one of the major causes of the insecurities (theft and the frequent rape cases) at the camp. Most of the refugees live with the fear of the unknown and as a result do not leave their houses later than 6pm. When it comes to their health needs, only children of 0-5 yrs , pregnant woman, breastfeeding mothers and the very old are taking care of as for the others they manage on their own reason they rely mostly on herbalist, which has become a source of livelihood for a few who know the act of combining natural herbs for treatment. The insecurity makes it really difficult for the mentally challenged as they are frequently raped and abused.

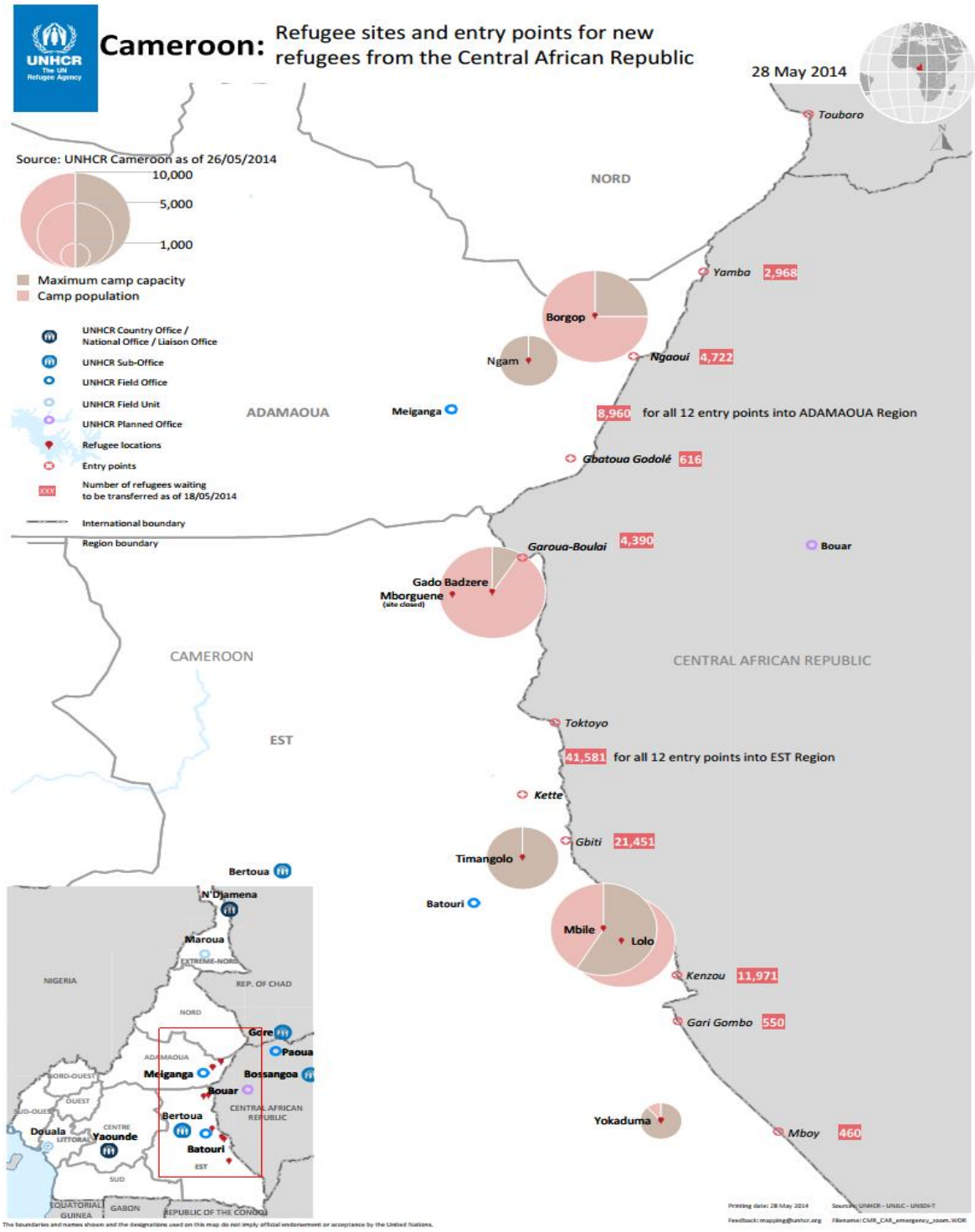
It should be noted that the refugees do not have hospitals and schools in the camp reason most of the refugee kids face challenges going to school as the have to manage the challenges of crossing the dangerous roads and walking long distances without help. This is actually a problem for the refugees as they have registered frequent cases of accidents and child disappearance. The refugees are as well responsible for the education of their kids' reason most of the children do not go to school because they cannot afford the minimal fees.

As concerns their psychological support, much attention is not paid to it as they is no specific agency in charge of that. From my observation and information gathered refugees depend on each other for psychological aid. Plan they said use to come around for psychological support but had not been around for like a year as to when this field research was carried out. In relation to hygiene, the refugees keep their camp clean and use pit toilets local made by them. At the entrance of the camp is carpentry workshop and a small market where these refugees sell a few things such as beniette, pap, masa that helps them survive.

Figure 2

Refugee's sites and entry points for new refugees from the Central African Republic.





Source: UNHCR 2014

The above figure shows the different entry points and sites (camps) for refugees in Cameroon, the number of refugees these different sites hosted as of 2014 and the location of the different sites in the national territory.

3.2. The Study Population

The population is 272,000 vulnerable refugees from the Central African Republic, (OCHA 2020), According to Polit and Hungler (1999), the study population as a subset of the target population, whereby the members of the subset conform to a set of specifications. UNHCR (2021), indicates that the population of Gado Badzere camp which is the target population has risen to 29,164 giving a 10.72% of Central African refugees with 57.80% of the population being less than 18 years and women/girls representing 53.23%. These 29,164 people have directly or indirectly benefited from UNHCR and its partners' support of psychosocial support. This researcher selected Gado Badzere refugee camp because it the largest of the five refugee camps found in the East Region of Cameroon. Also it is closer to Yaoundé as compared to Miaganga which is much more further and will have entailed more money to reach which was a constrain to the researcher.

We will work specifically with refugees from the age 15 and above, reason being that they can read and understand the questions appropriately and they are knowledgeable enough to know and talk about aspects of their quality of life and psychosocial support. Given that, some of the refugees have refugees' families who live in the Gado community in search of greener pasture; we will be focusing on refugees who live in the camp permanently. Due to the ongoing socio political unrest in CAR, refugee keep fleeing to the Gado Badzere camp for safety. As a result most of them arrived the camp at different intervals,, some of the refugees have been there just for a few months. While others have been there for a year or two and a few others have been there for three years and more. For the purpose of this work we will be focused on refugees who have been in the camp for at least a year or more. This is so because we believe that 1 year or more is enough time to have a life changing experience or to tell if your quality of life is favorable or not. Also we will not be considering refugees who are not mentally stable, reason being that they may not be able to give us coherent information about their lives worst of all concerning their quality of life.

Figure 3

Study population, targeted and sampled population.

Source: (personal work)

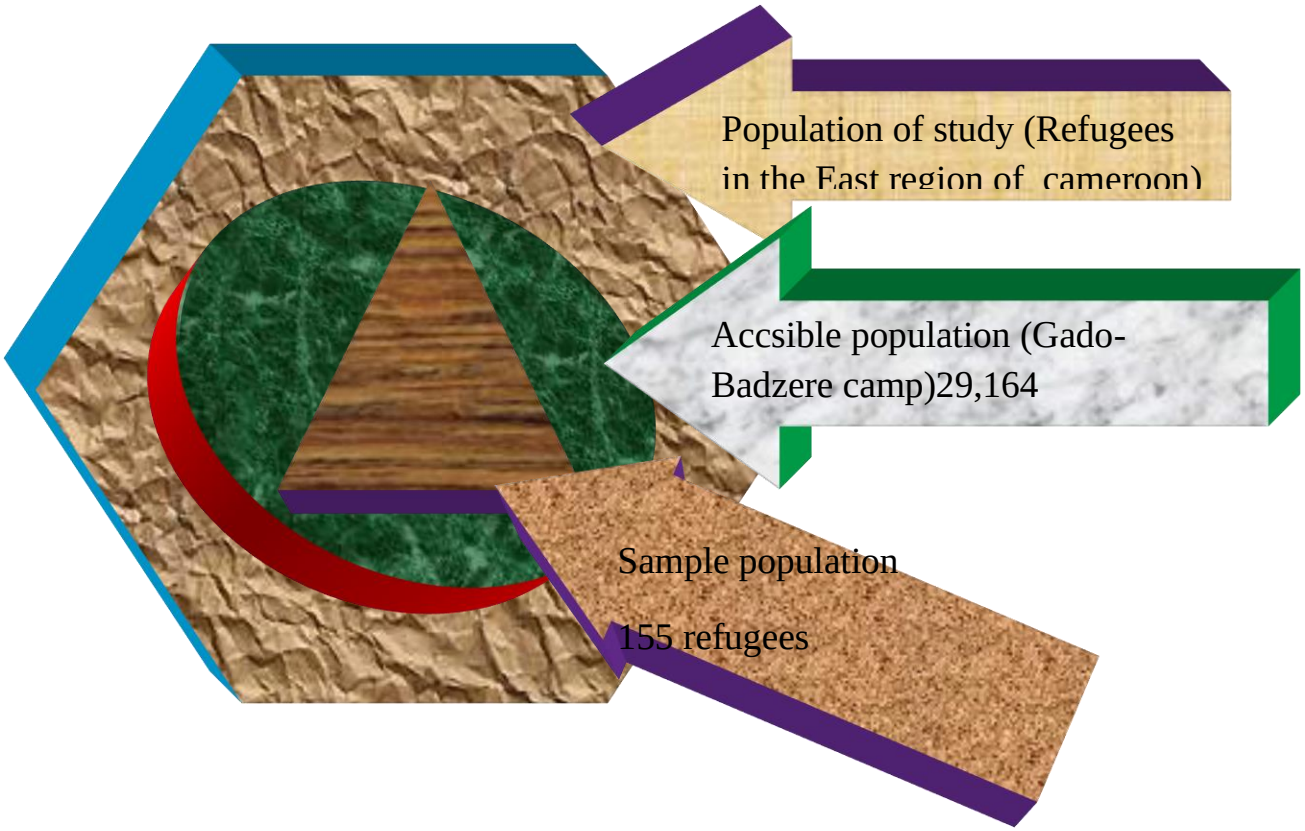


Table 2

Gado Population Statistics 2018-2023

Site: GADO (East Region	Population in Camp	Men	Women	Households
2018	18, 783	8,542	10,241	3,667
2019	23, 667	10,135	13,532	4013
2021	29,164	12,071	17,092	9,304
2022	29,032	12,011	17,021	9,604
2023	25,239	11,215	14,024	4207

Source: ADES 2023

The population of refugees in the Gado Badzere camp has been on a steady rise since the year 2018 but has experienced a slight drop in its population in the current year. The number households in this camp has been fluctuating over the years. Irrespective of this slight drop in

its population, it remains the camp in Cameroon with the highest number refugees as clearly indicated in the table below. This camp and other camps in the East region host strictly CAR refugees.

Table 3

Population Statistics for refugee camps in the East and Adamawa region of Cameroon for the year 2023

Refugee camps in Cameroon	Population in Camps 2023	Number of Households 2023
GADO	25,239	4207
BORGOP	11,058	1,843
NGAM	6,692	1,115
LOLO	12,126	2,021
MBILE	11,081	1,847
TIMANGOLO	6,798	1,133
NGARISSINGO	1,364	227
Average Population	74,358	12,393

Source: ADES 2023

The table above clearly indicates that Gado Badzere is the camp with the highest number of refugees. It is not just termed the largest camp in Cameroon because of its surface area, but because of the number of refugees it host on yearly bases.

3.3. Criteria of sample selection (inclusive and exclusive criteria)

According to Pepperdine University, establishing inclusion and exclusion criteria for research participants is a standard as adapted from, required practice when designing high-quality research protocols. Defining their inclusive and exclusive criteria increases the likelihood of producing reliable. Therefore, inclusion criteria within the context of this research are characteristics that the prospective subjects must have if they are to be included in the study, or the key features of the target population that the researcher will use to answer their research question. Typical inclusion criteria in this research include demographic, clinical, and geographic characteristics such as age, gender, race, ethnicity, marital status, educational experience, language, type of occupation, physical activity, medical conditions, and the presence of medical, psychosocial, or emotional conditions.

In contrast, exclusion criteria are defined as features of the potential research participants who meet the inclusion criteria but present with additional characteristics that could interfere with the success of the study or increase their risk for an unfavorable outcome. Common exclusion criteria with respect to this research include characteristics of eligible individuals that make them highly likely to be lost to follow-up (must be CAR refugees and living in Gado Camp), miss scheduled appointments to collect data (should be above 10 years of age can quickly remember past experiences as they flee the war and freely discuss), provide inaccurate data, have co-morbidities that could bias the results of the study, or increase their risk for adverse events such as side effects (most relevant in studies testing interventions), and reproducible results, minimizes the likelihood of harm to the subjects, and guards against exploitation of vulnerable persons. We have two types of variables in our research: an independent variable and a dependent variable.

Independent variable

The independent variable in this study refers to the psychosocial support given to refugees, which is viewed as the dynamic relationship between the psychological dimension of a person and the social dimension of a person. The psychological dimension includes the internal, emotional and thought processes, feelings and reactions, and the social dimension includes relationships, family and community network, social values and cultural practices. 'Psychosocial support' refers to the actions that address both psychological and social needs of individuals, families and communities. This variable has been operationalized using the inter agency standing committee for psychosocial support and the ecological model of Richard et al (1996), which takes as its point of interest the actions taken by professionals within ecosystems, referred to as interventions with a view to acting on the health of populations and groups of individuals, which operationalizes it into three modalities: the cognitive approach, the affective approach and the conative approach.

The cognitive psychosocial support dimension (intellectual wellbeing). It is concerned with the thought processes behind behavior. It see the mind as if it were a computer, taking in and processing information, and seeking to understand the various factors involved. Cognitive approach help us understand how people think, including how they acquire and store memories. By knowing more about how these processes work, psychologists can develop new ways of helping people with cognitive problems. The cognitive approach tries to understand the way people process information and how thinking patterns might contribute to psychological

distress. Its focus is to help people cope with memory disorders, make better decisions, recover from brain injury, treat learning disorders, structuring educational curricula to enhance learning and build capacity; evaluating educational programs to determine if intervention strategies are working; searching for ways to encourage people to reduce pollution; or offering advice to businesses or individuals who need help with conflict mediation. Some indices of the cognitive approach include:

Attention (our ability to process information in the environment while tuning out irrelevant details), Choice-based behavior--actions driven by a choice among other possibilities, Decision-making, Forgetting, Information processing, Language acquisition (how we learn to read, write, and express ourselves), Memory, Problem-solving, Speech perception (how we process what others are saying), Visual perception (how we see the physical world around us)

The affective Psychosocial Support dimension refers to emotional wellness. Affective dimension is concerned with managing emotions, both negative and positive. The way we perceive ourselves in relation to the rest of the world influences our behaviors and our beliefs. The opinions of others also affect our behavior and how we view ourselves. The Affective approach is interested in all aspects of interpersonal relationships and the ways that psychology can improve those interactions. For example understanding how people form attitudes toward others and, when these are harmful — as in the case of prejudice, for example — provides insight into ways to change them, positive affective environment helps learning in general. It is interested in helping an individual relate better with others and gain the ability to successfully handle life's stresses and adapt to change and difficult times It takes into consideration emotions such as anxiety, stress and relapses. Examples of affective support is encouraging and counselling learners, by helping them identify achievable aims and work towards autonomous learning, through personalizing activities, and through pair and group work. Some indices of affective support include; self-confidence, developing survival skills, change of perception (the ability of having a better view of things).

The social psychosocial support dimension refers to community ties. Social support in all aspects of personality and social interaction, exploring the influence of interpersonal and group relationships on human behavior. The way we perceive ourselves in relation to the rest of the world influences our behaviors and our beliefs. How we relate with our community and how the community in turn treats us, the opinions of others affect our

behavior and how we view ourselves. Social support is interested in all aspects of interpersonal relationships and the ways that psychology can improve those interactions, how social influence, social perception and social interaction influence individual and group behavior. The way individuals live, where there live, how they live what they eat and how these needs can be met.

Some indices of psychosocial support include: community perception, reunification (of refugee families, tracking down refugee family members in other camps, making people aware of other refugee plight, availability of basic needs and reaching out to parents or trusted adults.

Dependent variable

The dependent variable in this study refers to the quality of life of refugees, which is viewed as the person's perception of his or her position in life, in the particular context of his or her culture and values, in relation to personal goals, aspirations, standards and concerns. Two approaches have been established to define quality of life: the objective approach and the subjective approach. The objective quality of life measure takes into account several variables: socio-economic level, years of education, marital status, living situation, work, physical health, number of televisions in the home and municipal services. Subjective quality of life, on the other hand, takes into consideration the cognitive and emotional perception of the person. In this study, we consider both approaches.

Quality of life was operationalized in three dimensions according to the human ecological approach of Bubolz et al. (1980): the individual, the environment, social relationships (the interaction between individual and their environment)

Individual related quality of life encompasses the knowledge and skills to identify personal feelings and the ability to handle those emotions while being able to manage thinking patterns to overcome psychological distress. People with a high psychological quality of life cope with memory disorders, make better decisions, recover from brain injury, overcome learning disorders, build capacity, participate in educational programs, and relate well with self-others and their community. National Institutes of Health describes emotional wellness as “the ability to successfully handle life’s stresses and adapt to change and difficult times” (NIH, 2018). Your psychological quality of life influences how you think, feel, and behave in your daily life, your mood, stress management, self-care, suicide prevention, it affects each dimension in turn and includes coping with the normal difficulties of life.

Some indices of psychological quality of life include: a positive perception of others and self, feeling that the present environment creates opportunity for friendship, be willing to meet new people and do new things, feeling that the present environment allows for support from friends and peers and adults, having a sense of normalcy and feeling support in moments of distress

Environmental related quality of life encompasses all areas of health that relate to physical aspects of the body including, nutrition, exercise, weight management, ergonomics, tobacco use, disease, disease prevention, and more. (Having good living conditions.) For instance, being able to feed well (at least two times a day) being able to dress decently (no wearing of rags), live in good houses (houses without leakage) have freedom of movement not living in fear of the unknown (insecurity) having access to portable water and electricity and being able to freely interact and participate in community activities. Physical quality of life includes a variety of healthy behaviors including exercise, healthy sleeping, sexual health and substance use. It is interested in making sure individuals live healthy devoid of diseases afflicting their health and day to day functioning.

Some indices of physical quality of life include: balance social and personal time, ability to feed well, availability of water and electricity, freedom of movement and speech, good housing conditions and the ability to dress well. Physical and bodily wellness, availability of medical personnel, availability of good medical facilities and access to drugs.

Social related quality of life encompasses aspect of quality of life pertaining to social connections, interpersonal relationships and personal expression. How we interact with our community and those around us. It includes healthy relationships, consent, communication skills and support systems. It is also about building a support system of family, friends, peers, and professionals. It is interested on how social influence, social perception and social interaction influence individual and group behavior.it also focuses on building a network of family, friends, neighbors, and community members that is available in times of need to psychological and physical help.

Some indices of social related quality of life include: balanced social and personal time, be open minded to new-to-new experiences and people, observe others and ask questions to gain better understanding of unfamiliar customs and culture.

3.4. Hypotheses of the study

For this study, we have one general hypothesis and three operational hypotheses.

3.4.1. General hypothesis

Our general hypothesis is that psychosocial support predicts the quality of life of refugees. This general hypothesis was operationalized into three specific hypotheses.

3.4.2. Specific hypothesis

- Cognitive dimension predicts the quality of life of CAR refugees living in Gado Badzere Camp.
- Affective dimension predicts the quality of life of CAR refugees in Gado Badzere Camp.
- Social support dimension predicts the quality of life of CAR refugees living in Gado Badzere Camp.

3.5. Data collection

In this section, we will present the data collection instrument of our research. We will discuss the logic of its choice, its development, its validation and its implementation.

3.5.1. Choice of the instrument for collecting empirical data

In the context of our study, we have chosen to use the questionnaire. The questionnaire (It) is the instrument par excellence for collecting data in social and human sciences. We based ourselves on the work of Delhomme and Meyer (2003) for whom "the questionnaire is the most common technique in social and human science research" (p. 197). This instrument has advantages such as: the anonymity of the participants, the possibility of approaching at the same time and the ease of processing the collected information. It is a series of standardized questions designed to plan and facilitate the collection of information. The questionnaire is essential for its pragmatic virtues such as speed of administration and almost immediate access to calculations. It allows information to be collected from a large number of participants and also facilitates statistical processing.

3.5.2. Development of the questionnaire

The questionnaire format we used was inspired by Hall 2020: Laetitia Balcon. Adolescent quality of life scales in the general population: a systematic review of the literature using the PubMed database of articles 2319 to 4639.Life sciences [q-bio].2020.ffdumas-

0300328f. The questionnaire we used to collect our data is composed of three parts: the participants' socio-demographic information, a scale measuring the dimensions of psychosocial support and another for quality of life.

This first scale talks about identification **(**Sociodemographic) information of refugees which are sex, age, and longitivity in the camp. This will permit us better know our participants and be sure they meet our sampling criteria.

The second scale measures quality of life and takes into consideration the different dimensions of quality of life which are the psychological (individual), health, and physical. The psychological talks about refugees' intellectual and emotional stability expressed in their relationship with self and others while the health approach talks about their ability to live healthy free from sicknesses or being attended to when sick and lastly the physical approach focuses on refugees' and their basis needs food, shelter, clothing and the environment at large.

The third scale that measures psychosocial support takes into consideration the different variables of psychosocial support which are the affective, cognitive and the social. The affective talks about refugees' relationship with self and others while the cognitive approach talks about the intellect (intellectual activities) and lastly the social which focuses on refugees' relationship with the society.

3.5.3. Reliability of the instruments

3.5.3.1. Pre-testing and validation of the questionnaire

As Ghiglione and Matalon (2004) point out, when a first version of the questionnaire has been drafted, that is. when the wording of all the items and their order has been provisionally determined, it is imperative to ensure that the questionnaire is clearly understandable (without ambiguity) and that it actually responds to the researcher's problems. For this, a verification is necessary. We did a pre-test of our questionnaire with 25 Chadian refugees at trauma center in Yaoundé. This pre-test took place on January 18, 2023. At the end of it, it was found that the participants answered all the questions and were following the instructions assigned to each item.

To test internal consistency between items, we used the calculation of Cronbach's Alpha. The analysis of internal consistency is a necessary condition for the homogeneity of the scale. In this study, it was done by calculating Cronbach's alpha, the correlation of each item with the global scale (2nd column) and the multiple correlation coefficient (r2) which specifies

the strength of the link between the items (3rd column). Cronbach's alpha is calculated by removing one item from the scale each time (4th column) from the following formula: α = . = . [1-], with S corresponding to the sum of these items (X1+X2+X3+...+Xk); k=number of items and Var=Variance. An acceptable value of Alpha must be greater than 0.7, but a value too close to 1 reveals a poverty in the choice of items (Cronbach, 1972).

3.5.3.2. Procedure

According to Ghiglione and Matalon (2004), the questionnaire can be administered either in public places or at the participant's home. We proceeded with a direct administration, i.e. the participant filled in the questionnaire in front of us. To collect our data we translated our questionnaire from English to French because our participants speak French, fulfude and sango and we got an interpreter for those who could not speak French as they could understand and speak only Fulfulde or Sango.

The questionnaire was administered to them individually. We approached each participant personally and after a brief introduction summarizing the purpose of the survey, we gave them the questionnaire, a ballpoint pen and a blotter for filling it out. Participants filled out the questionnaire while seated and we took the time to clarify any questions they had. To maximize the response rate, we insisted that they answer all questions. After filling out the questionnaire, we debriefed the participants, revealing the real objectives and hypotheses of our research.

3.5.3.3. Difficulties encountered

The main difficulty encountered during the data collection process was the intellectual level of the participants. Indeed, for a good understanding of the questionnaire, it was necessary to have a certain level. Also, some participants required a financial motivation before completing the questionnaire. Others said that they did not have enough time to devote to us and gave us appointments that they often did not keep and a few others who could not understand Statistical data processing tool. Also the fact that some the refugees could not understand French and needed an interpreter was stressful, since I had to be there all the time to make sure the interpretation was rightly done.

3.5.3.4. Statistical data Processing tool

After collecting the data, we used the SPSS version 21 software for statistical processing. This software allowed us to perform two types of analysis (descriptive analysis and

inferential analysis). In reference to the objectives and hypotheses of this research, which seek to know if psychosocial support predicts the quality of life of refugees, we carried out correlations and completed by regression analysis.

Bravais Pearson Correlations

After data collection, we used the Statistical Package for the Social Sciences (SPSS) version 21 for statistical processing. Among the multitude of inferential analysis tools available to us (correlation analysis, chi-square, regression, student's t, and the "Pearson correlation"), we were able to identify the most important factors. Among the multitude of inferential analysis tools available to us (correlation analysis, chi-square, regression, Student's t-test, z-test, etc.), we chose correlations and regressions because many studies in the literature have used this type of analysis to measure the link between psychosocial support and quality of life. Correlational analysis allows us to verify the linear relationship between two quantitative variables, in this case psychosocial support (X) and quality of life (Y). The correlation coefficient, rxy, was developed by Pearson and its value varies between -1 and +1. It is calculated from the following mathematical expression

Formula: - n = Number of pairs of observations; - = Sum of the products of X and Y; - and Are respectively the sums of the observations of X and Y; - 2 = Sum of the squares of the observations of X; - 2 = Sum of the squares of the observations of Y; - ( )2 = Square of the sum of the observations of X - 2 = Square of the sum of the observations of Y; This coefficient is evaluated from the ratio of the covariance to the product of standard deviations, and it requires the metric data. This condition was satisfied since the quality of life and psychosocial support scores are numerical. A positive sign indicates that the two variables move in the same direction. In this case, the relationship is said to be direct and the increase or decrease in the scores of one variables is accompanied by an increase or decrease in the scores of the other variable. A negative sign is synonymous with a change in the opposite direction. In this case, the link is said to be indirect and the scores of one variable increase while those of the other variable decrease.

The calculated value of the r (provided by the statistical analysis software) must be compared with the table of values of Fisher's correlation coefficient r (Croutsche, 1997) in order to be able to effectively accept or reformulate the accepted hypothesis. The statistical functions proposed by SPSS allow 2 readings of the correlation r: either in terms of critical

value or in terms of statistical significance level. In the context of this research, we will read the r in terms of the statistical significance level.

Linear regression

The objectives of the regressions used in this work are:

- To establish linearity between our variables (psychosocial support and quality of life). This is the ability to predict quality of life as a function of psychosocial support. - Regressions will allow us to explain the variance of psychosocial support on quality of life. - Finally, it will allow us to identify which of the dimensions of psychosocial support best predict quality of life.

Table 4

The recapitulative table of the hypotheses, variables, indicators, modalities and statistical test.

General hypothesis	**Specific hypothesis**	**Independent Variable**	**Indicators**	**Indices**	**Dependent Variable**	**Indicators**	**Indices**	**Statistical Test**
Psychosocial support provided by UNHCR and its partners predicts the quality of life of refugees	Cognitive approaches impact the quality of life of refugees	Psychosocial support	Cognitive support	-Education (formal and informal education -Number of training sessions -Decision making skills -The ability to solve problems -Learning opportunities	Quality of life of refugees	Individual	-Positive perception of others and self -Feeling supported by peers and or friends in difficult times -Feeling that the current environment allows support from adults -Feeling that the current environment creates opportunities for friendship	Regression and correlation

							-Having a sense of normalcy	
	Affective approaches foretell the quality of life of refugees		Affective support	-Being able to communicate properly -One on one discussions -Self assistance -Having Survival skills -Relaxation practices and creative expression -Self Confidence -Feeling of loneliness -Change of perception		Environment	-Availability of drugs -Physical wellness -Good hospitals -Availability of medical personnels -Taking pleasure in what one does -Good housing -Ability to feed well -Availability of water and electricity -Being able to dress properly	Regression and correlation

	Social approaches predict the quality of life of refugees		Social support	-Reunification with families -Community perception -Reunification with families -Making people aware of the plight of refugees -Relationship with others -Feeling supported by peers and community in difficult times		Interactions between the individuals and their environments	-Balanced social and personal time -Be open minded to new experiences and people -Involvement and participation in community activities -Relationship with others and self -Being able to gain better understanding of unfamiliar customs and culture.	Regression and correlation

Conclusion

This chapter deals with the description of the methods and instruments used to collect information for this research work with specific focus on research design, the area of study, population of study, the sample and sampling techniques, instruments to be used for data collection, techniques of analyzing data, the variables, the indicators and recapitulative table. A critical examination of this chapter is therefore a gateway for the presentation of results and analysis of data collected from the field which is chapter four.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS OF RESULTS

In this chapter, we present the results we obtained from our data collection. The analysis was done in two stages: a descriptive analysis and an inferential analysis. The descriptive analysis focuses on the socio-demographic factors of the participants (age, gender, activities, etc.) and the inferential analysis focuses on the testing of the three operational hypotheses we formulated.

4.1. DESCRIPTIVE ANALYSIS

We use tables in this section to present our data because they provide better visibility. This analysis focuses on general information about the participants such as gender, age, education level, time spent in the refugee camp, etc.

Table 5

Distribution of participants by gender

Gender	Number	Percentage
Men	87	56,1%
Women	68	43,9%
Total	155	100,0%

The table above distributes our participants according to their gender. It informs us that we have 87 men (56.1%) and 68 women (43.9%).

Table 6

Distribution of participants by age group

Age groups	Number	Percentage
under 18years	17	11,0%
18 to 25 years old	21	13,5%
26 to 30 years old	14	9,0%
31 to 35 years old	31	20,0%
36 to 40 years old	29	18,7%
41 to 45 years old	9	5,8%
46 to 50 years old	20	12,9%
over 50 years old	14	9,0%
Total	155	100,0%

The above table sub divides down our participants according to their age groups. It shows that out of our 155 selected participants, 17 (11.0%) are under 18 years of age. 21 (13.5%) are between 18 and 25 years of age; 14 (9.0%) are between 26 and 30 years of age; 31 (20.0%) are between 31 and 35 years of age; 29 (18.7%) are between 36 and 40 years of age; 9 (5.8%) are between 41 and 45 years of age; 20 (12.9%) are between 46 and 50 years of age; and 14 (9.0%) are older than 50.

Table 7

Distribution of participants according to time spent in the camp

Time spent in the camp	Number	Percentage
More than two years	54	34,8%
More than three years	63	40,6%
One year	38	24,5%
Total	155	100,0%

The table above distributes our participants according to the length of time spent in the camp. It informs that 54 (34.8%) have spent more than two years in the refugee camp; 63 (40.6%) have spent more than three years in the camp and 38 (24.5%) have spent at least one year in the camp.

Table 8

Distribution of participants according to level of education

Level of studies	Number	Percentage
No school level	42	27,1%
Primary level	86	55,5%
Secondary level	28	18,0%
Total	155	100,0%

The table above distributes our participants according to their level of education. It shows that 42 (27.1%) have no schooling; 86 (55.5%) have primary schooling and 28 (18.0%) have secondary schooling.

Table 9

Distribution of participants according to activities

Activities	Number	Percentage
Housewives or unemployed	44	28,4%
Cultivators	69	44,5%
Traders	42	27,1%
Total	155	100,0%

The table above distributes our participants according to the activities they carry out in the refugee camp. It shows that 44 (28.4%) are housewives or unemployed; 69 (44.5%) are farmers and 42 (24.1%) are traders.

Table 10

Distribution of participants' means on the psychosocial cognitive support scale

	Average	Standard deviation
Good quality of intellectual life in the last 48 hours	3,45	1,378
Learning a trade since arriving at the camp	3,19	1,401
Teaching capacity building activities	3,37	1,372
Learning to Live in Peace	3,26	1,400
Learning about hygiene	3,68	1,274
Special teachings at the camp	3,41	1,283
teaching French to non-French speakers	3,15	1,373
Taking charge of children's education	1,99	1,297
Learning to live happily with others	2,94	1,197
Health education	3,19	1,395
Overall average	3,163	1,337

The table above distributes the averages of our participants on the cognitive social support scale. Overall, it shows that our participants benefit from fairly relative social cognitive support. The participants are more or less mixed on the contribution of social cognitive support (average= 3.163, standard deviation= 1.337). This overall position is also observed specifically. They were mixed on their good intellectual quality of life, on special teaching in the camp or

on health education. On the other hand, they do not agree at all about taking charge of their children's education and learning to live with others.

Table 11

Distribution of participants' means on the psychosocial emotional support scale

	Average	Standard deviation
I felt depressed	3,26	1,400
I was nervous or worried	3,68	1,274
Not being able to do the things I wanted to do	3,41	1,283
I felt sad	2,94	1,193
When I thought about the future, I felt terrified	3,19	1,230
In the last two days (48 hours) my life has been	3,34	1,281
I feel that I haven't accomplished anything	3,64	1,248
The level of control I had over my life was a huge problem	3,29	1,200
I felt good about myself as a person	3,87	1,247
They ask about my health and we talk.	3,33	1,339
Overall average	3,395	1,269

The table above distributes the averages of our participants on the psychosocial affective support scale. It informs globally that the psychosocial affective support of refugees is not acceptable. They almost disagree about receiving affective psychosocial support (overall average= 3.395; standard deviation= 1.269). This overall trend is the one observed specifically. During the last 48 hours, they felt depressed, worried, sad, unable to do things as they wanted to; are terrified about their future prospects, etc.

Table 12

Distribution of participants' average on the psychosocial social support scale

	Average	Standard deviation
communication with my loved ones has been difficult	3,48	1,407
We still have light in the camp	3,48	1,306
I felt supported	3,50	1,142
I have friends in the Gado community, I visit them	3,50	1,331
I have a source of income that allows me to take care of my family and myself.	4,29	,882
we are always looked after when we are ill	4,28	,937
We sometimes we have cases of theft and rape in the camp	4,40	,923

I have friends with whom I can share my joys and sorrows.	3,43	1,284
I can talk about my problems with my friends.	3,22	1,321
There are Special people in my life who care about my feelings.	3,32	1,405
My family is ready to help me make decisions.	3,36	1,395
Overall average	3,66	1,211

The table above distributes the participants' means on the social support scale. It provides overall information that the participants benefit from social support (overall average= 3.66; standard deviation=1.211). Specifically, our participants visit their acquaintances, they share their joys with their friends, and their friends are ready to help them when they can but they often have cases of anxiety, which they have difficulties in handling. Sadly, they often have cases of theft and rape in the camp, which sometimes limit their freedom of movement around the camp at certain hours.

Table 13

Distribution of participants' averages on the individual quality of life scale according to the activities carried out

	housewife or unemployed		farmer		Traders	
	Average	Standard deviation	Average	Standard deviation	Average	Standard deviation
Aspects of my financial life my quality of life has been good	3,77	1,159	3,88	1,132	3,90	1,179
Aspects of my physical life financial my quality of life has been good	3,95	1,099	4,10	,926	3,71	1,309
Aspects of my emotional life my quality of life has been good	3,80	1,025	3,88	1,290	3,49	1,468
Aspects of my social physical life my quality of life has been good	3,64	1,331	3,77	1,262	3,88	1,364
Aspects of my spiritual physical life my quality of life has been good	3,68	1,116	3,87	1,162	3,90	1,319
My physical symptoms have been problematic	3,14	1,407	3,13	1,248	3,24	1,319
I felt extremely unwell physically	3,39	1,280	3,61	1,215	3,44	1,285
I take care of myself and my family.	3,48	1,338	3,84	1,066	3,68	1,331
The climatic conditions in Gado is not very different from those in the CAR.	3,45	1,337	3,77	1,087	3,22	1,294
Overall average	3,588	1,232	3,761	1,154	3,606	1,318

The table above distributes the participants on the individual quality of life scale according to the activities they have carried out. Overall, it shows that the individual quality of life does not change much according to the activities carried out by the refugees. It appears that housewives or those without jobs (mean=3.588; standard deviation=1.232) have about the same individual quality of life as farmers (mean=3.761; standard deviation=1.154) and traders (mean=3.606; standard deviation=1.318). This general trend is also observed specifically.

Whether one is unemployed, a housewife, a farmer or a trader, the aspects of emotional, financial, social, spiritual life, etc. are almost the same for all refugees.

Table 14

Distribution of participants' averages on the quality of the living environment scale according to their livelihood activities carried out

	housewife or unemployed		farmer		Traders	
	Average	Standard deviatn	Average	Standard deviation	Average	Standard deviatn
I am comfortable in the house I live in.	3,20	1,374	3,51	1,184	3,15	1,370
My house is not affected by water.	3,55	1,302	3,48	1,208	3,29	1,289
We sometimes organize sports activities in the camp to keep fit	3,45	1,372	3,74	1,133	3,73	1,361
Whenever we have sports activities, I participate fully.	3,50	1,210	3,38	1,126	3,32	1,312
We have clean and well-maintained toilets in the camp.	3,70	1,304	3,84	1,106	3,63	1,318
The problem of the quality of toilets in some camps is not an issue here.	3,52	1,285	3,88	1,207	3,59	1,360
This camp is a safe place for us, we don't have any problems of insecurity.	3,30	1,424	3,67	1,196	3,44	1,467
The camp has a good playground for our children.	3,36	1,241	3,86	1,047	3,24	1,463
The hygienic conditions in the camp are not a concern.	3,39	1,166	3,77	1,087	3,24	1,374
We organise a clean-up campaign and keep the camp clean.	3,00	1,312	3,68	,978	2,98	1,255
We have clean and portable water	3,41	1,263	3,78	,998	3,37	1,199
The absence of insects such as flies and mosquitoes allows us to live in good health.	3,36	1,241	3,58	1,218	3,29	1,401
Overall average	3,395	1,291	3,680	1,124	3,355	1,347

The table above distributes the participants' averages on the environmental quality of life scale according to the activities carried out. Overall, we can observe that farmers seem to have a better environmental quality of life than the unemployed/households and traders (average farmers>average unemployed/households>average traders). This overall trend is confirmed in many respects at the specific level. Farmers seem to be more comfortable where they live, they don't seem to have too many security problems, they have drinking water, etc. than the unemployed/household.

Table 15

Distribution of participants' averages on the social network quality scale according to the activities carried out

	housewife or unemployed		farmer		Traders	
Activities	Average	Standard deviation	Average	Standard deviation	Average	Standard deviation
I can count on my friends when things go wrong.	3,36	1,143	3,84	1,052	3,32	1,422
In the last two days (48 hours), in my relationships with people I care about, I have felt more distance than I would have liked	2,05	1,275	2,42	1,344	2,46	1,267
Over the past two days (48 hours), I have felt supported	3,73	1,246	3,96	1,006	3,83	1,243
The people of Gado provide us with agricultural land if we need it.	2,98	1,210	3,52	1,244	3,24	1,445
I have friends in the Gado community, I visit them and they visit me.	3,16	1,238	3,43	1,266	3,00	1,378
I am in contact with my family back in the CAR	3,05	1,380	3,41	1,217	3,07	1,679
I miss my family sometimes and I wish to find them	2,77	1,309	3,03	1,306	2,71	1,419
We have portable water in the camp and it is always available.	3,16	1,219	3,30	1,264	2,76	1,241
I can feed myself three times a day.	2,98	1,210	3,14	1,364	2,49	1,098
I have a special person who is a real source of comfort.	3,07	1,283	2,99	1,266	2,66	1,196
I can talk about my problems with my family	3,41	1,207	3,17	1,150	2,98	1,235
Overall average	3,06	1,24	3,29	1,22	2,95	1,32

The table above distributes our participants on the scale of the quality of the social network according to the activities carried out. It shows that farmers seem to have a better social network than the unemployed/household and more so than traders. This overall trend is almost the same at the specific level. Farmers seem to be able to count on their friends, they feel supported, they are in contact with the rest of their family, they can talk about their problems to their families, etc.

Table 16

Distribution of participants' averages on the individual quality of life scale according to level of study

	without level		primary		secondary	
	Average	Standard deviatn	Average	Standard deviatn	Average	Standard deviatn
I am comfortable in the house I live in.	2,93	1,218	3,43	1,359	3,58	1,137
My house is not affected by water during the rainy season.	3,24	1,246	3,55	1,252	3,46	1,272
We sometimes organize sports activities in the camp to keep fit	3,64	1,100	3,70	1,293	3,69	1,379
Whenever we have sports activities, I participate fully.	3,17	1,146	3,51	1,215	3,38	1,203
We have clean and well-maintained toilets in the camp.	3,55	1,109	3,86	1,257	3,73	1,218
The problem of the quality of toilets in some camps is not an issue here.	3,64	1,186	3,76	1,337	3,65	1,164

This camp is a safe place for us, we don't have any problems of insecurity.	3,33	1,356	3,50	1,395	3,69	1,225
The camp has a good playground for our children.	3,31	1,259	3,66	1,261	3,54	1,240
The hygienic conditions in the camp are not a concern.	3,21	1,200	3,66	1,233	3,54	1,067
We organize clean-up campaigns to keep the camp clean.	3,10	1,226	3,38	1,248	3,27	1,079
We have clean and portable water	3,38	1,103	3,70	1,179	3,46	1,067
The absence of insects such as flies and mosquitoes allows us to live in good health.	3,33	1,223	3,41	1,341	3,69	1,158
Overall average	3,31	1,19	3,59	1,28	3,55	1,18

The table above distributes the participants' averages on the quality of life scale according to their standard of living. It informs us that regardless of the refugees' educational level, they have roughly the same individual quality of life. This overall trend is also noticeable at the specific level. They sometimes organize sports activities in the camp, the camp offers good playgrounds for their children, they organize cleaning sessions and try to keep the camp clean, etc.

Table 17

Correlation matrix between the dimensions of psychosocial support and individual quality of life

		1	2	3	4
cognitive (1)	r	1	,440**	,408**	,409**
	p		,000	,000	,000
emotional (2)	r		1	,671**	,565**
	p			,000	,000
social (3)	r			1	,713**
	p				,000
individual quality (4)	r				1
	p				

**. The correlation is significant at the 0.01 level (bilateral).

The table above is the correlation matrix between the dimensions of psychosocial support and individual quality of life among the refugees in Gado camp. This matrix indicates that overall all correlations between the dimensions of psychosocial support and individual quality of life are significant. Cognitive psychosocial support is significantly correlated with individual quality of life (r=0.409; p=0.000). This correlation is moderate and positive. Emotional support was significantly correlated with individual quality of life (r=567; p=0.000). Social support is significantly correlated with individual quality of life (r=0.713; p=0.000).

This correlation is strong and positive. We can say that the more effective psychosocial support is among the refugees in Gado camp, the better their quality of life.

Table 18

Correlation matrix between the dimensions of psychosocial support and environmental quality of life

		1	2	3	4
cognitive (1)	r	1	,497**	,520**	,511**
	p		,000	,000	,000
emotional (2)	r		1	,671**	,565**
	p			,000	,000
social (3)	r			1	,713**
	p				,000
environmental quality	r				1
	p				

**. The correlation is significant at the 0.01 level (two-tailed).

The table above is the correlation matrix between the dimensions of psychosocial support and environmental quality of life among the refugees in Gado camp. This matrix indicates that overall all correlations between the dimensions of psychosocial support and environmental quality of life are significant. Cognitive psychosocial support is significantly correlated with environmental quality of life (r=0.511; p=0.000). This correlation is moderate and positive. Affective support is significantly correlated with environmental quality of life (r=565; p=0.000). Social support is significantly correlated with environmental quality of life (r=0.713; p=0.000). This correlation is strong and positive. We can say that the more psychosocial support refugees in Gado camp have, the better their quality of life.

Table 19

Correlation matrix between the dimensions of psychosocial support and social network

		1	2	3	4
cognitive (1)	r	1	,587**	,515**	,496**
	p		,000	,000	,000
emotional (2)	r		1	,671**	,565**
	p			,000	,000
social (3)	r			1	,713**
	p				,000
social network	r				1
	p				

**. The correlation is significant at the 0.01 level (Bilateral).

**. The correlation is significant at the 0.01 level (Bilateral)

The table above is the correlation matrix between the dimensions of psychosocial support and the quality of the social network among the refugees in Gado camp. This matrix indicates that overall all correlations between the dimensions of psychosocial support and social network quality are significant. Cognitive psychosocial support is significantly correlated with social network quality (r=0.496; p=0.000). This correlation is moderate and positive. Affective support is significantly correlated with the quality of the social network (r=565; p=0.000). Social support is significantly correlated with the quality of the social network (r=0.713; p=0.000). This correlation is strong and positive. We can say that the more effective psychosocial support is among the refugees in the Gado camp, the better the quality of their social network.

4.2. INFERENTIAL ANALYSIS

In this section we have processed our data through regression analysis, which allowed us to draw conclusions about our research hypotheses. The choice of this test is not fortuitous; it is justified by the fact that we wanted to predict the different dimensions of quality of life as a function of the social support that Central African refugees in Gado receive.

4.2.1. First research hypothesis

This hypothesis was formulated as follows: psychosocial support predicts individual quality of life among the refugees in Gado camp. In practice, this theoretical hypothesis states that from the psychosocial support that these refugees receive within their camp, we can know their quality of life. The different dimensions of psychosocial support (cognitive, affective and social) predict individual quality of life. The table below presents the results of the linear regression analysis applied to this first hypothesis.

Table 20

Linear regressions of psychosocial support on individual quality of life

R=.614; R-two=.377; Adjusted R-two=.364; Standard error=.676; F=30.399; p=.000

Model	Non-standardised coefficients		Standardised coefficients	t	p.
	A	Standard error	Beta		
(Constant)	1,021	,281		3,640	,000
Cognitive	,141	,100	,129	1,410	,160
Affective	,121	,106	,118	1,149	,252
Social	,474	,090	,445	5,246	,000

Dependent variable: individual quality of life

The table above presents the results of the linear regressions of the psychosocial factor on the individual quality of life of Central African refugees in Gado camp. This table informs that the model of psychosocial support (cognitive, affective and social support) predicting individual quality of life among Central African refugees in Gado camp is significant (F=30.399; p=0.000). In addition to this result, the table shows that the psychosocial support model explains 37.7% of the variance in the quality of life of Central African refugees (R-two=0.377). The relationship between the psychosocial model and the individual quality of life of Central African refugees is moderate (R=0.614). The best predictor of individual quality of life for Central African refugees is social support (Beta=0.445; p=0.000). The other dimensions of social support are not good predictors of the individual quality of life of Central African refugees.

The above results clearly suggest that the psychosocial model that predicts individual quality of life among Central African refugees is significant. This model explains 37.7% of the variance in individual quality of life and the best predictor of individual quality of life is social support. These results are consistent with our first hypothesis, which is confirmed. It is confirmed.

4.2.2. Second research hypothesis

This hypothesis was formulated as follows: psychosocial support predicts environmental quality of life among the refugees in Gado camp. In practice, this theoretical hypothesis states that from the psychosocial support that these refugees receive within their camp, we can know their environmental quality of life. The different dimensions of psychosocial support (cognitive, affective and social) predict environmental quality of life. The table below presents the results of the linear regression analysis applied to this second hypothesis.

Table 21

Linear regressions of psychosocial support on environmental quality of life

R=.571; R-two=.326; Adjusted R-two=.313; Standard error=.820; F=24.376; p=.000

Model	Non-standardised coefficients		Standardised coefficients	t	Sig.
	A	Standard error	Beta		
(Constant)	,759	,340		2,231	,027
Cognitive	,062	,121	,048	,512	,610
Affective	,348	,128	,291	2,719	,007
Social	,375	,110	,302	3,421	,001

Dependent variable: environmental quality of life

The table above presents the results of the linear regressions of the psychosocial factor on the environmental quality of life of Central African refugees in Gado camp. This table informs that the model of psychosocial support (cognitive, affective and social support) predicting environmental quality of life among Central African refugees in Gado camp is significant (F=24.376; p=0.001). In addition to this result, the table shows that the psychosocial support model explains 32.6% of the variance in environmental quality of life of Central African refugees (R-two=0.326). The relationship between the psychosocial model and the environmental quality of life of Central African refugees is moderate (R=0.571). The best predictor of the environmental quality of life of Central African refugees is social support (Beta=0.302; p=0.001). The cognitive dimension is not a good predictor of the environmental quality of life of Central African refugees.

The above results clearly suggest that the psychosocial model that predicts the individual quality of life of Central African refugees is significant. This model explains 32.6% of the variance in environmental quality of life and the best predictor of individual quality of life is social support followed by emotional support. These results are consistent with our second hypothesis, which is confirmed. It is confirmed.

4.2.3. Third research hypothesis

This hypothesis was formulated as follows: psychosocial support predicts the quality of the social network among the refugees in Gado camp. In practice, this theoretical hypothesis states that from the psychosocial support that these refugees receive in their camp, we can know their quality of life. The different dimensions of psychosocial support (cognitive, affective and

social) predict the quality of the social network. The table below presents the results of the linear regression analysis applied to this first hypothesis.

Table 22

Linear regressions of psychosocial support on social network quality

R=.557; R-two=.310; Adjusted R-two=.296; Standard error=.754; F=22.596; p=.000

Model	Non-standardised coefficients		Standardised coefficients	t	Sig.
	A	Standard error	Beta		
(Constant)	,742	,313		2,374	,019
Cognitive	,078	,111	,067	,700	,485
Affective	,308	,118	,283	2,614	,010
Social	,314	,101	,278	3,118	,002

Dependent variable: quality of the social network

The table above presents the results of the linear regressions of the psychosocial factor on the quality of the social network of Central African refugees in Gado camp. This table informs that the model of psychosocial support (cognitive, affective and social support) that predicts the quality of social network among Central African refugees in Gado camp is significant (F=22.596; p=0.000). In addition to this result, the table shows that the psychosocial support model explains 31% of the variance in the quality of the social network of Central African refugees (R-two=0.310). The relationship between the psychosocial model and the quality of the social network of Central African refugees is moderate (R=0.557). The best predictor of the quality of the social network of Central African refugees is social support (Beta=0.278; p=0.000) followed by emotional support. Cognitive support is not a good predictor of the quality of the social network of Central African refugees.

The above results clearly suggest that the psychosocial support model that predicts the quality of the social network of Central African refugees is significant. This model explains 37.7% of the variance in individual quality of life and the best predictor of social network quality is social support. These results are in line with our third hypothesis. It is confirmed.

At the end of this forth chapter on the analysis of the results, which was done in two parts, one on the descriptive analysis and the other on the inferential analysis, the descriptive analysis showed that several factors are associated with quality of life (activities, level of education, etc.). The model that was used to predict the quality of life of Central African refugees in the Gado camp showed that this model predicts each of the dimensions of quality

of life (individual, environmental and social network) and explains a good part of their variance. For the most part, all the hypotheses were in line with the original predictions. We can safely conclude that our general hypothesis is validated. The results obtained from these analyses are open to discussion. This will be done in the last part of our study, which is the chapter.

CHAPTER FIVE
SYNTHESIS AND DISCUSSION OF RESULTS

The objective of our study was to predict the quality of life of Central African refugees in Gado camp based on psychosocial support. The results were essentially in line with our initial predictions: the three dimensions of quality of life (individual, environmental and social network) are effectively predicted by the psychosocial support model used for this study. In this chapter, we discuss the results of the inferential analysis, that is., those from which our hypotheses were formulated.

5.1. PSYCHOSOCIAL SUPPORT AND INDIVIDUAL QUALITY OF LIFE

Our first hypothesis was formulated as follows: psychosocial support predicts individual quality of life among refugees in Gado camp. In practice, this theoretical hypothesis states that from the psychosocial support that these refugees receive within their camp, we can know their quality of life. The different dimensions of psychosocial support (cognitive, affective and social) predict individual quality of life. This hypothesis was validated and our results showed that the social support model used in this study predicts the quality of life of Central African refugees in the Gado camp. This model explained 37.7% of the variance in individual QoL and the best predictor of individual QoL was social support.

Migration has a significant impact on the physical health of refugees (Mustafaeva & Shercliffe, 2010). The abundance of physical health problems faced by refugees may be associated with a variety of factors such as trauma experienced prior to migration, lack of health care in refugee camps, starvation, micronutrient deficiencies, diseases, and risk behaviors in the home country (Dhooper & Tran, 1998; Redditt *et al.*, 2015; Sastre & Haldeman, 2015). Virgincar, Doherty, and Siriwardhana (2016) reported that chronic diseases and physical health problems developed in the migration journey could affect refugees' psychological well-being and quality of life after resettlement.

The WHO defines mental health as "a state of well-being in which the individual can realize his or her potential, cope with the stresses of life, work productively and fruitfully, and contribute to his or her community" (WHO, 2009). Mental health is a necessary component of overall good health and quality of life. It is not only defined by the absence of mental disorders and problems, but also by the presence of various coping skills such as the ability to overcome

adversity, flexibility, and balance (Hansson, Lurie, & McKenzie, 2010). Refugee health is vital for coping with the challenges that resettlement to a new society brings and for full participation in economic, political, cultural, and social life (Josh *et al.*, 2013). In the next sections, we will see that refugees are at much greater risk of experiencing social exclusion than other immigrant groups as well as the rest of the Canadian population.

5.2. SUPPORT AND ENVIRONMENTAL QUALITY OF LIFE

Our second hypothesis was formulated as follows: Psychosocial support predicts environmental quality of life among refugees in Gado camp. In practice, this theoretical hypothesis states that from the psychosocial support that these refugees receive within their camp, we can know their environmental quality of life. The different dimensions of psychosocial support (cognitive, affective and social) predict environmental quality of life. This model explains 32.6% of the variance in environmental quality of life and the best predictor of environmental quality of life is social support followed by emotional support.

Access to low quality housing poses health risks for refugees (Newbold, 2010). In Canada, housing is considered affordable if the rent does not exceed 30% of monthly income (Sherrell, 2010). According to CLIA data, six months after arrival, 85% of refugees spend more than 30% of their household income on housing, compared to 74% of other immigrants (Murdie, 2010). Three years after resettlement, 50% of refugees spend more than 30% of their monthly income on housing, compared to 30% among other immigrants (Murdie, 2010). In addition, three years after arrival, only 19% of refugees become homeowners compared to 52% of other immigrants (Murdie, 2010).

Other articles based on the CLIA data reveal that access to quality, affordable housing is a major challenge among refugees (Murdie, 2010; Teixeira and Halliday, 2010; Wayland, 2010). They live more in cities and neighborhoods with poor quality housing stock (Hansson, *et al.*, 2010).

Regarding housing overcrowding, the 2001 LICS data reported that 40% of refugees lived in overcrowded housing compared to 23% of other immigrants (Murdie, 2010). This situation improves (increased) three years after resettlement when nearly one-third of refugees were still living in overcrowded housing compared to 15% of other immigrants (Murdie, 2010; Teixeira and Halliday, 2010).

In Canada, a combination of complex factors make housing affordability difficult: low income, being unemployed, high rent prices, low vacancy rates, lack of social networks, small unit size, lack of knowledge about rental stock, language, racism, and discrimination by landlords (Francis, 2010; Murdie, 2010; Teixeira and Halliday, 2010; Wayland, 2010). In Vancouver, Francis (2010) reports that many landlords take advantage of refugees' vulnerability by imposing restrictive rules such as increasing the cost of rent, overcharging for certain supplies, refusing to do work on the unit, and asking for a three-month rent deposit that, in some cases, is never refunded. In the national capital, the report of the Director of Public Health on social inequalities in health highlights that refugees experience social exclusion in their search for housing. It revealed that some landlords take advantage of non-French-speaking or illiterate refugees by increasing the cost of rent. Others would refuse to rent to them because of their ethnicity.

Elements related to overcrowded housing and overpriced rents have been reported (Hyppolite, 2013). There have been a concentration of poverty in certain Canadian neighborhoods that receive significant numbers of refugees (Wayland, 2010). Settling in disadvantaged neighborhoods could lead to long-term marginalization by limiting relationships with others in society (Phillimore & Goodson, 2006). However, the ethnic concentration of some neighborhoods can be beneficial in terms of social network formation. Spicer's (2008) sociological work with refugees in the UK reports that living in a socially cohesive neighborhood helps refugees develop their social networks. This makes it easier for them to cope with life's common difficulties, limits the risk of experiencing racism, and prevents poverty, depression, stress and anxiety.

Our search did not identify any studies of food insecurity that stratified results by refugee status. However, a few studies conducted in the United States found interesting evidence on this topic. Prior to resettlement, refugees often experienced episodes of malnutrition (Lindert *et al.*, 2016), and a few studies in the United States raise the point that even after resettlement, they encounter difficulties in obtaining good quality and sufficient food. A quantitative study of resettled refugees in the U.S. indicated that 86% of participants needed assistance from food programs to support themselves (Hartwig & Mason, 2016). Another 2013 study of resettled refugees in North Carolina, U.S., by Sastre and Haldeman (2015), to examine food security, concluded that refugees have difficulty obtaining products from their home country because of the high cost of food, but also because the products were not available in the host country. Additionally, this study raises the fact that refugees are often

located in neighborhoods with food deserts (no big box grocery stores) (Sastre & Haldeman, 2015). The study also notes that many refugees used community gardens to consume fresh food. However, some barriers to using community gardens were noted, including lack of transportation to get there (Sastre & Haldeman, 2015).

Food insecurity is associated with adverse health outcomes for refugees such as chronic diseases, direct effects on mental and physical health, and low reported health status (Salti & Ghattas, 2016).

Numerous Canadian and international research studies have documented the systemic barriers that resettled refugees face in accessing health systems (Davidson & Carr, 2010; Phillimore & Goodson, 2006; Sastre & Haldema., 2015; Shishehgar *et al.,* 2016). In Canada, the Mental Health Commission's Diversity Task Force report recognizes elements that facilitate access to health services for refugees: literacy, trust in institutions, interventions based on cross-cultural approaches, targeted health promotion based on cultural differences (Hansson *et al.,* 2010).

In Australia, data collected in the Settle MEN project conclude that 25% of refugees experience major barriers to accessing the health system (Correa-Velez *et al.*, 2013). In an article that explored the experiences of social exclusion among resettled refugees in the United Kingdom, Spicer (2008) raises that the difficulty in using health services is amplified by the lack of interpreter services. The literature from Canada, Australia, and the United Kingdom on access to refugee care reports that stigma, negative attitudes of medical staff, lack of transportation, long wait times, negative experiences with the health care system, lack of cross-cultural services, and insufficient information about health services reduce access to care (Dhooper and Tran, 1998; Grisales *et al*, 2016; Hansson *et al.* 2010; Newbold 2010; Phillimore and Goodson 2006; Robert and Gilkinson 2012; Sastre and Haldeman 2015; Spicer 2008). Other cultural factors restrict access to health services. For example, refugees sometimes have perceptions of health and illness that are different from those normally prevalent in Quebec (Grisales *et al.,* 2016). Davidson and Carr emphasized the importance of understanding them in order to determine if health services are meeting their needs.

Although mental illnesses have similar symptoms across cultures, the manifestations and how people describe and interpret symptoms may vary by ethnicity and culture. Therefore, in some cases, health care professionals may misdiagnose and the mental health problem may go untreated (Robert & Gilkinson, 2012). All of these systemic barriers to accessing health

services reinforce social exclusion and increase unmet health needs among refugees (Langlois *et al.*, 2016)

The notion of vulnerability is at the heart of the definition of refugee status as it is specified in international law. According to the 1951 Geneva Convention, a refugee is any person who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country" (Article 1T A/2 of the Geneva Convention). In other words, vulnerability is to be interpreted here as the risk of being persecuted and, by extension, of fearing for one's life or that of one's relatives. But with one important qualification.

The risk applies only to very specific situations: one must have left one's country for reasons that are all immaterial (religion, membership, political opinions, etc.). In the negative and *a priori,* people who have left their country of origin for reasons other than those mentioned are therefore excluded from refugee status. One does not become a refugee because one has left a country ravaged by a drought, an epidemic or an economic crisis. Finally, the definition of a refugee is strictly dependent on the drawing of borders and therefore on the political map of the world and the list of states recognized as such by the UN.3 In short, the issue of vulnerability among refugees is first and foremost a question of belonging and identity. It is consubstantial with discriminatory policies and practices that target particular categories of people living in the wrong place and belonging to the "wrong side" in times of crisis.

On the other hand, there is no reference to the situation of great economic and social vulnerability that prevails in the context of armed conflicts. This ambiguity gives rise to numerous controversies when the issue of labor immigration in Europe is superimposed on, but not confused with, the issue of asylum-seeking refugees. It is therefore understandable that, depending on the actors, interpretations are widely divergent. The administrations of the Northern states are working hard to flush out "false refugees" and are trying to restrict the scope of application of international conventions; humanitarian organizations, researchers and international bodies are divided between strict respect for the legal framework defined by the protection of human rights, on the one hand, and the extension of refugee status to various categories of migrants, on the other. As for the populations concerned themselves, depending on the place and the circumstances, they may experience refugee status as a humiliation, a constraint or, on the contrary, as their only way out (Cambrézy, 2006).

Moreover, while the Geneva Convention provides the legal framework for the definition of refugee status, it does not clearly define the modalities for the application of protection to this category of population. By being silent on the procedures for recognizing the status, it leaves States free to interpret it. Consequently, depending on the country and the political, economic and social context, the effective protection of victims of conflict is subject to an extremely broad interpretation which often does little to reduce the initial vulnerability of populations forced to flee violence and conflict. Thus, in the poorest countries, particularly in Africa, the *precarious protection of refugees fuels new mobilities.* These chain migrations are motivated by the search for durable and viable solutions to problems that humanitarian assistance is rarely able to resolve satisfactorily and that can be summarized in two key interrelated factors: the right to a legal status worthy of the name and the "right to inhabit".

In the case of civil wars and armed conflicts, flight and exile of displaced or refugee populations appear less as a "response" than as an emergency imposed by the need for survival. Forced migrants do not leave their country or region of origin in the hope of a better future. On the contrary, by fleeing to the unknown, these populations in most cases expose themselves to increased vulnerability and uncertainty of return. This being said, it should be noted in passing that this hardly allows one to decide whether or not it is relevant to distinguish between labor migration (or economic migration) and forced migration. It is therefore probably more useful to focus on the concrete forms of vulnerability that affect refugee and displaced populations as a result of armed conflict.

If we could be satisfied with the statistics, there would be reason to rejoice. Since the catastrophic situation in the 1990s, the number of refugees has decreased significantly. At the end of 2005, there were 8.4 million refugees in the world, the lowest number since 1980. In Africa, the 2.6 million refugees registered in 2005 compare to 6.7 million in 1994. The rather encouraging evolution recorded in recent years should therefore lead to optimism. However, this view does not stand up to analysis.

Indeed, without prejudging the future, even if several conflicts seem to belong to the past - in Rwanda, Angola, Liberia, or Sierra Leone,... (Sometimes by the death or exile of one of the protagonists of these wars: Jonas Savimbi in Angola, Charles Taylor in Liberia) -, other crises are appearing (Darfur) or are constantly reappearing as certain conflicts become internationalized (Somalia, South Sudan, etc.). On the other hand, sticking to the strict definition of the refugee as it is enshrined in international law cannot make us forget the

millions of displaced people who, for various reasons, have been unable or unwilling to leave their country of origin and often live in situations that are just as precarious as those of refugees who have crossed a border. Yet many civil wars "produce" as many - if not more - displaced persons (without status) as refugees (<<status).

If these populations are suspected of belonging to the "wrong side," it is not even the right to asylum that is at stake, but rather their survival. And this question is all the more serious because the parties to the conflict (government or opposition) often work to thwart the action taken by humanitarian organizations to ensure the protection of these people. However, other elements of the framework are also necessary. First of all, it should be remembered that the vast majority of refugees from conflicts in Africa remain confined to Africa and are massively concentrated in countries bordering countries at war, where the population obtains refugee status on a collective *(prima facie)* basis. However, this does not necessarily lead to better protection. Although the 1969 convention of the Organization of African Unity (OAU) broadens refugee status "without the need to demonstrate individual persecution", "this broadening of the notion of refugee is part of the phenomenon of Western States taking responsibility for crises that do not directly affect them" (Rodier, 2002). Thus, while 80% of refugees in Africa have obtained status on a collective or *prima facie basis, the* contrast is striking with Europe where the majority (if not all) of applicants have obtained refugee status on an individual basis. UNHCR concludes: "Regional differences in recognition are partly explained by the nature of the existing legal framework as well as by the level of economic development (individual refugee status determination is resource intensive)" (UNHCR 2005).

In the African countries of first reception, if linguistic and cultural proximity sometimes play in favor of a fairly good disposition of the local populations towards the refugee populations, these are only exceptions that confirm the general rule. As elsewhere, hospitality has its limits, and from the point of view of the host countries, the influx of refugees more often than not leads to fears of the worst in terms of insecurity, the export of the conflict beyond the borders, and environmental degradation (access to firewood, water, etc.). Finally, due to their reluctance as well as their material and financial inability to manage the emergency and deploy the necessary logistical means, African states rely heavily on the High Commission for Refugees to ensure the reception and protection of refugees, while at the same time negotiating bitterly - as a matter of sovereignty - the modalities of intervention of humanitarian organizations.

As a result, the protection of refugees is placed under a kind of double guardianship: that which is largely subordinated to the aid delivered by the international community through the UNHCR, but also that of the goodwill (of variable geometry) of the host state. From an institutional and political point of view, the divergence of interests and objectives, ambiguities of all kinds, and the mutual rejection of responsibility in the event of a dispute - constitute the background to any negotiation between a sovereign state and the United Nations (in this case, the UNHCR). Therefore, to say that the conditions for satisfactory protection of refugees are not met is clearly an understatement.

Moreover, not all refugees receive the same attention. It goes without saying that the protection enjoyed by deposed presidents, former warlords in disarray and their followers bears no relation to the tragedy experienced by the hundreds of thousands of civilians fleeing the combat zones. For the former, negotiations are conducted directly with the governments of friendly countries and, until recently, they were able to live in discreet and quiet exile with their families and followers, without being otherwise worried by possible legal proceedings.

On the other hand, apart from these special cases, the vast majority of refugees are grouped together in camps. Generally set up near the borders of their country of origin, these camps - which are supposed to be temporary - last as long as the conflicts last, i.e., several years or even several decades. The camps function according to a double logic - one security, the other humanitarian - the coherence of the "mechanics" of which must be emphasized. On the one hand, as far as possible, the aim is to control the movement of refugees in order to avoid their dispersal in the host country; on the other hand, the camps are designed to meet the most vital needs of these populations (shelter, health, food, water). The second function thus acts on the first. Meeting the needs of these populations is a way to make them stay where we want them to stay.

5.3. PSYCHOSOCIAL SUPPORT AND THE QUALITY OF THE SOCIAL NETWORK

Our first hypothesis was formulated as follows: psychosocial support predicts the quality of the social network among refugees in Gado camp. In practice, this theoretical hypothesis states that from the psychosocial support that these refugees receive within their camp, we can know their quality of life. The different dimensions of psychosocial support (cognitive, affective and social) predict the quality of the social network. This model explains

37.7% of the variance in social network quality of life and the best predictor of social network quality is social support.

Refugees arrive in a new country that they have chosen in a context filled with constraints and in which they are disoriented. The new social and cultural references of their host country are often unknown to them (Lacroix, 2004). Research reports that they remain socially and culturally excluded in the host societies.

Language proficiency is an important element that promotes full participation in society. In Canada, refugees face many barriers related to communication difficulties (Khanlou, 2010). In Quebec, an estimated 81.5% of refugees are allophone upon arrival (Grisales *et al.*, 2016). As mentioned in Chapter I, 7,610 refugees were admitted to Quebec in 2015. Of these, 36% knew neither French nor English, 32% knew only English, while 32% knew French. In addition, language proficiency increases access to various resources essential to health such as education, employment, and social support. Joshi (2013) and Gushulak (2011) argue that low language proficiency has also been associated with poor health status. In addition, some Canadian authors raise the point that citizens who do not speak up, such as refugees, are more likely to be excluded from debates that affect them (Mitchell, Shillington, & Foundation, 2002). They are not consulted politically about decisions that affect them and they are not aware of the procedures for asserting their rights (Mitchell, Shillington et *al.*, 2002). Rights belong to those who can claim them (Grove and Zwi, 2006). Moreover, experiencing social exclusion limits their ability to exercise their rights and to question and challenge their treatment (Grove and Zwi, 2006). In the health field, the literature review noted that public health professionals play an important role in promoting social inclusion and integrating the discourse of these marginalized populations (Grove and Zwi, 2006).

Other elements have emerged in relation to access to information. In Scandinavian countries and Australia, studies raise a strong association between non-access to information and social exclusion (Kennan, Lloyd, Qayyum, & Thompson, 2011; Olwig, 2011). Difficulty in finding information diminishes an individual's ability to fully participate in society and contributes to the marginalization of refugees (Kennan *et al.*, 2011). Indeed, refugee individuals encounter information-related problems since for them, almost every everyday situation is unusual, requiring new information on a regular basis. The difficulty in accessing information regarding basic needs such as employment, housing, education and health reinforces the social exclusion they experience (Kennan *et al.*, 2011).

In addition, for some refugees, lack of ability to use new technologies (such as computers) may reduce their ability to access and understand information. This can also cause problems with the government, among other things, with regard to administrative documents to be submitted via the Internet (Kennan *et al.*, 2011).

For refugees, resettlement does not guarantee becoming a member of a new community. It can also be associated with social exclusion when people in the host society do not make an effort to recognize the contributions that refugees might make (Grove and Zwi, 2006). Findings from some studies report that refugees are rarely perceived by others in society as individuals who can contribute or become assets to their new community (Grove and Zwi, 2006; Hyppolite, 2013).

In Quebec, the body of research on discrimination among immigrants suggests that there are many challenges related to social cohesion. A 2005 Montreal study of 254 immigrant and refugee families from the Philippines and the Caribbean reported that Caribbean teenagers are discriminated against in high schools. In fact, 43.2% mentioned having been insulted because of their ethnic difference, 34.7% were subjected to rudeness, 32.3% said they were treated unfairly and 12.7% said they were hit because of racism (Rousseau, 2010).

In the report of the Regional Director of Public Health on Social Inequalities in Health 2012: Understanding and Acting Differently to Aim for Health Equity in the National Capital, a group of refugees was consulted to better understand how they experience social exclusion. The results of this process show that refugees experience exclusion in different settings and to different degrees. Educational settings and institutions were identified as places where refugees experience a great deal of stigma because of their ethnicity. Forms of exclusion take the form of mockery, sarcasm, bullying, rejection, violence, and discrimination by some teachers. The findings also highlight that refugees feel stared at and unwelcome on public transportation (Hyppolite, 2013). In addition, racialized minority immigrants experience more inequality than non-racialized minorities. A study in the United Kingdom reports that "white" immigrants went through a transitional period of precarity, while "non-white" immigrants never reached equality with native-born people (Phillimore & Goodson, 2006).

Social networks are an important determinant of health. First, let us recall that during their forced migration, refugees have undergone several social and family disruptions, leaving behind their social networks, often during traumatic events (Dhooper and Tran, 1998; Guilbert, 2003; Joshi *et al.*,2013; Lindert *et al.*, 2016; Paquet, 2011). The loss of these social ties deprives

them of important social capital that could help them cope with the barriers encountered in their new society. In addition, some studies indicate that refugees face many difficulties in benefiting from family reunification programs in their new society. Two Canadian studies that examined stressors in the new host society cite delays in family reunification as a source of stress and anxiety (Newbold, 2010; Wilson *et al.*, 2010). The literature also indicates that refugees experience social isolation following resettlement and have little social support. A Canadian study by Hartwig and Massons (2016) with Karen and Bhutanese refugees reports that women experience more social isolation than men as they stay at home with children during the day. In an article compiling data from three U.S. studies, two Finnish studies, as well as a Lebanese study, Virgincar and colleagues (2016) conclude that social isolation and lack of social support after resettlement are associated with the risk of developing depression in refugees.

The processes of social exclusion have many knock-on effects on communities, social groups and individuals. Levitas (2007) reports that social exclusion affects the social cohesion of society as a whole. Conversely, good indicators of social inclusion and participation are associated with a state of well-being and indicators of good health among populations (Correa-Velez, Gifford, & McMichael, 2015; Stewart *et al.,* 2008). Multiple scientific research studies provide evidence that social exclusion adversely affects the health of marginalized groups such as refugees (Davidson & Carr, 2010; Davys & Tickle, 2008; Reidpath, Chan, Gifford, & allotey, 2005). Exclusionary processes directly impact the well-being of individuals and also cause deprivation that will also have negative effects on the health of individuals.

Social exclusion restricts individuals' participation in society, which has an effect on health and quality of life. Lack of participation can lead to poor mental health, stress, anxiety, loneliness, depression, shame, frustration, apathy, resignation and hopelessness (Stewart *et al.*, 2008). In addition, forms of exclusion such as discrimination, prejudice, denigration, devaluation, and violence also have negative effects on individuals' mental and physical health. For example, the 1998 survey on the cultural communities of Quebec (ECCQ), which provides a portrait of the health of recent immigrants, reveals that the perception of discrimination is a more important determinant of mental health among recent immigrants than employment or mastery of one of the two official languages (Rousseau & Drapeau, 2002). In other Canadian and international studies, the, data also reveal that perceived racial discrimination is an important risk factor for mental illness affecting refugees (Caxaj & Berman, 2010;Velez *et al.*, 2015; Maharaj *et al.,* 2016; Robertson *et al.*, 2016; Shishehgar *et al.*, 2016).

Ultimately, the inability to maintain social relationships or experiencing social exclusion can lead to a lack of resources, goods, and services available to the majority of people in society (Correa-Velez *et al.*, 2013; Davys, & Tickle, 2008; Taket *et al.*, 2009). As we have seen in the results of the studies in this literature review, these restrictions cause deprivations such as exclusion from the labor market, poor working conditions, low income, food insecurity, and poor access to quality housing. Difficulty accessing these resources causes highly deleterious effects (Popay *et al*, 2010; Van Bergen, Hoff, Van Ameijden, & Van Hemert, 2014). Population health research has associated social exclusion and the resulting deprivation with a variety of health problems ranging from chronic diseases to mental health issues (Correa-Velez *et al.*, 2013; Davidson & Carr, 2010).

The social dimension makes it possible to analyze the quality of supportive relationships with friends, family, neighbors and the host population, as well as the absence of ties with other members of society (Popay *et al.*, 2010). For refugees, the important elements to consider in this section are the disregard for identity, the difficulty of creating social ties with Quebecers, the breakdown of social ties with relatives in the country of origin and the main sources of support available to them.

First, a difficulty experienced by almost the majority of the participants concerns identity-based scorn. Recall that almost half of the sub-Saharan refugees had been disparaged, insulted, or vandalized by their neighbors or roommates because of their different ethnicity. Interviews even showed that children had been beaten while playing in their building's yard because they were black. The testimonies also reveal that many participants experienced racial discrimination in public places such as on the street, in businesses, and on public transportation, which can lead to travel deprivation. In this regard, one person avoided taking public transportation because of the discrimination experienced. Thus, the forms of exclusion in the social dimension are mainly related to identity-based contempt.

Second, the interview data suggest that the majority of refugees have difficulty making social connections with people in the host population. The testimonies reveal that they have very few people in their network. In the interviews, the majority of participants spoke of the difficulties they experienced in making social connections in Quebec City and also of the lack of knowledge of how to interact with others. Some testimonies reveal that refugees do not know how to approach people on the street, how to greet them, what forms of politeness they should

use. These findings are not about unequal power relations, but they are important to consider as refugees are deprived of socialization opportunities that could facilitate their inclusion.

Thirdly, it must be remembered that all the refugees we met had experienced a significant break in their social ties after migration. Forced migration implies leaving family, friends, acquaintances and neighbors under urgent and sometimes brutal circumstances. For the majority of the interviewees, the separation from loved ones is difficult to accept. In addition, almost all the participants reported difficulties in maintaining social ties with their social network in their country of origin or in the camps. Many lost contact with their loved ones during exile, while for others, limited access to the Internet for some people in Africa makes it difficult to maintain social ties. In addition, for one of the participants in our study, lack of knowledge of virtual social networks and computers prevented him from staying in touch with his loved ones. Thus, the absence and difficulty of maintaining social ties with people in the country of origin clearly weakens the social inclusion of resettled refugees by depriving them of emotional support in their integration and by depriving them of important social ties, but does not constitute a form of social exclusion according to the conceptual framework used for this dissertation. Rather, it is a consequence of the social exclusion experienced in the country of origin.

The disregard for their identity, the difficulties in rebuilding their social networks, and the severing of social ties with loved ones result in various deprivations, including opportunities for socialization, travel, leisure, respect for others, opportunities to make friends, and informational and emotional support. Moreover, the interviews show that sub-Saharan refugees have a great need for information. The topics on which they need information are very diverse: the cultural norms of the host society, access to the labor market, successful integration experiences, daily customs and much more. Recall that for the refugees who participated in this study, almost every everyday situation is unusual, which frequently raises a need for information. The inability to access information limits their social inclusion. As discussed in the literature review, Scandinavian and Australian research raises a strong association between non-access to information and social exclusion as difficulty in finding information decreases an individual's ability to fully participate in society (Kennan, Lloyd, Qayyum, & Thompson, 2011; Olwig, 2011). Emotionally, our study indicates that it is the desire to be listened to in times of difficulty, to receive encouragement in times of distress, to welcome guidance in times of adversity, and the receipt of moral support that sub-Saharan refugees lack.

Fourth, despite deficits in social support, the interviews show that refugees have four main sources of support: family, African friends, community organizations, and churches. Recall that nine out of ten participants had immigrated with immediate family members. In general, all the refugees mentioned that they had good relationships with them and that their presence gave them emotional support in times of adversity.

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CONCLUSION

In the framework of our study on the psychosocial support of central African refugees, refugees in the East region of Cameroon with the case of the Gado Badzere camp, we sought to investigate if psychosocial support predicts the quality of life of these refugees. The interest of the this work was also to find out if the Psychosocial support given by the various stakeholders meet the quality of life of refugees and possible recommendation for effective and timely Psychosocial support policies that can improve refugees quality of life.

Given that Refugee camp in general signifying a place of the protection of refugees in the international legal framework, a detail study of the Gado Badzere camp, international laws, policies, and frameworks were equally discussed in chapter two of this work. Drawing it relevance from the 1951 Geneva Convention on the status of refugees, this study uses the quantitative survey research method to arrive at stunning results. The study showed proof of several psychosocial support dimensions used such as affective dimensions and the impact they have on quality of life. This therefore confirms our first hypothesis.

In the second hypothesis of this study, we sought to find out if the cognitive psychosocial support received by CAR refugees in the Gado Badzere refugee camp predicted their quality of life. These results reveal a positive predication recorded. A hand full of the refugees attest that although some of the Refugees benefit from cognitive psychosocial support such as education, they are still very much lacking in this aspect as a larger portion of their cognitive psychosocial support needs are not met.

In the third hypothesis, we want to find out if social psychosocial support dimension predicts the quality of life of refugees in Gado Badzere camp. The result revealed was positive as not just their social needs has been impacted but it has had a significant influence on their quality of life. It has consequently increased their participation in sporting and recreational activities as the Refugees themselves confirm that these psychosocial dimensions have helped solve many of their problems. In addition, the national laws contribute but also the international laws as most of the Refugees are comfortable with the laws and attest that it is for their safety

In the face of several challenges such as inadequate scale for Refugees support, lack of sustainable development projects, livelihood projects, complex donor policies and limited development partners among others, this study propose some recommendations. The equalizing of the Psychosocial support scale, the development of livelihood projects to improve

refugees quality of life, the training of both medical and educational staff to handle refugee related needs are very essential aspects for an effective psychosocial support development. The Refugees on their own part wish for their reinstallation to their countries of origin, more mental health/special education specialists and installation of refugees outside of the camp, the cultivation of a stronger partner versus refugee relationship and the introduction of more social activities (sports and recreational activities)

Psychological treatment can prevent dangerous consequences at the Gado Badzere camp, such as trauma, violence, and rise of mental condition such as anxiety, depression and suicide. This strongly indicates the need for a specialized team of clinical psychologist and counselors, along with a training mental program aimed at reviewing cases in need of special psychological evaluation and treatment. It is interesting to note that Refugees staying in tents reported a higher need for Psychological support than those staying in mud houses. This relationship between the housing condition and the different psychological needs at the camp warrants further attention and investigational studies. It has been demonstrated that living conditions and insecurity are important factors that influences general psychological health status.

Central African refugees at the Gado Badzere camp suffer from numerous psychological distress that require urgent attention by the responsible authorities. Many of the Refugees as portrayed in the result reported dissatisfaction with the care provided to them and to their family members at the camp. Refugees staying in tents reported greater dissatisfaction compared to refugees staying in mud houses. Results of this study necessitate the establishment of a dedicated medical team to assess and coordinate the care delivered by the different international field hospitals available at the camp, with a special focus on the Refugees mental health.

To address growing restrictive interpretation and implementation of the national Refugee and Psychosocial support policies, UNHCR and its partners should continue monitoring how Refugees experiences evolve, using this as a basis for advocacy with the government. Furthermore, donors and development partners should commit to investing in long-term developmental support to the Refugee situation in the Gado camp in particular as well as other Refugee camp in the country. With the support of development banks, donors need to invest funding and attract partners with the right expertise to tackle such structural obstacle to the livelihoods of both Refugees and even locals in host communities. At the same

time, humanitarian organizations and UNHCR need to operate in a more adaptive manner, managing both assistance and services to the most vulnerable Refugees and investment in the livelihood of refugees.

A limitation in this study is that the results regarding the respondents reporting poor quality of life at the camp do not reflect whether these problems emerge from inadequate psychosocial support implementation or its variant. Nevertheless, the reality that refugees at the Gado Badzere have a poor quality of life answers the main aim of the study and calls for the development and implementation of sustainable development programs targeted at increasing their livelihood while improving their quality of life.

Recommendations

To the government

The government should foster the training of special needs (competence base teachers) teachers to respond to refugees needs. Trainings should be organized for teachers and staff in residential refugees' settings with competencies focused in recognizing and responding to special emotional needs. Training of general/specialized healthcare providers to meet the needs of Refugees and asylum seekers to ensure satisfactory systems should be put in place to allow prompt access to social, health and educational systems, in other to promote wellbeing and social inclusion of asylum seekers and Refugees.

It is important for actors across all sectors to be aware of the continuum of MHPSS needs of children and families in emergencies and to ensure functional referrals up and down the layers of the pyramid (PSS). Interventions can best reach children and families when they are integrated within sectors and structures, such as education, health and protection structures, rather than as standalone programs (for example specialized services without other layers of support).

MHPSS programs also should avoid over- targeting sensitive groups (For example, survivors of sexual and gender-based violence (SGBV), rape, or children formerly associated with armed forces/ groups) in ways that further their discrimination and exclusion in communities. Instead, it is best to work towards broad support and advocacy to promote the inclusion and wellbeing of all community members.

To International and regional organizations (NGOs)

International and regional organizations should equate psychosocial support scales and community engagement. NGOs should understand the needs of Refugees. That is guide them on where and how to live such that they become able to build their livelihood as a prerequisite to cope with daily life challenges. In complex situations, careful attention must be paid to the process of approaching communities and ensuring inclusion and participation throughout the program cycle. Engaging communities begins with recognizing and acknowledging their resilience, capacities, skills and resources for self-care and self- protection. It involves working with the community and its leaders, understanding the community's dynamics and structures, building on community capacities and strengths to find solutions to identified concerns and working in partnership to plan, implement and monitor interventions at all phases of the program management cycle. The process of community engagement raises awareness of the needs of vulnerable or marginalized groups. It can play a powerful role in reducing stigma and discrimination affecting vulnerable children and families.

Communities displaced by an emergency also interact with host communities in variety of ways- sometimes being absorbed and integrating with them, sometimes living separately. Tension may arise over resources or sociocultural differences. The relationship between affected people and host communities needs to be examined with host communities involved in the process. Environment also influence community engagement processes. For example, when Refugees or displaced families are scattered in an urban environment, identifying and engaging with them requires different strategies than if they are located together in a refugee camp.

NGOs should integrate mental health into all humanitarian services in Gado Badzere refugee camp in the East region of Cameroon. According to Sannoh mental health services are very important and should therefore be integrated into all humanitarian services in refugee camps in the world with that of Gado Badzere inclusive. Sannoh adds that not only should psychosocial actors' organize brief mental health trainings for general health staffing refugee sites but they should equally ensure that health workers in the general (non-specialized) health services in the camps diagnose patients with mental disorders as well. Drawing facts and observation from the Data Refugee camp in Kenya, Sannoh explains that health workers whether general or specialized in psychosocial issues have a general caseload, which consists of significant numbers of people with uncommon mental disorders. Therefore,

a short training for them to detect and manage people with unexplained somatic complaints and mild to moderate mental disorders should be organized.

Agencies dealing with health programs in the camp should equally train traditional and religious healers on mental health issues. Capacity building of mental health workers and communities has to be diversified to other practical approaches such as mentorship and support supervision.

Capacity building and income generating activities should be organized at the camp for refugees. Refugees should be given proper trainings on activities that generate them income for them to improve their livelihood and consequently quality of life. Sustainable agricultural projects could be developed for refugees such as poultry farming, maize and vegetable cultivation, pig raring and cattle raring.

Refugee Youths who have college degrees should be gotten jobs at their local communities or integrated into camp staffs by the NGOs in charge of camp programs. It is needless for these youths to be trained and send back to the camp without the opportunity to put the acquired skills into practice.

Recommendations proposed by Refugees in the Gado Badzere camp.

Among other issues recommended such as the increasing of psychosocial support scale to Refugees to enable them to move beyond a hand-to-mouth existence, the refugees proposed the following recommendations.

Reinstallation in country of origin, implementation of sustainable development programs and income generating activities, more mental health specialists, Installation outside of the camp, build stronger relationships between partners and Refugees and more social activities.

Following the results gotten from the questionnaire, the Refugees were questioned on their recommendations to better their psychosocial support and quality of life. Out of the 155 Refugees who answered the questionnaire, 30 recommended that they need the government and other stakeholders to create platforms for them to be reinstated in their country of origin. 71 requested for sustainable development programs and income generating activities that will permit them improve their livelihood, 18 requested for more specialist in the mental health domain, 6 of the Refugees population requested for introduction of more social and recreational

activities such as football matches, movie watching and many other activities in the camp. 18 appealed for the construction of a stronger partner versus refugee relationship while 12 persons preferred to be established outside of the Refugee camp in order to avoid the stigma of being referred to as refugees.

Suggestions for further Research

Looking at the limitations and delimitation of the study, the researcher makes the following recommendations for future studies. Further research can be carried out on the following topics: the impact of sustainable development projects on Refugees in the Gado Badzere camp, which variant of psychosocial support best predicts quality of life and the state of the mental health of children and women Refugees in the Gado Badzere refugee camp in the East region of Cameroon. These suggestions were made to promote research spirit among scholars and to avoid hasty and generalized conclusions on certain key issues.

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APPENDIX

RÉPUBLIQUE DU CAMEROUN
Paix – Travail – Patrie

Université de Yaoundé I
Centre de Recherche et de Formation Doctorale en Sciences Humaines, Sociales et Educatives
UNITÉ DE RECHERCHE ET DE FORMATION DOCTORALE EN SCIENCES DE L'ÉDUCATION ET INGÉNIERIE ÉDUCATIVE

REPUBLIC OF CAMEROON
Peace – Work – Fatherland

The University of Yaoundé 1
Post Graduate School for Social and Educational Sciences
Doctoral Research Unit for Human and Social Sciences
DOCTORAL RESEARCH AND TRAINING SCHOOL IN EDUCATION AND EDUCATIONAL ENGINEERING

QUESTIONNAIRE

CONSENTEMENT LIBRE ET ÉCLAIRÉ

Mesdames, Messieurs,

Le présent questionnaire est anonyme et sert strictement à des fins de recherche. Nous vous demandons, s'il vous plaît, de répondre à toutes les questions en toute franchise et liberté. Votre participation est volontaire, vous pouvez vous retirer à tout moment unilatéralement.

D'autre part, il n'y a ni bonnes ni mauvaises réponses, seul votre avis nous intéresse.

Nous vous assurons que la confidentialité totale de vos réponses sera préservée conformément aux dispositions de l'article 5 de la loi n°91/023 du 16 décembre 1991 sur les enquêtes statistiques et les recensements au Cameroun. Aucune information permettant de vous identifier d'une façon ou d'une autre ne sera publiée. Ainsi, votre participation ne devrait pas vous causer de préjudice.

Par avance, nous vous remercions de votre participation.

PARTIE A: INFORMATIONS GENERALES.

1. Vous êtes une femme ou un homme?
2. Vous avez entre : 1. Moins de 18 ans ; 2. 18-25 ans ; 3. 26-30 ans ; 4. 31-35 ans ; 5. 36-40 ans ; 6.41-45 ans ; 7. 46-50 ans ; 8. Plus de 50 ans
3. Depuis combien de temps résidez-vous dans le camp : 1. Plus de 2 ans ; 2. Plus d'un an ; 3. Moins de 6 mois

Que pensez-vous des assertions suivantes sur la consommation d'alcool au volant? Pour chaque assertion, marquer (x) sur une valeur de 1 à 5 en fonction de vos croyances.

1- Totalement en désaccord **2-** en désaccord **3-** ni en accord, ni en désaccord **4-** en accord **5-** totalement en accord.

Qualité de vie

Individuel						
	En tenant compte de tous les aspects de ma vie financière ma qualité de vie au cours des deux derniers jours (48 heures) a été bonne	1	2	3	4	5
	En tenant compte de tous les aspects de ma vie physique financière ma qualité de vie au cours des deux derniers jours (48 heures) a été bonne	1	2	3	4	5
	En tenant compte de tous les aspects de ma vie émotionnelle ma qualité de vie au cours des deux derniers jours (48 heures) a été bonne	1	2	3	4	5
	En tenant compte de tous les aspects de ma vie physique sociale ma qualité de vie au cours des deux derniers jours (48 heures) a été bonne	1	2	3	4	5
	En tenant compte de tous les aspects de ma vie physique spirituelle ma qualité de vie au cours des deux derniers jours (48 heures) a été bonne	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), mes symptômes physiques (exemples: douleur, nausée, fatigue et autres) ont été problématique	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), je me suis senti(e) extrêmement mal physiquement	1	2	3	4	5
	Je dispose d'une source de revenus qui me permet de prendre soin de moi et de ma famille.	1	2	3	4	5
	Un groupe de personnes vient chaque mois nous parler de notre santé	1	2	3	4	5
	Les conditions climatiques de Gado ne sont pas très différentes de celles de la CAR.	1	2	3	4	5
Environnement						
	Je suis à l'aise dans la maison où je vis.	1	2	3	4	5
	Pendant la saison des pluies, je ne m'inquiète pas pour ma maison parce qu'elle ne craint pas l'eau.	1	2	3	4	5
	Nous organisons parfois des activités sportives dans le camp pour rester en forme	1	2	3	4	5
	Chaque fois que nous avons des activités sportives, j'y participe pleinement.	1	2	3	4	5
	Nous avons des toilettes propres et en bon état dans le camp.	1	2	3	4	5

	Le problème de la qualité des toilettes dans certains camps ne se pose pas ici.	1	2	3	4	5
	Ce camp est un endroit sûr pour nous, les réfugiés, nous n'avons pas de problèmes d'insécurité.	1	2	3	4	5
	Le camp dispose d'un bon terrain de jeu pour nos enfants.	1	2	3	4	5
	Les conditions d'hygiène de ce camp ne sont pas un sujet de préoccupation.	1	2	3	4	5
	Nous organisons une campagne de nettoyage dans le camp tous les mois, ce qui nous permet de garder le camp propre.	1	2	3	4	5
	Nous disposons d'eau propre et portable dans le camp pour nos activités quotidiennes.	1	2	3	4	5
	L'absence d'insectes tels que les mouches et les moustiques nous permet de vivre en bonne santé.	1	2	3	4	5
Relations Sociales						
	Je peux compter sur mes amis lorsque les choses vont mal.	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), dans mes relations avec les personnes qui me sont chères, j'ai senti plus de distance que je ne l'aurai souhaité	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), je me suis senti(e) soutenu(e)	1	2	3	4	5
	La population de Gado met à notre disposition des terres agricoles en cas de besoin.	1	2	3	4	5
	J'ai des amis dans la communauté Gado, je leur rends visite et ils me rendent également visite.	1	2	3	4	5
	Je suis en contact avec ma famille restée en CAR	1	2	3	4	5
	Ma famille me manque parfois et je souhaite la retrouver	1	2	3	4	5
	Nous avons de l'eau portable dans le camp et elle est toujours disponible.	1	2	3	4	5
	Je peux me nourrir trois fois par jour.	1	2	3	4	5
	J'ai une personne spéciale qui est une véritable source de réconfort.	1	2	3	4	5
	Je peux parler de mes problèmes avec ma famille	1	2	3	4	6

Soutien Psychosocial

Cognitive						
	En tenant compte de tous les aspects de ma vie intellectuel ma qualité de vie au cours des deux derniers jours (48 heures) a été bonne	1	2	3	4	5
	J'ai pu apprendre un métier depuis que je suis dans ce camp	1	2	3	4	5
	Il ya quelqu'un qui vient nous enseigner quelques activités de renforcement des capacités	1	2	3	4	5
	Chaque mois quelqu'un vient nous apprendre a vivre en paix	1	2	3	4	5
	Chaque mois un groupe de personnes vient nous parler de notre hygiène	1	2	3	4	5
	Nous avons the professeurs spéciaux qui nous enseignent aux camp	1	2	3	4	5
	Nous avons des cours de langue ici au camp pour ceux qui ne parlent pas français	1	2	3	4	5
	Mes enfant vont à l'école et ils ont des professeurs qui leur enseignent.	1	2	3	4	5
	Il y a un groupe de personnes qui viennent nous apprendre a vivre heureux les uns avec les autres.	1	2	3	4	5
	Un groupe de personnes vient chaque mois nous parler de notre sante.	1	2	3	4	5
Affective						
	Au cours des deux derniers jours (48 heures), je me suis senti déprimé(e)	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), j'ai été nerveux (se) ou inquiet (ète)	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), être dans l'incapacité de faire les choses que je voulais faire n'a pas été un problème	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), je me suis senti déprimé(e	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), j'ai été nerveux (se) ou inquiet(ète)	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), je me suis senti(e) triste	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), quand j'ai pensé à l'avenir, je me suis senti terrifié	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), ma vie a été	1	2	3	4	5

	En pensant aux buts que je m'étais fixé dans la vie, je sens que je n'ai rien accompli du tout	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), le niveau de contrôle que j'ai eu sur ma vie a été un énorme problème	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), j'ai eu une bonne opinion de moi-même en tant que personne	1	2	3	4	5
	Chaque mois, quelqu'un vient s'enquerir de mon etat de sante et nous discutons.	1	2	3	4	5
social						
	Au cours des deux derniers jours (48 heures), la communication avec les personnes qui me sont chères a été difficile	1	2	3	4	5
	Nous avons toujours de la lumière dans le camp	1	2	3	4	5
	Au cours des deux derniers jours (48 heures), je me suis senti(e) soutenu(e)	1	2	3	4	5
	J'ai des amis dans la communaute de Gado,je leur rends visite et ils me rendent visite egalement	1	2	3	4	5
	J'ai une source de revenus qui me permet de prendre soin de moi et de ma famille.	1	2	3	4	5
	Lorsque l'un des membres de ma famille ou moi-même sommes malades, on s'occupe toujours de nous.	1	2	3	4	5
	Nous avons parfois des cas de vols et de viols dans le camp	1	2	3	4	5
	J'ai des amis avec lesquels je peux partager mes joies et mes peines.	1	2	3	4	5
	Je peux parler de mes problèmes avec mes amis.	1	2	3	4	5
	Il y a une personne spéciale dans ma vie qui se préoccupe de mes sentiments.	1	2	3	4	5
	Ma famille est prête à m'aider à prendre des décisions.	1	2	3	4	5

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