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Experience with Social Support Systems Among Women Exposed to Intimate Partner Violence in Cameroon

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Walden University
2016

Abstract

Experience with Social Support Systems Among Women Exposed to Intimate Partner

Violence in Cameroon

by

Ahone Esther-Alice Ngujede

MA, Grambling State University, 2008

BS, University of Buea, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

May 2016

Abstract

The southwest and northwest regions of Cameroon have experienced high rates of intimate partner violence (IPV). Limited information is available about IPV victims' experiences with social support systems. This phenomenological study was aimed at investigating IPV victims' lived experiences with social support systems in Cameroon. Some of these systems are the judicial system, police officers, hospitals and clinics, and domestic violence agencies. The Health Belief Model (HBM) and the Transtheoretical Model of Change (TTM) were used to understand how 8 self-identified victims of IPV were able to discuss their lived experiences with social support systems. The research questions addressed women's experiences with social support systems as victims of intimate partner violence. The study also addressed participants' willingness to use social support systems again if the systems were made available to them. Data were gathered through face-to-face interviews using a purposeful-criterion sample that discussed the themes developed after the interview. The participants were selected with the help of 2 local domestic violence organizations based in the northwest and southwest regions of Cameroon. Study findings, which were generated via inductive analyses, indicated that victims sought the help of social support systems at least 3 times in hopes of changing their situation but were not satisfied with these systems. The study conveys social change by encouraging the need to educate social support systems in implementing and developing culturally-sensitive programs to eradicate IPV in Cameroon.

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Dedication

To my extraordinary parents, Bob and Alice.

And to my son, my treasure, Jorden.

I love you!

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Chapter 1: Introduction to the Study

Intimate partner violence (IPV) is a global problem that affects more than 35% of women worldwide and about 38% of those women die as a result (World Health Organization [WHO], 2013). Intimate partner violence is a severe, preventable, public health issue that involves psychological, physical, economical, and sexual harm by a former or current spouse or partner (Centers for Disease Control and Prevention [CDC], 2014a). Females in the Republic of Cameroon have always been subject to severe abuse, a majority of which is deemed a normal and acceptable practice by society (Teke, 2009). Violence against women in this region, including forceful marriage, rape, genital mutilation, breast ironing, and horrifying rituals after the death of a husband/partner is widespread, yet not fully addressed by the civil and criminal codes (Teke, 2009; U.S. Department of State, 2010). The inequitable status of girls and women in the Cameroon society manifests itself in all spheres of their lives. There is little to no evidence that the government has taken action to improve the societal condition of girls or women or to provide them with support groups or systems that could help them prevent abuse.

The WHO (2013) describes domestic violence as all the acts of gender-based abuse or violence. This would most likely result in suffering like mental/emotional and physical harm as well as threats and liberty deprivation whether it is in private or in public. Many terms are used to explain violence against women and girls including but not limited to IPV, battering, abuse, spousal abuse, and gender-based violence.

Several risk factors have contributed to domestic violence in Cameroon, to include poverty, low level of education, illiteracy, especially for women, and alcohol use

(Immigration and Refugee Board of Canada, 2010). Other risk factors include cultural or customary laws, gender inequality, exposure to domestic violence as a child, and witnessing constant violence between friends, families, and parents (Immigration and Refugee Board of Canada, 2010). The most prevalent risk factor is cultural or customary laws that make it almost impossible for women to seek help (Teke, 2009). The socioeconomic cost of domestic violence is high and has continual effects on society. Victims usually suffer from isolation, depression, limited ability to care for their children and for themselves, unable to work, experience severe injuries, contract a disease, and face possible death (WHO, 2013). Pregnant women are either faced with low birth weight children or infant mortality (WHO, 2013). Children who experience domestic violence in their families also suffer from emotional and behavioral problems, which could go on for the rest of their lives (WHO, 2013). The effect of IPV on women concerning mental and physical health is seen through the trauma that is experienced by the victims. Economically, significant financial costs are felt through the reduced productivity of these women in their farms and market sales (United Nations, 2013). The women particularly depend on their farms, so it could be a major problem for them.

Domestic violence social support systems/groups focus on protecting women from future abuse. However, very few women all over the world use these systems, do not have the means of reaching out to the support systems, or do not even know they exist in their community (United Nations, 2013). It is particularly common in developing countries like Cameroon where people believe it to be the cultural norm for women to be abused (Munge, 2009; Teke, 2009). Several studies have also suggested that many of

these women do not report the abuse or do not realize they are being abused (Alio et al, 2011; United Nations, 2013). Focusing on IPV victims' lived experiences with support systems is the priority of this study.

Domestic violence is a social concern and a public health issue that continues in the Cameroonian community. The focus of this study was to explore the perceptions that women who experience IPV in the Cameroon society have about support systems and how they felt about using these systems to help them prevent domestic violence in their lives and the lives of their children. The research focused specifically in the Northwest and Southwest Regions of Cameroon. Eight women from these two regions were interviewed about their experiences with social support systems and how these systems may have helped them cope with IPV. Women in these regions experience high rates of IPV including spousal rape, widow malpractices, beatings, financial restraint, and forceful marriage (U.S. Department of State, 2012). The reason why female genital mutilation and breast ironing are also mentioned in this study is that these practices also lead to women suffering IPV later on in life as most of them are forced into marriage (Abdulcadir, Magaizaz, Boulvain, & Irion, 2011; Dugan, 2013; Tapscott, 2012). Due to their low sexual drive, which results from genital mutilation or breast ironing, these women are prone to rape by their spouses or partners (Immigration and Refugee Board of Canada, 2010; U.S. Department of State, 2012). They may as a result be subject to intimate partner violence, low self-esteem, and the feeling of rejection.

Based on my literature search, there is no known research on the experience with social support systems among women exposed to IPV in Cameroon. A qualitative

research was necessary to understand the thinking of these women in relation to their experiences with social support systems. The phenomenological study was based on research that could improve intervention strategies to address the social circumstances in which these women who experience IPV live. Through the dissemination of study findings, social change for this research could be that it would improve social support systems that help women and girls who experience IPV in Cameroon. It would most likely provide a more stable plan of action for these women and could also improve women's trust and use of support systems, considering that they do not feel supported in a society that encourages domestic violence.

This chapter includes the problem statement, purpose of the study, nature of the study, research questions using a qualitative, phenomenological approach, and conceptual framework using the HBM and the TTM (Stages of Change). It also defines key terms related to the study, and provides the limitations, assumptions, delimitations, and significance of the study.

Background of the Study

IPV is a major public health issue that violates human rights (WHO, 2014). IPV causes short and long term emotional/psychological and sexual/physical problems. This also includes an increased vulnerability to mental health problems, reproductive problems, and sexually transmitted diseases including HIV (WHO, 2014). The phenomenon is common in Africa, regardless of socioeconomic status, with the burden faced mostly by women and girls (WHO, 2012).

In order to get to the focus of this study, a brief background of IPV in Cameroon must be addressed. IPV against women is a widespread problem in Cameroon that has not been adequately addressed by its civil and criminal codes (U.S. Department of State, 2012). Recent data are yet to be made public, but a survey conducted in 2004 posited that at least 13% of women and girls in Cameroon have been sexually assaulted (Teke, 2009). IPV is still prevalent, but not explicitly interdicted under the Cameroonian Penal Code (U.S. Department of State, 2012). Dangerous practices like female genital mutilation and breast ironing occur in almost every region and span through religious and ethnic groups (U.S. Department of State, 2012). Understanding these malpractices would give a better insight on IPV in Cameroon.

IPV is perpetrated in Cameroon by numerous people in the society especially spouses, family members, parents, community members, and public authorities (United Nations [UN], 2013). Traditions and customs of IPV are numerous such as condoning a husband beating his wife, a male family member inheriting the wife after the death of her husband, female genital mutilation, and early/forceful marriage (UN, 2013). It further exceeds as the Cameroon society discriminates against boys and girls especially in the low representation when it comes to decision making and control of family resources (UN, 2013). It makes it extremely difficult for women to prevail in the society.

Although the Cameroonian laws interdicts rapes and provide penalties of about 5-10 years of imprisonment for convicted rapists, the court and police officers hardly prosecute or investigate rape cases (Teke, 2009; UN, 2013). It is also important to note that the Cameroonian law does not address or recognize spousal rape (U.S. Department

of State, 2012). Even more disturbing is that spousal abuse is not grounds for a woman to file for divorce, which in part is also common in the society (UN, 2013).

Customary laws further impose limits on women especially because many regions in the country still consider women and girls as the property of their husbands and fathers (U.S. Department of State, 2012). As a result of these traditions and customs, the few civil laws that are intended to protect women are usually not enforced (UN, 2013). Despite that, the Ministry of Women's Empowerment and the Family has worked tirelessly with other nongovernmental organizations and support systems to promote the legal rights of women, which are yet to be considered a means to success (UN, 2013; U.S. Department of State, 2012).

Social support systems are known in many studies, particularly in the western world, to provide domestic violence services to women including therapy, emergency housing, support groups, church clergy, and criminal justice systems (Zweig & Burt, 2007). Leaving an abusive relationship usually requires emergency shelters, particularly because most of these women are with children and often lack a source of income (Botein & Hetling, 2010). Community based social support systems not only provide therapy and shelter for victims and survivors, they may also act as a place where the women can share their experiences. These experiences with social support systems could encourage the women to get in touch with their hopefulness of being free from domestic abuse and making a better life for them and their children. Several studies have shown that formal and informal social support systems have protected women who have experienced IPV, more so in part by initiating the women and girls' efforts in coping with the violence

(Coohey, 2007; Emmelin, 2013; Hayati, Eriksson, Hakimi, Hogberg, & Hetling & Zhang, 2010). Women believe that they could better cope with IPV through the help of social support systems, especially their families and their communities.

The literature for this study focused on several studies from many geographic locations that concentrated on social support systems and women faced with IPV or domestic violence. Several researchers (Abadi, Ghazinour, Nojomi, & Richter, 2012; Abadi, Ghazinour, Nygren, Nojomi, & Richter, 2013) discussed the effects of social support on women especially those of child bearing childbearing ages and/or pregnant women. They argued that the number of social support programs available did not provide substantial protection for women; however, the researchers insisted that the quality of the social support helped the women (Abadi et al, 2012; Abadi et al, 2013). Other researchers posited that battered women felt like they were not being protected by the legal system (Bendall, 2010; Cabanilla, 2011). This may be a predictor that social support systems could be another reason why some women acknowledge that domestic violence is a problem. Unfortunately, the women never have the courage to either take action or may still be in the contemplation stage of getting out.

Problem Statement

The prevalence of IPV raises the critical question of how women and girls are able to cope in society without the help of support systems like counseling, financial support, and a safe place to escape in the event they felt their lives were in danger. The Republic of Cameroon, with a population of about 21,699,631, has extremely limited laws pertaining to women's rights and domestic violence (The World Bank, 2014). These

laws do not exactly forbid domestic violence, although assault is sometimes punishable by fines and imprisonment yet not always prohibited (U. S. Department of State, 2011). La Maison des Droits de l'Homme (The House of Human Rights) a nongovernmental organization in Cameroon, posited in its 2008 study that nearly 40% of women had suffered some kind of physical abuse from their partners (The U.S. Department of State, 2011). Another survey from the national newspaper Cameroon Tribune indicated that about 20% to 40% of women living with a male partner were victims of either physical or psychological violence (as cited in U. S. Department of State, 2011).

Advocates for women's rights stated that consequences for IPV perpetrators were insufficient or nonexistent in many communities. Spousal abuse or wife battering, especially spousal rape was not any legal ground for women to divorce their husbands (Seelinger, 2010; U. S. Department of State, 2011). These women are physically, sexually, emotionally, or psychologically abused by their partners or spouses and are usually exposed to degradation and torturing after their husbands pass (Duarte, 2008; Seelinger, 2010). Girls as young as 10 years of age are forced to undergo genital mutilation and breast ironing, all these for sake of customary laws (Duarte, 2008; Seelinger, 2010). The 2009 Social Institutions and Gender Index (SIGI) for Cameroon, published under the Organization for Economic Cooperation and Development (OECD), stated that there is a lack of dependable statistics on the number of girls and women affected by violence in the region. They also explained that the number of media reports on these activities is an indication of the widespread phenomenon of IPV (Immigration and Refugee Board of Canada, 2010).

Most domestic abuse occurs with the victims knowing their perpetrators (cohabitation, marriage, or an intimate partner), but it could also occur with a complete stranger, which is extremely common in Africa (Immigration and Refugee Board of Canada, 2010). Domestic violence affects people of every work of life, age, gender, religion, and race (Alhabib et al., 2010). The process could start early in life with a few malpractices. Breast ironing is serious problem in the community and is performed by a close female relative of the girl, usually the mother or grandmother (Alhabib et al., 2010). It was first discovered in 2005 during a survey on incest and rape in Cameroon that was conducted by the German Technical Cooperation Agency (GTZ) (Tapscott, 2012). Those who practice it usually have the notion that it prevents early pregnancies, rape, or sexual harassment, but this has proven to be untrue (Dugan, 2013; Sa'ah, 2006). Breast ironing is a common practice in all 10 regions of Cameroon especially those in the Littoral, northwest, and southwest regions of Cameroon (Mabuse, 2011). This process can be extremely painful and could cause tissue damage (Mabuse, 2011). Scientific studies are yet to confirm, but medical experts believe that there is a chance of women and girls who were victims of breast ironing to later develop severe health problems (Dugan, 2013; Tapscott, 2012). Some of these problems are associated with breastfeeding, cysts, depression, and low sexual drive, which could also lead to IPV or forceful marriage (Dugan, 2013; Tapscott, 2012) and reduce the self-esteem of the women.

Another serious problem that provokes IPV at a later age in Cameroon is female genital mutilation (FGM). It is usually performed on girls between the ages of 10-15 years old and most of the time, the older women in the community initiate and carry the

procedure out; they believe it brings honor to the girl child (WHO, 2013). The older

women feel that if FGM is not done, these girls would be excluded from society;

particularly because the procedure reduces a woman's sexual drive, which they believe is

a sign of purity (United Nations Children's Fund-UNICEF, 2013). Women who have

experienced genital mutilation usually report low sexual drive, psychological problems

such as depression, and feelings of betrayal and shame (Abdulcadir et al., 2011). Despite

the international fight to stop FGM, about 2% of the Cameroonian population still

practice it (UNICEF, 2013). Widow malpractice is prevalent in Cameroon (Jator, 2013).

The painful experience of losing a partner or spouse is not considered enough pain for the

grieving woman. The widow is usually subjected to discriminatory practices from her late

partner's family and society; for example she may have to stay with her former husband's

corpse until it is buried (Jator, 2013). Add summarizing sentences to fully complete the

paragraph. All these malpractices in part subject the women to be future victims of IPV.

There is a great deal of information that is known about the domestic violence

experienced by these women in a community where very few women's rights exist (Teke,

2009). But it is extremely difficult for the victims to identify the few social support

systems that exist, considering that the law already works against them (Duarte, 2008).

The few women who have the courage to report their abusers are usually given brief

counseling sessions at the police station or sent to social centers provided by the Ministry

of Social Affairs and the Ministry of Women's Empowerment and Family at their

expense (Immigration and Refugee Board of Canada, 2010). More so, they are usually

advised to return home to their abusers with no further action taken (Immigration and

Refugee Board of Canada, 2010). This brings the issue here of the relevance of the social

support systems or social support groups to either help them rebuild their lives or run

away from their abusive partners.

Many studies have demonstrated that both informal social support systems

(family, friends, domestic violence advocates, and social groups) and formal social

support systems (police, crisis hotline workers, and shelter) have done an effective job at

protecting battered women and girls against constant violence, possibly in part by

initiating their coping efforts of IPV (Hayati et al., 2012; Panaghi, Ahmadabadi, Ghahari,

& Mohammadi, 2012). Many girls and women in Cameroon face the probability of

returning to their abusers. No known study has been conducted on whether women may

consider not returning if they had support from their families and the communities they

lived in. This was the main focus of this phenomenological study.

Social support systems in every community are critical resources and are

important especially in emergency housing, therapy, and support groups (Zweig & Burt,

2007). Several domestic violence survivors have reported that they were able to live

independently and escape from abuse because of the help of social support systems like

counseling and shelters (Lyon, Lane, & Menard, 2008; Postmus, Severson, Berry, &

Yoo, 2009). However, these services are only utilized or accessible to these women if the

women feel they reap the benefits (Allard, Tolman, & Rosen, 2003). This study was

designed based on a growing amount of international literature that suggested the

experiences of women with social support systems like legal services, shelters,

counseling, and advocacy helped them to escape abusive relationships (Hetling & Zhang,

2010). Given previous findings, this study was framed to explore the lived experiences of abused women with social support systems in Cameroon. Although several studies have researched on the effects of social support systems in many countries, no study has been done in Cameroon. The gap in knowledge with regard to social support systems represents a possible gap in service necessities for victims. Effective and appropriate intervention would entail an understanding of the context of victimization as well as response from social support systems. Investigating IPV victims' lived experiences with social support systems could benefit IPV victims and social support systems by increasing the response to related sensitivity for IPV victims.

Purpose of the Study

The purpose of this qualitative study was to explore the perceptions women and girls have about using social support systems in the southwest and northwest regions of Cameroon. The study explored how they felt about comfortably using these services if they were made available to them. Descriptions of these services to abused women contributes to research in the IPV field, especially in Cameroon, and may also inform domestic violence organizations as they try to connect with victims of IPV. The relevance of social support systems and its performance for victims of IPV has become increasingly significant in curbing domestic violence in Cameroon. Interactive assistance to social support system may offer a cost effective option for victims of IPV and may also broaden the efficacy and scope of services to victims. An essential first step was to understand how IPV victims think about the social support systems and how they respond to these services. This study focused on how comfortable the women would feel using these

services if they were made available to them. A description of these lived experiences

would help to inform social support organizations about how to improve their services to

the women. One important step was to understand how victims of IPV interact with

social support systems and otherwise respond to the consequences of abuse, which was

the primary focus of this study.

Research Questions

One of the conceptual frameworks of this research was the use of the TTM to

focus on women in IPV relationships who may regard the abusive relationship to be

problematic only if they leave the abuser (Catallo, Jack, Ciliska, & MacMillan, 2012). As

a result of the complication in abusive relationships in which the abuser controls all

decisions and situations, the victim's autonomy to make changes is affected. TTM was

intended to be used in relation to the changes and decisions that abused victims can

control despite being in an abusive relationship. Most of these decisions made are

through their experiences of social support systems.

The HBM was also used in this study to understand the lived experiences of these

women in relation to how they cope with IPV and social support systems. Selection of

this framework was based on my observation that victims of IPV seemed to endure their

ordeal. The HBM in this context is an expectation theory, which assumed that an

individual possesses the desire to get better based on their belief that a specific health

action (social support systems) is available for them. These two theories were used to

answer the research questions:

Research Question 1: What social support systems have women used in Cameroon?

Research Question 2: What are women's experiences with social support systems in Cameroon?

Research Question 3: How do women cope with or endure IPV through the help of social support systems?

Research Question 4: How would IPV victims use the social support systems should they get all the services they need?

Nature of the Study

The nature of this study was qualitative research with a phenomenology approach. Using the phenomenology method assisted in recognizing the validity of the participants' experiences and support them in exercising control over their own health in particular and their lives in its entirety (Lin & Niu, 2011). I examined the need for support systems and their experiences and identified the social support systems and coping mechanism phenomena through which they were perceived by the participants in the situation they found themselves in (Davhana-Maselesele, 2011).

Theoretical Foundation

Two theories guided the conceptual framework for this qualitative, phenomenological study. They were the transtheoretical model of change, TTM (stages of change), and the health belief model, HBM. These were used to describe some reasons women and girls are not conversant of, or willing to use, social support systems in Cameroon. The TTM evaluates individuals' willingness to act on healthier behaviors,

provide strategies of change for guiding the individuals through the stages of change to action and maintenance (Greene et al., 1999). These stages of change to action and maintenance include (a) precontemplation/not ready for change, (b) contemplation/getting ready for change, (c) preparation/ready for a change, (d) action/acquiring healthier behaviors, (e) maintenance/sustaining the action, and (f) termination/making sure they do not return to unhealthy behaviors (Prochaska & Velicer, 1997). Curbing IPV in Cameroon could be an extremely daunting process. Studying experiences of lived experiences of IPV victims and support systems could be explored through the stages of change using the TTM. The TTM supported research findings and acted as a guide to improve support systems or make them more accessible in order to effectively evaluate interventions.

Developed in the 1950s, the HBM was developed to predict and explain health behaviors, especially with regard to health services (Carpenter, 2010). The theoretical constructs that guide this theory are perceived severity of a health issue, perceived susceptibility or subjective assessment of the health problem, perceived benefits of a health action taken, perceived barriers, cues to action or trigger to engage in health promotion, and self-efficacy to successfully change a behavior (Carpenter, 2010; Chapin, 2011). Going through the five constructs of the HBM, these women's lived experiences with social support systems could provide further information on whether their experiences with social support systems are helping the women perceive the health benefits of living violence free lives. The models were also used to encourage them to improve their quality of life and that of their children (Hodges & Cabanilla, 2011;

Munge, 2009). Cameroonian women's perspectives about social support systems were examined in this study as well as the domestic violence resources they felt are available or accessible to them.

Conceptual Framework

A phenomenological research was the conceptual framework used for this study. The study was aimed at exploring victims of IPV's lived experiences of social support systems in Cameroon and the phenomenological approach focused on their lived experiences. The approach focused on discussions, storytelling, and allowing room for many questions in respect to the study. As the researcher, I was given the opportunity to follow up on questions and draw conclusions from a variety of health-related issues. Data were collected from eight participants who have experienced IPV and have used social support system including family, friends, legal system, church, or other social support organizations. I used a pilot study to test the questions that were used for the eight participants in the study. The data were collected in the form of face-to-face, semi structured interviews in an environment that was most comfortable for the participants. The locations selected were the two organizations that were selected for the Northwest and Southwest Regions in Cameroon. Discussion on the data collection strategies is provided in detail in Chapter 3.

Definitions of Terms

Several terms were defined and briefly discussed to support the basics of this study on IPV.

Abuser/Perpetrator: These are people, usually men who find pleasure in looking down on others, usually women and children. They sexually, emotionally, physically, and financially assault others, causing mental and/or physical harm to the victims (Rooij, Haaf, & Verhoeff, 2013).

Breast ironing or breast flattening is an extremely painful procedure that involves pounding and massaging of a girl's breasts with the use of a heated object in an attempt to stop the breast from developing or to make them disappear (Mabuse, 2011). The heated object usually includes a pestle, stone, and/or cast-iron pan (Mabuse, 2011).

Domestic Violence Social Support Systems are formal programs of assistance that are available for domestic violence victims or survivors (Heaney & Israel, 2008). Some social support systems include public health officials, police officers, and the judicial system or could be informal supports from community members/groups, family members and friends (Heaney & Israel, 2008). Social support systems range from shelters, emergency money, counseling, encouragement, and therapy.

Female genital mutilation (FGM) or female circumcision is a ritual practiced in about 30 countries in the Middle East and Africa whereby the female genital organ is intentionally altered or cut off for nonmedical reasons (WHO, 2013).

Intimate Partner Violence (IPV) is interchangeably used with domestic violence. IPV or domestic violence is a patterned behavior that affects women and men alike all over the world which involves one person abusing another and the abuser feels the act is acceptable and justified (Alhabib, Nur, & Jones, 2010). Domestic violence could involve many things including sexual, emotional, physical assault or aggression, verbal control,

humiliation, domination, or intimidation, and economic abuse or deprivation (Ortiz-Barreda & Vives-Cases, 2013).

Widow malpractice is extremely common in Cameroon and some of the malpractices include sleeping on the floor (sometimes in the same room with the corpse of her husband before he is buried) or on bamboo for a certain number of days, shaving their hair, and wearing black for up to 1 year (Jator, 2013). The widows have to leave in seclusion, her husband's properties confiscated by his family, and she is sometimes given to her late husband's brother as his wife (Jator, 2013).

Assumptions

The main assumption of this research was that women's lived experiences could give social services an idea of how to prioritize their interventions. Research has identified social support systems as a feature of opportunities for addressing a variety of IPV issues, including coping with serious chronic and infectious diseases (Coursaris & Liu, 2009) like depression and sexually transmitted infections. Communities in Cameroon could also develop more effective ways to respond to violence if they have a better understanding of the causes.

Another assumption in this study is that social support systems can either be a generally positive activity that victims of IPV find beneficial as they address abuse concerns, or viewed as a problem for victims of IPV because social support systems can as well create negative consequences depending on the way the support is accessible (Trotter & Allen, 2009).

It was also assumed that the phenomenological, qualitative research would identify messages that could help social systems present better messages to the media and the government in order to join the international fight of curbing domestic violence. These assumptions are backed by another assumption that women and girls who have experienced IPV would be the main sources of information in respect to their experiences with social support systems and how their lives have been affected by domestic violence. Only these women can best explain their situations, so their experiences with support systems are extremely important.

Scope and Delimitations

The scope of this phenomenological study focused only on victims of IPV's lived experiences with social support systems in the northwest and southwest regions of Cameroon. The study focused on social support systems to find out if they were helpful to victims of IPV and to pave room for further research on how to develop better intervention strategies for abused women all over Cameroon.

A delimitation to this study is the setting of the research. The population for the study was limited to the northwest and southwest regions of Cameroon, which was one of the criteria for participants to take part in the study. Other parts of the country were not included in this study due to time constraints and the diversity of the population of Cameroon.

Limitations

The main limitation of this study was the small sample size. Eight participants were interviewed for this study; four to five from the southwest region and/or four to five

from the northwest region of Cameroon. These participants had to be experiencing or had

experienced IPV and contacted social support systems. Data collection from these two

areas would mean that the study cannot be generalized to the greater population, which

has 10 regions and an estimated population of 23 million (World Bank, 2013).

Another limitation was researcher bias. My personal views as the researcher

might have influenced the study, from the questions to the findings and interpretation

(Haj-Yahia & Cohen, 2009), which are vital components to the study. I had to be less

judgmental and remain open minded throughout the process.

Significance

The results of the study could provide a better understanding of how participants

felt about using social support systems. Are they accessible and would the services help

them curb the domestic abuse they experience in their homes and communities (Sarkar,

2010)? This study aimed at broadening and understanding victims' lived experiences

with social support systems. The experiences could provide information for future

research on the role of social support systems in Cameroon including their effectiveness,

availability, and their success in curbing IPV in Cameroon. Considering that this is a

qualitative research, future studies would be needed to get insight of more participants.

This would have to include a bigger sample size so that the results could be generalized

to the general population (Banerjee & Chaudhury, 2010). The findings in this study could

also contribute to social change by possibly influencing the activities of social services in

Cameroon and other personnel who interact with victims of IPV. Understanding how

victims use services could contribute to more vigorous strategies for intervention. It

would account for the full variety of advice, information, and support to which victims may have been exposed to from participating in social support systems of domestic violence. Furthermore, through this study and future studies, prosecution, probation, and law enforcement officers could modify their procedures and practices to accommodate IPV victims' needs. This would mean increasing their safety and improving outcomes that could be more or less extremely devastating to the woman in particular, her children and the family in its entirety. Ultimately, a deeper understanding of women's use of social support systems in Cameroon could improve the domestic violence agencies that strive in this area to serve victims of IPV both in their home and their workplace. Focusing on this parameter is in hopes of bringing forth social change. According to Walden University (2012), social change is involvement in activities that include leveraging knowledge for addressing challenges in a given community. It is usually one that the researcher belongs to, and that could bring forth a change in behavior. Therefore, using the TTM and the HBM in addressing women's lived experiences with social support systems, further research could address whether the women are aware of the danger of domestic violence through these support systems. They would understand if they know the benefits and are willing to leave their abusers to make a better life for themselves and their children.

Summary

Intimate Partner Violence is a significant public health problem that brings with it great effects on women, young girls, their families, and the socioeconomic community. IPV victims respond to abuse differently, especially in the Cameroonian community.

Some believe it is a normal situation to be abused and others try to leave it with little or no support. The few who have had some support from social support systems would be examined in this study using the TTM and the HBM. Chapter 1 provided a brief overview and history of IPV, particularly in Cameroon; some definitions that would be frequently used in the study as well as the study's purpose, significance, scope, limitations, delimitations and research questions were presented. Chapter 2 provided a review of the literature as concerns social support systems and IPV, including studies that have been carried out all over the world. Chapter 3 explained the methodology chosen for this study as well as some background of the selected cases that would be used as the data for this study. Chapter 4 provided an interpretation of the findings that could be applicable to social change in the Cameroon community. Chapter 5 provided suggestions including further studies on the subject that was being discussed.

Chapter 2: Literature Review

Introduction

Intimate partner violence is a complex public health problem that affects families and communities all over the world. The abuse occurs in every setting and among all cultural, religious, and socioeconomic backgrounds with the overwhelming burden borne mostly by women and children (WHO, 2012). A comparative analysis of data was collected from nine African countries. The researchers discovered that the percentage of women who reported ever experiencing violence by their current or former partner ranged from 18% to 48%, 20% to 75%, and 4% to 17% for physical, emotional, and sexual violence respectively (WHO, 2012). In a 2004 study, Cameroonian women reported high rates of IPV with about 39% reporting that they had been physically abused (Alio et al., 2011). Also, 30.7% reported emotional abuse while more than 14% explained that they had experienced sexual abuse by their partners (Alio et al., 2011).

The prevalence of IPV has given attention to the need for the ability of girls and women to cope in the community with or without the help of social support systems. They are usually in need of a safe shelter, the community's help, financial support, and counseling. Several studies carried out, particularly in the western world, suggested that social support systems are known to provide domestic violence services to women, particularly criminal justice systems, emergency housing, therapy, church clergy, and support groups (Botein & Hetling, 2010; Hayati et al., 2013; Zweig & Burt, 2007). Leaving abusive relationships often requires emergency shelters, especially for the

women who leave with their children and usually have no source of income (Botein &

Hetling, 2010).

Although substantial research has been done on social support systems all over

the world, no known research has been related to IPV and support systems in Cameroon.

Considering the focus of this study, this review was linked to extensive research that had

been carried out on social support and the lived experiences of women who are victims of

IPV. It may have also traced the most recent developments concerning IPV victims'

experiences and the potential benefits and challenges of social support systems. The

significance of this study was strengthened by the analysis of similar studies that

examined IPV victims' lived experiences with social support systems in general and in

the context of developing countries in particular.

Problem

The prevalence of IPV in Cameroon raises the critical question of how women

and girls are able to cope in society without the assistance of social support systems,

which include mental health and counseling, financial services, and a safe place to escape

in case they felt their lives were in danger. Despite the fact that much is known about IPV

experienced by the women in a community where very few women's rights exist (Teke,

2009), it is even more difficult for the victims to identify the few social support systems

that exist. This is because the Cameroonian law already works against their favor

(Duarte, 2008). The few women who have the courage to report their abusers are usually

given brief counseling sessions at the police station or sent to social centers provided by

the Ministry of Social Affairs and the Ministry of Women's Empowerment and Family at

their expense (Immigration and Refugee Board of Canada, 2010). More so, they are usually advised to return home to their abusers with no further action taken. This brings the issue of the relevance of social support systems or support groups to either assist victims in rebuilding their lives or run away from their abusive partners.

Many studies have demonstrated that both informal social support systems and formal social support systems have done an effective job in protecting battered women and girls against constant violence, possibly in part by initiating their coping effort to IPV (Panaghi, Ahmadabadi, Ghahari, & Mohammadi, 2012). Some of the informal social support systems include family, friends, domestic violence advocates, and social groups. The formal social support systems include police, crisis hotline workers, and shelters. Many girls and women in Cameroon face the probability of returning to their abusers. No study has been conducted on whether they may consider not returning to the abusive situation if they had support from their families and the communities they lived in.

Social support systems in every community are extremely important, especially emergency housing, therapy, and support groups (Zweig & Burt, 2007). Several domestic violence survivors have reported that they were able to live independently and escape from abuse because of the help of social support systems like counseling and shelters (Lyon, Lane, & Menard, 2008; Postmus, Severson, Berry, & Yoo, 2009). However, the services are only utilized or accessible to these women if the women feel they reap the benefits (Allard, Tolman, & Rosen, 2003). The study builds on a growing amount of literature that suggested that the woman's experiences with social support systems like

legal services, shelters, counseling, and advocacy have helped them escape abusive

relationships (Hetling & Zhang, 2010).

Given previous findings, this study was framed to explore the lived experiences of

abused women with support systems in Cameroon. Although several studies have

researched on the effects of social support systems in many countries, no study has been

done in Cameroon. The gap in knowledge with regard to social support systems also

represents a possible gap in service necessities for victims. Effective and appropriate

intervention would entail an understanding of the context of victimization as well as

response from social support systems. Investigating IPV victims' lived experiences with

social support systems could benefit IPV victims and social support systems by

increasing the response to related sensitivity for IPV victims.

Purpose

The purpose of this qualitative study was to explore the perceptions women and

girls have about using social support systems in the southwest and northwest regions of

Cameroon. The study explored how they felt about comfortably using these services if

they were made available to them. Description of these services to abused women

contributes to research building in the IPV field, especially in Cameroon, and could also

inform domestic violence organizations as they try to connect with victims of IPV. The

relevance of social support systems and its performance by victims of IPV has become

increasingly significant in curbing domestic violence in Cameroon. Interactive assistance

by social support systems victims of IPV may offer a cost effective option for provision

of assistance and may also broaden the efficacy and scope of services to victims. An

essential first step was to understand how IPV victims think about the social support

systems and how they respond to these services. This study focused on how comfortable

the women would feel using these services if they were made available to them. A

description of abused women's lived experiences would help in informing social support

systems on how to improve their services to the women. One important step was to

understand how victims of IPV interact with social support systems and otherwise

respond to the consequences of abuse, which was the primary focus of this study.

Synopsis of Current Literature Relevant to the Study

The literature for this study laid emphasis on several studies from different

geographic locations that focused on social support systems and women faced with IPV

or domestic violence. Some researchers (Abadi, Ghazinour, Nojomi, & Richter, 2012;

Abadi, Ghazinour, Nygren, Nojomi, & Richter, 2013) discussed the effects of social

support on women, especially those of child bearing ages and/or pregnant women. They

argued that the number of social support systems available did not provide substantial

protecting effects, but the quality of the social support helped the women. Other

researchers posited that battered women felt they were not being protected by the legal

system (Bendall, 2010; Cabanilla, 2011). This could be a predictor that social support

systems could be another reason why some women may acknowledge that domestic

violence is a problem. Unfortunately, they do not have the courage to take action or are

still in the contemplation stage of getting out.

Another researcher posited that some victims or survivors relied on online

information and groups for social support (Hurley, Sullivan, & McCarthy, 2007). Some

domestic violence victims face enormous barriers of using social support systems because of the influence of community leaders and government officials (Kulwicki , Aswad, Carmona, & Ballout, 2010), while social norms affect women's perceptions of spousal abuse (Linos, Slopen, Subramanian, Berkman, & Kawachi, 2013). This, of course, is very common and related to the Cameroonian society that was examined in this study. Peltzer and Pengpid (2014), Salihu et al., (2010) and Simister (2010) discussed the malpractices like female genital mutilation and breast ironing and how there was a need for the women to be enlightened by social support systems in order not to accept the malpractices. This was further explained by Ortiz-Barreda and Vives-Cases (2013), who addressed several domestic violence laws for women and girls. The Pan American Health Organization (PAHO) and the United Nations implemented laws to help reinforce Violence against Women (VAW) inhibition and offer better cohesive victim care, protection, and support.

Other researchers believed that social support should be extended especially to hospitals and clinics where victims usually have first contact after an abusive experience. Selic, Pesjak, Kopcavar-Gucek, and Kersnik (2008) and Trevillion, Agnew-Davies, and Michele (2012) posited that the relationship between patients and their doctors, and the patients' willingness to open up if the doctors asked them should be examined. This is because their doctors could be used as their primary support systems.

Strategy Used for Literature Review Search

A review of journal articles and related information on IPV victims' lived experiences with social support systems was conducted in order to give a synopsis of

what the women in Cameroon experience with social support systems. These journal

articles were taken from MEDLINE, CINAHL, PubMed, Science citation index, Science

direct, and Sage. Peer-reviewed articles were used as the primary search studies, most of

them published within the last 10 years. Since not many studies about IPV and social

support systems have been conducted in Africa and Cameroon, several journal articles

were used from all over the world. Key terms used during the search included *IPV*

prevalence in Cameroon, *social support in Cameroon*, *coping with breast ironing*, and

widow malpractices. It also included *IPV statistics, lived experiences of abused women*

and support systems, domestic violence in Cameroon, IPV risk factors, IPV effects, and

social support and IPV in Cameroon.

Combination of the Search Terms Used

Several combinations of search terms were used to increase access to literature

and relevant information for the study. The main search terms used were *IPV, domestic*

violence, women, girls, widowhood, Cameroon, gender inequality, Cameroon history,

and *Cameron culture*. Other terms included *social support, support systems, IPV risk*

factors, IPV effects, Africa, and *women's health*. Some other search phrases were used in

combination of the terms like *social support networks in Ca*meroon, and *women's rights*

in Cameroon. Additional terms used were *women's rights in Africa, prevalence and*

incidence of domestic violence in Cameroon, practice of widowhood in Cameroon/Africa,

IPV and social support in Africa, patriarchal rights, and *gender inequality*. These

phrases and keywords were used to conduct an inclusive literature review, which

contributed to the evaluation of the beliefs, attitudes, and knowledge of Cameroon in

particular and Africa in general's lived experiences of social support systems as a victim of IPV. Since not much was found in African studies, the search was further extended to developing countries and global effects of IPV as well as risk factors.

Description of the Iterative Search Process

The iterative search process provided a brief explanation of the specific search terms that were used and the corresponding databases. These databases and terms were exploited to provide and inform relevance for the study.

EBSCO HOST: IPV and social support, domestic violence in Cameroon, and role of social support and domestic violence.

CINAHL: Gender inequality in Cameroon and Africa, IPV and the role of social support, and history of IPV and social support.

PUBMED: Social support systems, IPV, Cameroon, Africa, and women's lived experiences with social support.

MEDLINE: Social support, domestic violence, IPV in Cameroon and Africa, support for breast ironing, and support for widowhood in Africa.

SCIENCE DIRECT: Social support, IPV, domestic violence, and gender inequality in Cameroon and Africa.

SAGE: Gender inequality, Cameroonian and African culture, IPV victims' perception of social support systems, the role of support systems and IPV or domestic violence, and domestic violence and social support in the world.

SCIENCE CITATION INDEX: Social support, IPV, domestic violence, women, gender inequality, breast ironing, and widow malpractices.

Theoretical Foundation

The two theories examined in this study were the heath belief model and the

transtheoretical model of change or the stages of change. The TTM model has been used

for effective interventions of promoting healthy behavioral changes. These stages of

change to action and maintenance include (a) precontemplation/not ready for change, (b)

contemplation/getting ready for change, (c) preparation/ready for a change, (d)

action/acquiring healthier behaviors, (e) maintenance/sustaining the action, and (f)

termination/making sure they do not return to unhealthy behaviors (Prochaska & Velicer,

1997). The model was used in understanding the order of events that have led to IPV

disclosure to social support systems for key participants.

The TTM explored processes of change that people usually undertake when trying

to make behavioral changes following these major steps: precontemplation,

contemplation, preparation, action, and maintenance (Prochaska, DiClemente, &

Norcross, 1992). In the precontemplation stage, the victims of IPV do not recognize the

abuse and are not interested in change (Catallo et al., 2012). They respond by living in

denial and remaining defensively resistant to the external pressures of the process of

change (Catallo et al., 2012) described the women in this stage as refusing to

acknowledge that their partners are abusive and feel their relationships with these men

are normal. This attitude is extremely common in the Cameroonian society (Teke, 2009).

In the contemplation stage the women recognize the abuse as a problematic behavior and

have some kind of awareness of the advantages and disadvantages of the process of

change (Burke, Denison, Gielen, McDonnell, & O'Campo, 2004). Most of the time, IPV

victims in this stage are usually not yet ready to leave their abusers. This is sometimes

because women do not have control of their situations (Burke et al., 2004; Catallo et al.,

2012). There are definitely no time periods for victims to move from one stage to

another, but they may remain in the precontemplation and/or the contemplation stages for

several years (Prochaska et al., 1992).

In the preparation stage, women who experience IPV recognize that the abusive

behavior is problematic. At this stage, they intend to change and even develop an escape

plan (Burke et al, 2004). Victims at this stage usually do not have an effective action plan

but have tried many actions of escape. Chang et al (2006) posited that in the preparation

stage of the TTM model women attempted to create plans for change which was more

obvious during the action stage. Here, participants commit energy and time to modify

their behaviors (Chang et al., 2006).

Brown (1997) argued that with women exposed to IPV, relapsing into a

previously attempted stage has a lower chance of occurring in the maintenance stage than

in the action stage. Brown further explained that women in the maintenance stage of the

TTM model are those that leave their abusers and attempt to rebuild their lives, hoping

never to return to their abusers. Several studies explored the change process among

women who have experienced IPV and their need for social support systems in order to

help them leave abusive relationships (Catallo et al., 2012). Because of the complication

of IPV where the abusers exert control over the situation as well as many other decisions,

these impacts abused women's independence to make changes (Catallo et al., 2012). As a

result, the TTM, would be considered in relation to changes and decisions that these

women can control despite the fact that they are still in the abusive relationships (Catallo et al., 2012). Some of the things they can control are using social support systems especially for financial, physical, and emotional support. Very little is known about abused Cameroonian women's decisions and changes when preparing to reveal IPV to support systems and how they feel after revealing their problems to them. Recognizing the stages of change for these women and their experiences with social support systems could help improve social support systems in planning suitable support for IPV disclosure.

The second model that was addressed in this study was the HBM. Developed in the 1950s, the HBM was developed for predicting and explaining health behaviors, especially with regard to health services (Carpenter, 2010). The HBM suggested that a diversity of factors affect an individual's self-reported probability of participating in preventive efforts (Cornelius, Sullivan, Wyngarden, & Milliken, 2009). The theoretical constructs that guide this theory are (a) perceived severity of a health issue, (b) perceived susceptibility or subjective assessment of the health problem, (c) perceived benefits of a health action taken, (d) perceived barriers, (e) cues to action or trigger to engage in health promotion, and (f) self efficacy to successfully change a behavior (Carpenter, 2010; Chapin, 2011). Going through the five constructs of the HBM, these women's lived experiences with social support systems could provide further information on whether their experiences with support systems are helping the women perceive the health benefits of living violent-free lives. The HBM could be applied to describe the health behaviors when there is a delayed use of social support services. Social support systems

have to acknowledge battered women's beliefs and behaviors so as to properly provide the most suitable intervention as well as prevent further delay for IPV victims. According to the HBM, an IPV victim needs to acknowledge perceived susceptibility prior to changing her condition in order to further prevent abuse (Chapin, 2011). The perceived benefits and barriers of the IPV victim could be influenced by their decisions to either get out of the abusive environment or remain there. The many barriers including lack of suitable or sufficient resources could prevent an IPV victim from either trying to change their situation or get some assistance from social services.

Intimate Partner Violence as a Public Health/Social Problem

Intimate partner violence is fundamentally associated with the societal oppression of girls, children, women, individuals with disabilities, bisexuals, transgender, gays, lesbians, and many other ostracized groups (National Coalition against Domestic Violence [NCADV], 2009). Different target groups experience unique problems of abuse that stem from various sociocultural, societal, and historic realities and experiences. Therefore, the work to eradicate or reduce IPV involves work across all lives, races, ethnicities, tribes, religion, and countries (NCADV, 2009). Intimate partner violence is usually referred to abuse that occurs within a couple, which could be cohabitation or marriage and the perpetrators are usually men (Briones-Vozmediano, Agudelo-Suarez, Goicolea, & Vives-Cases, 2014; Krug, 2002). The WHO defines IPV as a behavior in an intimate partner relationship that has caused sexual, physical, and psychological (especially controlling) behaviors of the abuser, and economical harm to one of the partners (WHO, 2002).

According to the NCADV (2009), one out of four women have experienced domestic abuse in their lifetime and over 1.4 have been victims of IPV every year. The research further explained that 85% of these victims are women and most of them personally knew their perpetrators. Also, those at greatest risk were women between ages 15 and 24 with very few of them ever reporting the abuse (NCADV, 2009; WHO, 2013). Research conducted from 10 countries revealed that about 15% to 71% of girls and women were victims of IPV especially sexual and/or physical abuse. In a recent study, over 30% of women globally have experienced IPV with about 38% of these women being murdered by their intimate partners (WHO, 2013). It was also reported that about 54 % reported intimate partner abuse within 12 months prior to when the study was conducted (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). The WHO also reported that the prevalence was highest in Eastern Mediterranean (37%), South-East Asia (37.7%), and African (36.6%) regions, with an estimated 37% of women and girls having experienced IPV in their lives at some point.

Researchers in Africa find it extremely difficult when collecting proper data about domestic violence especially because of certain gender norms or societal expectations about the man's patriarchal responsibilities, roles, and rights over women, girls, and children (Shamu, Abrahams, Temmerman, & Zarowsky, 2013). In South Africa for example, there are several estimates (Gass et al., 2010), but a study that was nationally conducted indicated that about 19% of women had a lifetime of IPV prevalence (Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009). Another study from South Africa also indicated that a woman was murdered by her intimate partner every six hours (Mathews

et al., 2004). Bergen and Bukovec (2006) also found out that spousal or intimate partner

rape ranged from 10% to 14%, rates that are believed to be higher than researched.

Interventions are constantly needed to protect these women and girls from their abusers.

Cameroon, which was the main focus of concern in this study, also faces high

rates on IPV. A 2004 survey posited that over 12% of women and girls in Cameroon

were sexually assaulted (Teke, 2009) and another estimate posited that more than

500,000 were raped (The Advocates for Human Rights, 2014). The girls especially had to

undergo precarious practices like breast ironing and female genital mutilation, which was

common in several regions and spanned throughout religious, ethnic, and cultural groups

(U.S. Department of State, 2012). Intimate partner violence is perpetrated in Cameroon

by numerous people in the society especially spouses, family members, parents,

community members, and public authorities (United Nations, 2013). Traditions and

customs of IPV are numerous like condoning a husband beating his wife, wife inheritance

by a male family member after the death of her husband, female genital mutilation, and

early/forceful marriage (United Nations, 2013). It further exceeds as the Cameroon

society discriminates against boys and girls especially in the low representation when it

comes to decision making and control of family resources (The Advocates for Human

Rights, 2014).

Effects of Intimate Partner Violence

Intimate partner violence is a huge public health threat as well as a disturbing

societal epidemic that violates human rights (Catalano, Smith, Snyder, & Rand, 2009). It

threatens the wellbeing of several families and individuals across socioeconomic and

ethnic groups (Williams, Oliver, & Pope, 2008). The socioeconomic cost of IPV is immense with rippling effects on communities. Victims usually suffer from limited ability to care for themselves and their children, depression, isolation, inability to work, contract sexually transmitted infections (STIs), especially HIV, are severely injured, and sometimes left to die (WHO, 2013). Intimate partner violence is extremely problematic during pregnancy as it negatively impacts women's health and most likely affects their babies. Many studies have shown that IPV affects pregnancy complications, low birth weight, miscarriages, gynecological disorders, chronic pain, neurological disorders, anxiety, disability, post-traumatic stress, STIs and/or HIV, and abortions (Abadi et al., 2013; Audi, Correa, Latorre Mdo, & Santiago, 2008; Shamu et al., 2013). It has also led to other conditions like cardiovascular diseases and hypertension. Many researchers believe that breast ironing causes breast cancer, especially for women who have experienced it over a long period of time (Dugan, 2013; Tapscott, 2012; WHO, 2013).

Many incidents of injury and death (38%) have been reported worldwide and majority of them come from IPV, which in turn reduces victims use of health services (WHO, 2013). Women who had experienced IPV especially sexually and physically reported higher rates of serious health issues (WHO, 2013). Compared to women who have not experienced IPV, they were 32% more likely to commit abortion, 16% more likely to have a baby with a low birth weight, about 40% more likely to be depressed, and 25% more likely to contract an STI, especially HIV (WHO, 2013).

Intimate partner violence has also been linked to poor child development and health, with some children learning from the abuse and becoming abusers themselves

(Lang and Stover, 2008). More than half of the children who witness IPV intervene in some way either by yelling for the abuser to stop, trying to get away from the abuse, or calling for help (Hamby, Finkelhor, Turner, & Ormrod, 2011). These usually leave the children traumatized for life with some trying to walk their way through it the best way they can or also becoming abusive or getting into abusive relationships. Several studies have indicated that post-traumatic stress disorders (PTSD) are major concerns for children who were witnesses to IPV, having to deal with emotions like depression and anxiety (Lamers-Winkelman, Schipper, & Oosterman, 2012). They also faced problems like sleeping disorders, bad eating habits that usually led to obesity, pain, lack of self-esteem, and possible self inflicted harm (Hamby et al., 2011). A study conducted by Hamby, Finkelhor, Turner, and Ormrod (2010) found out that more than half of IPV abusers and victims had witnessed domestic violence in their lives. This is especially common with children in Cameroon who are exposed to these problems at a tender age and with the patriarchal upbringing, they usually feel it is a right and it is normal in society (Munge, 2009; Teke, 2009).

Intimate partner violence economically affects low income and middle income countries with the severity highly witnessed in poorer countries (WHO, 2015). Due to underreporting, there are few studies that give exact estimations of the economic effects of IPV in these countries. In comparison with high income countries, economic losses linked to productivity tend to be underestimated in low and middle income countries since the losses are based on unavoidable income and wages (WHO, 2015). An IPV homicide for example is said to cost about $15,000 in South Africa, but increases when it

comes to high income countries with about $80,000 in New Zealand, about $600,000 in Australia, and a whopping $2 million in the United States (WHO, 2015). In all, IPV reduces the rate of productivity and the quality of life for those that are affected by it.

Brief History of Cameroon and Women's Role in Society

The republic of Cameroon is a country in Central Africa located on the Gulf coast of Guinea. It shares borders with Chad, Central African Republic (CAR), Equatorial Guinea, Nigeria, Gabon, and Republic of Congo (Awasom, 2002). Cameroon got its name from the Portuguese during the 16th century who found a lot of shrimp in the Wouri River and decided to name the colony 'Rio dos Cameros,' which means the 'river of prawns' (Awasom, 2002). The original residents of Cameroon are Pygmies from Baka who are still in the East and South Regions of the country (Awasom, 2002). Around the mid-1800s, Cameroon and parts of its neighboring counterparts became a German colony. It was later named Kamerun, and the Germans made the capital Buea, and then later changed it to Yaoundé (Awason, 2002).

By the end of the World War I, Cameroon was partitioned by the League of Nations, giving 80% to the French and the remaining 20% to the British. A self-governing leadership was created by Ahmadou Ahidjo in 1959, of which he became President and later helped Cameroon gain independence on January 1, 1960 (Muko, Tchangwe, Ngwa, & Njoya, 2004). Southern or English Cameroon, which had become part of Nigeria, later voted to join English and French Cameroon in 1961 (Awasom, 2002). Ahidjo was replaced as president of Cameroon (or Cameroun) in 1982 by his vice

president Paul Biya. Biya has been the head of the government since 1982, making him one of the longest presidents in the same position (Awasom, 2002).

During the colonial era in Cameroon, men were recruited by colonial masters to fight each other in various villages (Kuate, 2009). This in turn made the men feel more important than the women, thus stretching the gender inequality gap. Men were also offered opportunities to get education as well as own lands, work in the public and government services, thus were considered higher in status than women (Kuate, 2009). Men were also given the power and right over women to decide about their families on things like how to bring up their children, divorce, healthcare, land ownership, and marriage (Kuate, 2009). Men had rights and power to decide over vital social issues like marriage, healthcare, divorce, land ownership, and child upbringing (CEDAW Report, 2011). These inequalities have since molded ideology, beliefs, and attitudes of women and men in terms of their sociocultural issues, health, and the economy.

Several risk factors have contributed to IPV in Cameroon. Most of these factors include high illiteracy rates especially among women and girls, customary/cultural laws, poverty, having been exposed to domestic violence as a child, witnessing constant violence among family (especially parents), friends, alcohol, and gender inequality (Immigration and Refugee Board of Canada, 2010). What particularly increases the core risk factor is customary and/or cultural laws that make it almost impossible for women to seek help from their abusers, even if they wanted to (Teke, 2009).

Incidence and Prevalence of Intimate Partner Violence in Cameroon

Women and girls in Cameroon are constantly faced with IPV, majority of them believing it is a natural circumstance in the community. Intimate partner violence in this region, especially horrifying rituals after the death of a partner, rape, breast ironing, forceful marriage, genital mutilation, and beatings, are not being properly addressed by the criminal and civil court of justice (Teke, 2009; U. S. Department of State, 2010). The imbalanced status of women in society demonstrates that in all spheres of their lives, with extremely limited evidence, the government has not taken any actions to ameliorate their status or provide them with social support systems that could help them curb domestic violence in their lives.

Bamiwuye and Odimegwu, (2014) conducted a study in Cameroon for married women ages 15 to 49 and found out that out of the 3,691 women surveyed, 57.6% reported having experienced physical, sexual, and emotional abuse. Another study conducted in Eastern Cameroon discovered that the lifetime prevalence of partner abuse among these women was as high as 35% and a lifetime incidence of abuse was about 64% (Parmar, Agrawal, Greenough, Goyal, & Kayden, 2012). The women also reported that most of these assaults were inflicted by their partners or husbands, while a few reported that some of the perpetrators were armed groups (Parmar et al., 2012).

Some other estimates have projected that every year in Cameroon the number of women that were raped was as high as 500,000 (The Advocates for Human Rights, 2014). Intimate partner violence is still prevalent, but not explicitly interdicted under the Cameroonian Penal Code. Dangerous practices like female genital mutilation and breast

ironing occur in almost every region and span through various religious and ethnic

groups (U.S. Department of State, 2012).

Intimate partner violence is perpetrated in Cameroon by numerous people in the

society especially spouses, family members, parents, community members, and public

authorities (United Nations, 2013). Traditions and customs of IPV are numerous like

condoning a husband beating his wife, wife inheritance by a male family member after

the death of her husband, female genital mutilation, and early/forceful marriage (United

Nations, 2013). It further exceeds as the Cameroon society discriminates against boys and

girls especially in the low representation when it comes to decision making and control of

family resources (The Advocates for Human Rights, 2014).

Risk Factors of Intimate Partner Violence

Understanding the risk factors that are associated with IPV helps to frame the

lived experiences of women and their various reasons for seeking help from social

support systems, helping to recognize better intervention strategies and determining

effective measures. Anyone can be abused regardless of their level of education, income,

ethnicity, age, and income level. Risk factors are accompanied with the likelihood of IPV

perpetration and victimization.

It should be noted that not everyone who is considered at risk of IPV will actually

become a victim or perpetrator and the risk factors may or may not have direct causes

(CDC, 2014). Victim and perpetrator risk factors are sometimes the same, while others

could be associated with each other like being a victim of physical or sexual abuse as a

child puts the individual at a higher risk of being a future victim or perpetrator in

adulthood (CDC, 2014). Risk factors of IPV could be combined with societal, communal, individual, and relational factors. It is therefore important to understand these factors when trying to identify certain opportunities of prevention especially when support systems are the first window of opportunity to help victims (Catallo et al., 2012). Social support for victims of IPV could reduce the impact of domestic violence on mental and physical health.

Victims of IPV are particularly in need of social support services for many reasons. The women are usually not willing to disclose to social support systems that they are going through abuse, considering the stigmatization that comes with it especially in the African setting where abuse is considered normal or the man's right over the woman (Immigration and Refugee Board of Canada, 2010). These reasons of course put women at higher risks of domestic abuse or IPV.

Another major risk factor is that the women may also seek social support but may feel like they are blamed for the abuse. As a result of the lack of institutions to provide help for victims of IPV in Cameroon, even hospitals and police officers reject and turn victims away (Time, 2012). Also, women who have experienced breast ironing and FGM are also at higher risk of being victims of IPV. These practices are widespread in the Republic of Cameroon (Tapscott, 2012). Female genital mutilations are usually performed between the ages of zero to 15 years and most of the time initiated and carried out by the older women, who believe it brings honor to the girl child (WHO, 2013).

A cross-sectional study was conducted in Mali to determine whether FGM is a risk factor for IPV and its subtypes like emotional, physical, and/or sexual abuse (Salihu

et al., 2010). Using the 2006 Demographic and Health Survey (DHS), 7875 women were interviewed between ages 15 to 49 years. The study found out that women had gone through FGM as early as three years of age (Salihu et al., 2010). More than 26% of women who had been circumcised reported some form of IPV, compared to 17.3% who were not circumcised. Emotional and physical abuse was generally higher in women who had experienced severe FGM than those who reported moderate FGM, but the rates were similar when it came to sexual abuse (Salihu et al., 2010). Scientific studies have yet to confirm, but medical experts believe that there is a chance of women and girls who were victims of breast ironing to later develop problems with breastfeeding, cysts, and depression (Dugan, 2013). Breast ironing could also result the woman's low sexual drive, which could lead to IPV or forceful marriage (Dugan, 2013; Tapscott, 2012).

This review provided a deeper understanding of how women faced with IPV in Cameroon feel about the support systems they have had access to. So the risk factors identified also provided a visual understanding of the women's willingness to leave their abusers. This helps to categorize where they fall in the HBM and TTM model.

Defining Social Support Systems

Social support systems have been defined and identified as important factors in health, especially for victims of IPV (Uchino, 2004). Social support as described by Ferreira, Nunes, Reis, Morraye, and Rocha (2012) is a process that involves bonds of formal and informal friendship that establishes exchanges in order to meet the needs of people. These needs could be of any kind so long as it brings about positive behavioral and emotional change for the individuals receiving it to experience a sense of relief to

some extent in the crisis they are facing (Ferreira et al, 2012; Pedro, Rocha, &

Nascimento, 2008).

Domestic violence social support systems or groups are formal programs of

assistance that are available for domestic violence survivors or victims. They are either

government or non-governmental agencies including public health officials, police

officers, and the judicial or legal system (Taylor, 2011). They could also be informal

supports from community members/groups, family members and friends (Heaney &

Israel, 2008). These social support systems range from shelters, transitional housing,

emergency money and food, counseling, encouragement, and individual and/or group

therapy. Social support systems are extremely important determinants of coping with

difficult experiences (Bolger & Amarel, 2007), thus making it an important determinant

factor in this study.

Social support systems could bring both positive and negative effects when

offered to victims of abuse (Trotter & Allen, 2009). So the support systems have to be

properly orchestrated so that they could actually help the women in an abusive situation

and give them more hope and courage to speak about it to other women. This was

extremely important in this study as IPV victims' lived experiences of social support was

exclusively examined.

The Role of Social Support Systems

The lack of social support services has been recognized as a main link to IPV, an

obstacle to seeking medical, personal, social, and legal services as well as a major risk

factor for health issues that are associated with IPV (Lyon et al., 2008). Intimate partner

violence survivors or victims have always reported that successfully getting out of a violence environment has been a less hard transition because of the help of social support systems like public cash assistance, shelters, and counseling (Botein & Hetling, 2010; Lyon et al., 2008; Simmons, Farrar, Frazer, & Thompson, 2011). This is extremely common with low income women who are more at risk of IPV and desperately need financial assistance and shelter for themselves and their children (Lyon et al., 2008). This is extremely common in Cameroon and throughout Africa. But the services would be only useful and accessible if the women have access to them and if they would not be turned downed or shunned from society (Fanslow & Robinson, 2010).

Social support, formal or informal, could reduce an IPV victim's chances of developing a variety of mental health issues including depression, post-traumatic stress disorder (PTSD), and alcohol abuse (Coker et al., 2002). Another study by Kaslow et al. (2010) found out that it could also reduce the risk of suicide both in women and their children. Uchino (2004) also posited that social support systems reduced mortality rates in its entirety and deaths as a result of serious health problems like hypertension, cancer, cardiovascular diseases. It also increased the lifespan of victims and reduced the rates of STIs, especially HIV/AIDS (Uchino, 2004). When victims of IPV are no longer able to cope with the abuse they experience, they would at times seek external resources especially agencies available in the community (Haj-Yahia & Cohen, 2009). Many studies posited that social support services including emergency shelters for victims of IPV serve more than three million children and women on a yearly basis in at least 2,000 societies (Stark, 2007).

Social support systems help women of IPV in many ways. These include transitional/emergency shelters or housing, individual and/or group therapy, hotlines, safety planning, medical services, legal advocacy, and support groups (Fanslow & Robinson, 2010; Zweig & Burt, 2007). Victims of IPV may decide that leaving an abusive relationship could be problematic to them because they may not have a place to go for shelter (Botein & Hetling, 2010). Researchers found that IPV was one of the highest rated causes of homelessness in women and children (Aratani, 2009). Over 90% of these women and children rely on domestic violence shelters or homeless shelters and foster homes (Aratani, 2009). Intimate partner violence also affected women and children in that many of them had to move from one place to another causing instability in the lives of the women and children (Baker, Niolan, & Oliphant, 2009).

Individual and/or group therapy and support groups are a representation of services that are supposed to help victims of IPV (Zweig & Burt, 2007). Intimate partner violence victims who develop battered woman syndrome are definitely in need of effective interventions that would satisfy their personal needs of overcoming domestic violence (Hearns, 2009).

Being knowledgeable of these services would stand as a constructive strategy for understanding women in Cameroon's lived experiences of social support systems and what they think of these services in terms of tailoring their needs as victims of abuse and helping create a better intervention to curb IPV in Cameroon.

Review of Related Studies

Not much has been studied on IPV victim's lived experiences of using social

support systems or groups in Africa, considering that this continent has one of the highest

levels of IPV in the world (De la Harpe & Boonzaier, 2011). The literature therefore

focused on several studies from many geographic locations that examined social support

systems and women faced with IPV or domestic violence.

It should be considered an urgency for victims of IPV when seeking social

support and the services should applicably and actively meet the needs of these women.

Fanslow and Robinson (2010) posited that social support services should be extremely

prompt when giving responses to women considering that they may have very limited

time. In their study, they drew a sample from 956 women between ages 18 and 64, data

that was gotten from the New Zealand Violence against Women Study (Fanslow &

Robinson, 2010). They were trying to find out the help seeking behaviors of women who

had ever experienced sexual and/or physical abuse by an intimate partner. These help

seeking behaviors were the result of either formal or informal social support. They also

wanted to find out if the women were comfortable discussing the abuse they experienced

with their friends, families, and other formal support systems like healthcare providers

and the police (Fanslow & Robinson, 2010). More than 75% of the women who reported

the abuse they experienced were found in the study to remain with their abusive partners.

This is because society perceived the abuse as normal or not enough reason to walk away,

even though the women felt like they could no longer endure the abuse (Fanslow &

Robinson, 2010). Over 40% of the women indicated that they had told their families and

friends, but received little or no help from them (Fanslow & Robinson, 2010). Less than

20% reported to have told formal social support systems, but this support was not helpful

either. The findings in this study suggested that a comprehensive outreach would be

essential in the community to ensure that friends and families were able to provide

applicable support for IPV victims especially those that try to reach out to them (Fanslow

& Robinson, 2010).

Another study suggested that women's capacity for developing resilience and the

need for a domestic violence agency was comprised by various perilous factors. These

factors were related to the women's perceptions about the barriers they face when getting

help from domestic violence agencies. This is especially with regard to the lack of

attention of the impact this abuse has on their mental health (Aldridge, 2013). The

inappropriate acknowledgment and support from abused women's families, friends, and

the community was as a result of the lack of emphasis on broader socioeconomic and

political understanding of IPV. It was also the effects of severe fiscal cutback of

expenditure that put women at an even higher risk of IPV (Aldridge, 2013). After

conducting the Write It Project and an Analysis of Mental Health Data, it was discovered

that women who discussed their lived experiences of domestic abuse were willing to get

away from their abuse if they could do it all by themselves. Three women from the

project narrated physical and emotional abuse and how they had survived the abuse

without the help of any social support (Aldridge, 2013). The mental health data explained

that 23 women believed that they experienced mental disorders like obsessive compulsive

disorder (OCD) and chronic depression. The women explained that it was as a result of

the emotional and physical/sexual abuse they had experienced from their abusers

(Aldridge, 2013). These two data sources revealed that more women felt like if there was

more support for them, they would be able to leave their abusers and maybe develop

more resilience in fighting IPV (Aldridge, 2013). These support systems would have to

include friends, families, and the community, as well as the government.

In a similar cross sectional study, mental and physical health problems were

linked to IPV. It was prevalent among women who sought help in walk in community

organizations, which meant that the prevention and intervention programs had to be

upgraded (Kamimura, Parekh, & Olson, 2013). The study was conducted in a large city in

one of the 54 Family Justice Centers (FJC). One of the 25 centers was used during a four

month period in 2012. The FJC staff administered the survey to 117 women (20 or 17%

of whom lived in the FJC shelter) (Kamimura et al., 2013). They selected women 18years

of age and older, with the average age being 32 years (Kamimura et al., 2013). They were

required to ask the women if they wanted to participate in the survey and made sure they

signed consent forms. They also had them fill in the self administered forms which

usually took about 15 minutes to complete, and gave them $10 as compensation for

filling out the survey (Kamimura et al., 2013). The Short Form and the 5 or 3 point Likert

scale was used to measure the mental and physical health functioning. The General

Health Questionnaire (GHQ) was used to measure psychological problems along with the

Patient Health Questionnaire (PHQ9) for depression. The Michigan Oral Health related

Quality of Life Scale (MOHRQoL) Adult Version was used to measure overall

perceptions of oral health, including injuries to the mouth (Kamimura et al., 2013). Social

support was also measured using the 9-item Medical Outcomes Study Social Support

Survey (MOS-SSS). And finally, the 20 item Danger Assessment was used to measure

the severity of the victims' experiences with IPV (Campbell, Webster, & Glass, 2009;

Kamimura et al., 2013).

The results of the study found out that better health was as a result of the use of

social support. Participants who used social support reported better mental, oral, and

physical health. They also reported a lower risk of depression and psychological distress

than those who were not living in the FJC shelter (Kamimura et al., 2013). Even though

the FJC was not designed for long term services to women suffering from IPV, the study

revealed that there was a dire need for many of these services. The few women who

experienced IPV revealed that they had a better quality of life when they used social

support (Beeble, Bybee, Sullivan, & Adams, 2009).

In another study, Dichter and Gelles (2012) postulated that police interventions

are essential responses to IPV but it is not a guarantee for the victim's safety in the future.

The study was aimed at identifying factors that are associated with IPV survivor's

perceptions about risk and safety in terms of re-victimization after a police intervention.

Police contact was also seen as open window of opportunity for victims to connect with a

range of social and health services. With a combination of nonexperimental quantitative

and qualitative data gathering, a self-report questionnaire was used for data collection. A

subgroup of women who completed the questionnaire was also asked to be part of a

qualitative, indepth interview (Dichter & Gelles, 2012). Participants were selected from

Philadelphia in the state of Pennsylvania between September 2006 and June 2008. They

all spoke English, ranged from ages 18 to 64 years, had a history of IPV with a former or present partner, and had called the police about IPV intervention (Ditcher & Gelles, 2012). With the help of research assistants, 173 participants were recruited from four organizations. The organizations provided support and counseling to IPV victims or survivors and a hospital's emergency department (ED). Data collection took place in a private area at the organization or hospital from which the participants were recruited.

Key variables measured in this study were violence victimization and perpetration, relationship factors, social support and resources, and perceptions about safety and risks (Ditcher & Gelles, 2012). For the quantitative part of the study, SPSS 16.0 was used in conducting statistical analyses of quantitative data. Also used was Crosstabs and the Pearson chi square test of statistical significance. For the qualitative part of the study, a technique of constant comparative analysis was used based on the grounded theory (Ditcher & Gelles, 2012; Strauss & Corbin, 1990).

The findings from this research suggested that 49.4% of the participants said they felt unsafe after calling the police. About 51% thought it was likely that their partners would surely use violence against them again in the future, thus putting them at risk for future abuse (Ditcher & Gelles, 2012). More than two thirds of the women believed that the threat of separation, lack of social support, and death was reduced after they left their abusers with the help of the police. They believed that the support of friends and families were able to also help them. But they insisted that they would love to have more support from the judicial system as well (Ditcher & Gelles, 2012). They also felt like the

organizations were not fair to them or treated them as low priority, which was a main concern for the women.

In another related cross-sectional study, 600 young mothers were investigated. The researchers had the aim of finding out the prevalence of domestic violence experienced by pregnant women in Iran and the relationship to social support and self-esteem (Abadi et al, 2012). The Social Support Questionnaire (SSQ), a self developed sociodemographic form was used for women between ages 15 to 29 years shortly after giving birth. Of the 26% of women who reported verbal abuse, physical and sexual abuse was reported at 4.8% and 5.5% respectively (Abadi et al., 2012). Exposure to domestic violence was not connected to the number of available social support. But the incidence of verbal abuse was adversely linked to the satisfaction with the accessible social support (Abadi et al., 2012). This suggested that the IPV victims in this study generally lacked social support, especially that cultural morals dictated that Iranian women were not allowed to discuss domestic violence even with their family. If they could not do that, then they could not be possibly provided with social support and have their self-esteem boosted (Abadi et al., 2012).

Another study aimed at assisting healthcare professionals in identifying and effectively responding to domestic violence. Healthcare professionals need to develop some skills that would be used to identify a victim of IPV or domestic violence. Women receive support from healthcare professionals who are knowledgeable in recognizing signs of IPV. With this knowledge, they could have the ability to prioritize and assess the safety of their patients (Department of Health [DH], 2013). Trevillion, Agnew-Davies,

and Michele Howard (2013) examined a vast literature of studies that suggested that service use has increased overtime, but healthcare professionals are still unable to identify signs of domestic violence. These finding are extremely important because patients who have experienced IPV may not have any other direct contact or may have limited access to social services other than the healthcare provider (Trevillion et al., 2013). This limited or lack of access was a result of several reasons like language barriers, social norms, and inaccessibility to social support. Research in international countries especially in developing countries suggested that maternity, primary, and mental health services did not usually ask patients about potential domestic abuse experiences (Bacchus et al., 2008; Trevillion et al., 2013). They may fail to document or incorporate information about treatment plans for these victims.

Healthcare professionals could become extremely active in supporting the needs of patients who may have experienced IPV by applying these four steps: Ask, Record, Respond, and Refer (Department of Health [DH] 2013). These would help the women overcome their feelings of isolation, fear, and shame. They would encourage the victims to disclose more of their experiences through support services referred to them in a non-judgmental environment (Trevillion et al., 2013). Patients in turn would be more open to their primary care physicians who would act as the liaison to other social services especially the legal system.

Kulwicki, Aswad, Carmona, & Ballout (2010) conducted another study on Arab American community leaders who had come across victims of domestic violence in their communities. Ten focus group discussions were used in the study to explore the role of

social support systems, religion, family, culture, and personal resources when trying to use domestic violence services by Arab immigrants. Community leaders who participated in the study were legal team, law enforcement, religious, grass roots community leaders, health and human services providers. Sixty five of them were chosen and the focus group discussions lasted over a period of six months (Kulwicki et al., 2010).

The study found out that deterring roles that affect a victim of domestic violence are as a result of cultural norms and lack of personal resources (Kulwicki et al., 2010). The findings from the study further exposed the disapproval against community agencies and leaders for not implementing appropriate treatment against perpetrators and also neglected the victim's confidentiality. The inefficiencies reflect a vast negligence of domestic violence in Arab communities (Kulwicki et al., 2010). It is also a reflection of many Middle East and African countries that do not recognize domestic violence as a social and public health problem.

The Internet and other forms of computer communications are indisputably beginning to have an effect on many aspects of people who are victims of IPV. In online groups, members are often very upfront in revealing their personal experiences and information, even if it is to complete strangers (Hurley et al., 2007). Data were collected from Internet support groups specifically formed for victims of IPV. The individuals who reported abuse on the site were open about telling their stories, and compared themselves to other people in the site (Hurley et al., 2007).

The findings from this study suggested that many people relied on online support and it actually worked out for them (Hurley et al., 2007). The phenomenological study

stressed on some of the benefits of online groups for victims of abuses especially IPV. The study also drew attention to the possible opportunities that victims of domestic violence had to write new problems every day and valued themselves to a huge audience from the safety of their computers (Hurley et al., 2007).

The findings in these studies have reinforced the necessity to treat IPV victims and survivors as a multifaceted phenomenon in the public's practical, theoretical, and empirical approaches. The findings have identified factors to take into consideration when evaluating women's individual service needs and safety risks (Ditcher & Gelles, 2012). The community and public health officials should not only question the women about their perceptions of future risks and feelings of safety. They should also be able to identify the meanings, forms, and contexts of violence from the perspective of the victim so as to match them with better interventions.

The Phenomenology of Lived Experiences

Phenomenological approaches in qualitative studies focus on the perceptions and lived experiences of individuals and their relation with the phenomenon (Creswell, 2009). Phenomenological research studies help the researcher to comprehend the experiences that people may have on particular situations or phenomena (Creswell, 2009). A phenomenological study was ideal for this research because it will describe the lived experiences and perceptions of IPV women's experiences with social support in Cameroon. Phenomenology is extremely valuable when analyzing IPV victim's accounts because it stresses subjective experiences (Spinelli, 2005).

This phenomenological study was assisted by individual interviews where information on their lived experiences with social support systems was examined. Eight interviews followed an interview protocol and the data from these participants were coded using NVIVO. This methodology information was further discussed in detail in Chapter 3 of this study.

Many phenomenological studies have concentrated on recognizing external influences that affect women's decisions to stay or leave their abusive marriages. Others have highlighted the internal factors of these survivors or focused on both the internal and external influences (Davies, 2002; Hayati, Eriksson, Hakimi, Hogberg, & Emmelin, 2013). The reasons that encourage women to stay, however, have not been properly examined. Hayati et al. (2013) conducted a study in Purworejo District in the Province of Central Java, Indonesia. They used a phenomenological approach, which is best used for transforming the lived experiences of individuals into recorded expressions (Davies, 2002). They posited that the phenomenological approach would provide IPV survivors the opportunity to voice out their perspectives of their life experiences (Hayati et al., 2013). In-depth interviews were used for a criterion sample as informants were selected with the help of the Office of Social Affairs and People Empowerment (OSAPE) in Indonesia. Seven women with an average age of 39 years consented to the interview process while two declined because they were not ready or comfortable discussing their IPV experiences (Hayati et al., 2013). The 7 interviews took place in places that the participants were most comfortable with and it stretched between December 2006 and August 2007. The semi structured interview questions comprised of the women's reasons

for either deciding to leave or stay in their marriage, abuse experiences, marriage history, their children's situations, their efforts in trying to reduce the abuse, and social interactions (Hayati et al., 2013).

The study found out that participants hesitated between getting suitable support and being denied institutional (formal) or social (informal) support from their communities. Most of the women expressed the willingness of family members and friends in helping them, but they felt that was not enough because they were not able to stop the abuse from their husbands as opposed to them going to formal support governmental or non-governmental organizations (Hayati et al., 2013). The women in the study also explained that there was the lack of suitable institutional support from legal institutes, police departments, and other relevant government organizations. It was extremely disappointing that only one of these women had been helped by the police after she reported the abuse to the police (Hayati et al., 2013). The women further addressed the fact that they gained more confidence in themselves and developed the strong will of changing their situation as they received more positive responses from the formal bodies (Hayati et al., 2013). This meant that women could be significantly encouraged to end their IPV relationships if they received more support from formal support systems.

Another study posited the belief that victims of IPV are able to cope if they get as much support from social services as possible including medical and mental health, child protection and custody, and financial support (Haeseler, 2013). The authors believed that women's multifaceted needs have to be met to satisfy every ecological life space of the women. Several studies sturdily advocate for professionals to step up their leadership by

representing more cohesive and collaborative care, especially that victims of IPV are still at a staggering disadvantage for unified service delivery (Haeseler, 2013). Experts could include expediting improved inter-agency assistance, which includes reducing agency restrictions and encouraging more networking (Bolman & Deal, 2003; Haeseler, 2013).

The phenomenological, qualitative study was primary data that were gathered through field notes and semi structured interviews. Eight female participants from ages 25 to 50 years from the western New York region were selected for the study, which lasted from June through July of 2006 (Haeseler, 2013). They all worked for domestic violent agencies and had no history of IPV. The participants in this study reported that in order to better serve women of IPV, there was the need for a more potentially adoptive, agency to agency, and organizational structure and that they could actually benefit from each other through informal workshops with other consultants and educational trainings (Haeseler, 2013). It was obvious in this study that women of IPV are still being underserved, causing them to stay in relationships that could be prevented.

When women tried to leave an abusive relationship, they looked for ways in which they would have to cope with certain situations like shelter for them and their children, help from friends and families, and also formal help from the judicial system, finances, mental health, and child custody and support (Carpiano, 2002; Haeseler, 2013). The level of coping experiences must be handled differently considering every woman's level of abuse and stage of acceptance to leave the perpetrator. Haesler (2013) explained that these multi-dimensional coping experiences have to be properly understood by agencies offering support to the women. This qualitative, phenomenological study was

gathered through primary data that were conducted from semi-structured interviews. Eight non-abused, female, social service professionals were selected from four agencies, two from each agency that served both poor and wealthy women who have experienced IPV. The women ranged from their 20s to their 50s and were recruited through phone calls to the four agencies with two sessions each, all lasting about two and half hours.

The results were interesting in that the professional participants said women who left abusive relationships still suffered from physical trauma, low self-esteem, depression, and feelings of fear, something that is similar to women who are still in the relationship (Haesler, 2013). This means that the women needed more social support in and out of the abuse and sometimes relied on social networks for that support, which was usually never met. It was most difficult having to deal with child custody issues as the perpetrators were never really prosecuted. The judicial system was not hard enough and majority of the perpetrators did not respect court orders (Haesler, 2013). Women who remained in IPV relationships developed defensive storytelling. Others who left either returned, entered another abusive relationship, or tried to better themselves depending on the level of social support they got from family, friends, and formal social support. The professionals interviewed in this study had a complete grasp of understanding coping mechanisms for women who have experienced IPV and the services they required. They all agreed that all the women needed different levels of social support (Haesler, 2013). They most importantly needed the services to be fully engaged in getting them to better environments for a better life.

It is believed that one way to reduce IPV against women is by doing an intervention for men (De la Harpe & Boonzaier, 2011). In another interpretative phenomenological study, the authors investigated a male IPV South African intervention program. It was done by listening to women's experiences of their partners who attended the intervention. Six women whose husbands were attending the intervention program were recruited to do in depth, semi structured interviews (De la Harpe & Boonzaier, 2011). The interviews provided an opportunity for the researchers to listen to the lived experiences of the participants from their own point of view. The intervention program was feminist in orientation with the aim of educating men about IPV and explaining to them the effects of control and power. It aimed at challenging beliefs and norms, identifying proper alternatives, and providing alternative behaviors to stop domestic abuse in the home (De la Harpe & Boonzaier, 2011). The female participants were recruited through a manager of the program who was assisted by social workers.

The findings of this study were divided into two themes of behavior change and future violence (De la Harpe & Boonzaier, 2011). All the women felt that even though physical abuse was reduced, they still felt like the program was not working because of the long-term consequences. One woman clearly stated that she knew the abuse would definitely return and that it would only be a matter of time after the male intervention was over. They expressed these views especially because the men accused them of being the abusers and minimized the rates of abuse during the intervention (De la Harpe & Boonzaier, 2011). In essence, physical abuse reduced but the rate of psychological and emotional abuse increased during the intervention period. The women felt like the men

were not taking responsibility for the abuse so it was most likely to return. Some participants indicated that even though the program sessions seemed positive, they would not be sufficient in preventing future violence (De la Harpe & Boonzaier, 2011). This study continued to emphasize the importance of listening to the women and asking for their voices and opinions about social support systems. There is a possibility that interventions could be improved through those voices.

Summary

Women in the Republic of Cameroon have always been faced with severe abuse, a majority of which are deemed normal by society. Violence against women in this region, including forceful marriage, rape, genital mutilation, breast ironing, and horrifying rituals after the death of a husband/partner is so widespread, yet not fully addressed by the civil and criminal codes (Teke, 2009; U. S. Department of State, 2010).

Minimal research has explored IPV victims' lived experiences with social support systems in Africa and Cameroon in particular. In a 2007 shadow report submitted to the UN Committee on the Elimination of Discrimination against Women (CEDAW), it was reported that IPV or domestic violence is extremely widespread yet it is not recognized as a social problem considering that it is regarded as an accepted norm in Cameroon (The Immigration and Refugee Board of Canada, 2010). This, of course, produced problems for women who sought social support either within their families or in the community. This study aimed to explore the experience with social support system among women exposed to IPV in Cameroon.

Chapter 2 presented the available research relevant to this study in terms of IPV victims' lived experiences with social support. It also provided information on relevant studies that expounded on the importance of social support for victims of IPV and the effects of the lack of support when experiencing domestic violence.

The next chapter, Chapter 3, will focus on how the qualitative phenomenological study was addressed. It also focuses on what questions were asked, how participants were recruited, and how the information from participants was collected, analyzed, and organized.

Chapter 3: Research Method

Introduction

An understanding of abused women's lived experiences with social support systems was evaluated. The study explored the lived experiences of social support systems and how that has defined their stages of leaving abusive relationships. This study was modeled using the TTM model and the HBM. It focused on women who have not only experienced IPV, but who have had contact with social support systems and were able and willing to share those experiences.

Purpose

The purpose of this qualitative study was to explore the perceptions women and girls have about using social support systems in the southwest and northwest regions of Cameroon. The study explored how they felt about comfortably using these services if they were made available to them. Description of these services to abused women contributed to research building in the IPV field especially in Cameroon and could also inform domestic violence organizations as they try to connect with victims of IPV. The relevance of social support systems and its performance by victims of IPV has become increasingly significant in curbing domestic violence in Cameroon. Interactive assistance by social support systems for victims of IPV could offer a cost effective option for provision of assistance and could also broaden the efficacy and scope of services to victims. An essential first step is to understand how IPV victims think about the social support systems and how they respond to these services, which was the principal purpose of the study. It also focused on how comfortable the women would feel using these

services if they were made available to them. A description of these lived experiences could help in informing social support organizations on how to improve their services to the women. One important step was to understand how victims of IPV interacted with social support systems and otherwise respond to the consequences of abuse, which was the primary focus of this study.

The following topics will be covered in this Chapter 3:

1. Procedures used to recruit participants and information on the instruments for data collection.

2. Participants in the study, research design, rationale, and role of the researcher.

3. Methodology used for collecting, describing, and analyzing data on abused women's lived experiences with social support systems.

4. Ethical procedures implemented to guarantee the credibility, validity, and the trustworthiness of the study.

Research Questions/Design and Rationale

One of the conceptual frameworks of this research was using the transtheoretical model of change [TTM] to focus on women in IPV relationships who may regard the abusive relationship to be problematic only if they leave the abuser (Catallo, Jack, Ciliska, & MacMillan, 2012). As a result of the complications in abusive relationships where the abuser controls all decisions and situations, the victim's autonomy to make changes is affected. The TTM was intended to be used in relation to the changes and decisions that abused victims can control despite being in an abusive relationship. Most of these decisions are made based on their experiences with social support systems.

The health belief model [HBM] was also used in this study to understand the lived experiences of these women in relation to how they cope with IPV and social support systems. Selecting this framework was based on the observation that victims of IPV seemed to endure their ordeal. The HBM in this context would be an expectation theory, which would assume that an individual possesses the desire to get better based on their belief that a specific health action (social support systems) is available for them. The TTM and HBM theories would be used to answer the research questions below:

Research Question 1: What social support systems have women used in Cameroon?

Research Question 2: What are women's lived experiences with social support systems in Cameroon?

Research Question 3: How do women cope with or endure IPV through the help of social support systems?

Research Question 4: How would IPV victims use the social support systems should they get all the services they need?

Research Tradition/Conceptual Framework

The qualitative method that was used for this study was phenomenological in nature. This study looked at the experience with social support systems among women exposed to IPV in Cameroon. This approach made room for discussions and storytelling (Creswell, 2009) regarding the problem of IPV in the Republic of Cameroon. A phenomenological approach was aimed at describing particular phenomena as people's lived experiences (Speziale & Carpenter, 2007). The lived experiences give meaning to

every individual's discernment of a phenomenon and presents to them what is true or real in their lives (Giorgi, 2005). Phenomenological methods do not aim at discovering or explaining causes. Their pivotal aim is clarifying meanings of phenomena derived from lived experiences of participants in a study. Phenomenology suggests a significant change from a positivist cause-effect attention to human subjectivity while realizing the meaning of actions (Giorgi, 2005). The phenomenological method would be the route for follow up and secondary questions that would assist in the collection of important data for the study (Creswell, 2009). It would assist in understanding the experience with social support systems among women exposed to IPV.

A phenomenological approach is suitable for changing lived experiences into textual expressions. Phenomenology would provide these abused women the opportunity to voice out their perspectives about their live experiences (Davis, 2002). From an in-depth interview, a woman who has experienced IPV from past to present is able to share, validate, and explore her insights and feelings (Davis, 2002).

A study similar to the phenomenological approach that is discussed in this study aimed at women's lived experiences of coping with domestic violence in rural Indonesia (Hayati et al, 2013). Seven women with an average age of 39 years were chosen from rural Java in Indonesia using a criterion sample from the Office of Social Affairs and People Empowerment (OSAPE). These women were chosen because they had gone through IPV and were willing to discuss their experiences (Hayati et al., 2013). The semi structured guide that was used was developed during the interview process. It focused on the victims' marriage histories, their experiences with abuse, their efforts to curb the

abuse, sociocultural reactions and responses, their children, and their reasons for staying or leaving their abusers (Hayati et al., 2013).

The results of the study supported the elastic band theory, which implied that the women knew they had to leave their abusers (Hayati et al., 2013). However, due to the lack of support from families and friends and limited support from official social support systems, they would leave and return or they would not leave at all. They made efforts to oppose the violence but they were not given much of a choice than to return and accept the abuse.

This study focused on the lived experiences with social support systems among women exposed to IPV in Cameroon. This study was made up of individual interviews for gathering data on the beliefs, knowledge, and attitudes of women exposed to IPV and how they are coping with the violence through the help of social support systems.

Role of the Researcher

As the researcher for this study, my role was that of an observer during the interview process. I asked the questions and the follow-up questions as needed. As the observer, I made sure that my personal ideas, thoughts, and personal experiences did not influence that of the participants. Creswell (2007) emphasized that the researcher, when conducting a study, must be mindful of prejudgments and subsequently bracket their experiences. Research found that participants would feel they are cared for if the researcher not only listened to but also acknowledged their views and opinions (Beck, 2005). I controlled bias by eliminating assumptions and viewpoints, as Creswell (2007) described. I located particular phrases from participants that affected the phenomenon. I

asked for clarifications from participants, if any, without drawing my own conclusions and then defined the themes to the study. I made sure that all participants did not have any professional or personal relationship with me. This was to reduce the potential for any bias in the study.

I audio recorded the one-on-one interviews during this process. After each interview, I gave participants a 5,000 francs CFA ($10) Leader Price Voucher as a thank you gift for participating in the face-to-face interview. I realized that there is a moral obligation of not taking advantage of these women and their potential experiences of material lack (Shaw, 2005).

Methodology

Logic for Selecting Participants

For this study I recruited eight participants who were at least 18 years of age and were from the southwest and northwest regions of Cameroon. Three people were first interviewed as part of the pilot study to test the questions, but they were not part of the study of eight participants. The northwest and the southwest regions of Cameroon are two of the four territories of the Southern Cameroons that are found in the western highlands of Cameroon. Until 2008, they were previously known as northwest and southwest provinces before President Biya signed a decree to change it (Central Intelligence Agency, 2010). They are the only two Anglophone (English speaking) regions of Cameroon. The capital of the northwest region is Bamenda and the capital of the southwest region is Buea. The southwest region is estimated to have a population of

about 1.4 million while the northwest region is estimated at about 1.9 million as of 2010 (Republic of Cameroon Statistics, 2010).

The northwest region is home to tourist sites like Menchum Falls, Lake Nyos, Lake Oku, and Lake Awing (Mbaku, 2005). The southwest region is also home to Atlantic beaches and considered one of the best regions to visit in Cameroon (Mbaku, 22005). Mount Fako or Mount Cameroon is the highest mountain in the country, an active volcano, and the highest point in Sub-Saharan Africa (Delancey & Delancey, 2000). It is also the fourth most prominent peak in Africa and the 31st in the world. The regions are noted for l boarding schools and two of the best universities in the country (Mbaku, 2005). These two regions are known to protect their culture from decades, which is a reason why IPV is still an enormous problem (Muma, 2014). It is for that reason that the northwest and the southwest regions of Cameroon were chosen for this study.

The participants were recruited using a purposeful criterion sample. The sample population must have suffered from IPV and may have also underwent female genital mutilation or abuse at an early age. The nongovernmental organizations (NGOs) distributed the flyers (See Appendix A), which included my contact information. NGOs distributed the flyers to women who self-identified as victims of IPV and had visited the NGOs for help. Participants were given information or letter of invitation about the study (see Appendix E) while they were visiting the NGOs. In order to protect participants from feeling pressured about participating, they were given sufficient opportunities to consider participating or not. In order to clarify any doubts, participants were allowed to ask all the questions they may have had during the demographic phase (see Appendix B).

The flyers that were given to the women who visited the agency could read them and return them without taking them home for their safety.

The eight participants were recruited from two organizations, one from each region that focuses on domestic violence domestic, gender inequality, and female rights. Reach Out Cameroon (ROC), located in Buea, is a woman and youth-centered NGO (Tangwing, 2014), that works with local women's groups like SUMEDIANG and Bakossi Women's Association Douala (BWAD). The NGO focuses on development-oriented projects and community outreach activities for women and youths (Tangwing, 2014). The other NGO used in recruiting participants in Bamenda was Hope for the Needy Association (HOFNA) Cameroon, which focuses on implementing and designing innovative programs to improve girls and women's political and socioeconomic opportunities as well as enhance their rights (HOFNA, 2012). The Presidents of these local organizations were contacted and they provided letters of cooperation allowing me to conduct the study in their organizations.

The NGOs distributed flyers, which included my contact information, to women who self-identified as victims of IPV and had visited the NGOs for help. The participants were able to call me to get more information about the study. They were also informed that the study was optional, confidential, and strictly for academic purposes. During the interview sessions, I explained again what the research was about and defined what social support systems are. The inclusion criteria were marital/partner status, female gender, must be at least 18years old, must live in the northwest and southwest regions of Cameroon, and have Basic English language skills.

After reading the flyers and the letter of invitation, the participants were selected using a participant screener (see Appendix C). Interested participants filled the demographic data form (see Appendix B), which took about 10 minutes. After completing the form and determining their eligibility, they were scheduled for an interview. The interview process took about 40 minutes using the interview guide (see Appendix D). The participants met at the location of the NGOs, either in the northwest or southwest region of Cameroon. This did not only provide security for them (since they came there in the first place), the NGO also provided some privacy during the interview process. Participants selected for this study had their interviews conducted during a 4 to 5 week period in Cameroon.

Instrumentation

The demographic form (see Appendix B) that was used for the study helped to facilitate data collection during the interviewing session. An audio tape recorder was used to record data so that content validity could be established without the major risks of bias. The recorded information could be played back either for accuracy or for data transcription. As earlier mentioned, data collected from these women took place at two locations. The interviews for the northwest region took place in Bamenda at HOFNA Cameroon. The interviews for the southwest region took place in Buea at ROC. The organizations signed a letter of cooperation and provided a private office in their organizations for the interview sessions.

Audio tape Recording Transcription

Another form participants were required to sign was the consent form (see

Appendix F) permitting me to record the interviews. The women's lived experiences with

social support systems were from the recordings as well as notes taken during the

interview sessions. The semi structured questionnaire (see Appendix D) were first tested

with three participants known as the pilot study. These three participants did not include

the eight participants and were not part of the study. The three participants' feedback was

used in recruiting and interviewing at least eight participants for the study. The process

increased and established reliability and validity of the study.

Consent Demographic Data Form

A demographic form was used for collecting the main demographic information

that was needed for the criterion of this study. Gender, age, level of education,

employment status, region of residence, and marital/partner status were included in the

form. A signed consent form was also required at the beginning of every session by all

the women who participated in the study. I explained to the women that the information

gathered would be strictly used for research/academic purposes.

<div align="center">

Data Analysis

</div>

I transcribed the data collected from the abused women with lived experiences of

social support systems in Cameroon. The data were transcribed using Creswell's

approach of data organization, data reduction into themes, and condensation of data

(Creswell, 2007). Participants were coded with pseudonyms for the sake of privacy and

the information provided were grouped into themes for easy data coding. Sentences, statements, and phrases that were significant to the study were coded using NVIVO.

Trustworthiness

Participants were given a 5,000 francs CFA ($10) voucher or gift card for Leader Price shopping center as a thank you gift for taking part in this study. Follow-up questions were asked throughout the procedure in order to strengthen validity. Internal validity was increased using member checks. In phenomenological studies, member checks enhance the rigor of studies, thus increasing internal validity (Dunne, Sullivan, & Kernohan, 2005). Member check was performed by reaffirming responses from participants during the interview process. Triangulation protects against bias and ensures trustworthiness and credibility (Nastasi & Schensul, 2005). Triangulation was used to increase the study's dependability. Theory/perspective triangulation was used for multiple theoretical perspectives in order to interpret and examine the data (Rothbauer, 2008). The HBM and the TTM were addressed to understand IPV victim's lived experiences. From the themes developed after the interview, I was able to address the theoretical perspectives of the study.

Since the study was conducted solely on abused Cameroonian women's lived experiences with social support systems, it could be relevant for future studies concerning the same group of women. It could also be relevant for programs that target the same group of women in Cameroon. Also, bracketing was used to control research bias. My views about abused women and lived experiences with social support systems were

limited. I focused on the questions and follow-up questions to reaffirm answers given by the participants.

Ethical Considerations

Data for this study were not collected until approval from the Walden University's Institutional Review Board (IRB). My IRB approval number is 09-10-15-0337833. The data collected will be stored on a disk for a five year period during which only I will have access. The data will be referenced for any information that is needed from the study. After the 5year period, the data will be destroyed. Consent forms were used for every participant before any interview sessions began. Data were strictly used for academic or research purposes in public health. The participants were also informed that the data including their main identifiers were strictly confidential. The participants were abused women who have had lived experiences with social support systems in Cameroon.

The main concern during this interview session was the security and privacy of participants. These women did not want their information disclosed so there was some reluctance in opening up or participating in the study. The participants were assured that their information would remain confidential and that they would be identified using pseudo names. Personal identifiers of the participants were not used for any reason. Participants were informed that they had the right to refuse to participate in the study even if they had previously accepted. They also had the right to decline responding to any questions they felt were too invasive or inappropriate.

Summary

Intimate partner violence against girls and women in Cameroon occurs on a daily basis with most of the acts committed by men (U.S. Department of State, 2011). Sociocultural norms allow for these practices such as female genital mutilation (FGM), humiliating widow rights, and other physical and psychological acts of violence (Teke, 2009). One of the main causes of the persistently high rates of IPV against girls and women in this region is the fact that most of them are ignored or accepted by society (Duarte, 2008; Teke, 2009).

This chapter is on a phenomenological methodology that outlined the rationale and research design for this study. Data analysis, data collection, and data interpretations were discussed to understand the depth of the study. This chapter is followed by the findings and interpretations about IPV women's lived experiences with social support systems in Cameron. Conclusions of the study follow in Chapter 5.

Chapter 4: Results

The purpose of this qualitative study was to explore the gap in literature of the perceptions women have about using social support systems as victims of intimate partner violence (IPV) in the southwest and northwest regions of Cameroon. I sought to find out if participants would feel comfortable about using the social support systems if they were made available to them. Description of these services to abused women contributes to research building in the IPV field especially in Cameroon and can also inform domestic violence organizations as they try to connect with victims of IPV. The relevance of social support systems and its performance by victims of IPV has become increasingly significant in curbing domestic violence in Cameroon. Interactive assistance by social support systems may offer victims of IPV a cost effective option for provision of assistance and may also broaden the efficacy and scope of services to victims. An essential first step was to understand how IPV victims think about the social support systems and how they respond to these services, which was the principal purpose of the study. A description of the lived experiences would help in informing social support organizations on how to improve their services to victims of IPV. One important step was to understand how victims of IPV interact with social support systems and otherwise respond to the consequences of abuse.

This chapter includes descriptions of the pilot study, demographics/biography of sample population and data collection, the study setting, data analysis, and themes and research questions. In this chapter, I also present evidence of trustworthiness, results of the data collection, and summary. Below are four research questions:

Research Question 1-What social support systems have women used in Cameroon?

Research Question 2- What are women's experiences with social support systems in Cameroon?

Research Question 3- How do women cope with or endure IPV through the help of social support systems?

Research Question 4- How would IPV victims use the social support systems should they get all the services they need?

The Pilot Study

Pilot studies are extremely important in undertaking phenomenological qualitative inquiry for culturally competent research (Kim, 2011). I conducted three interviews that became the pilot study. I used the three interviews as a trial run for my methodology to test my recruitment approach. The three participants allowed me to understand how to better conduct face-to-face interviews. The participants were able to answer all the interview questions and provided me with the experience I needed to conduct further interviews. After the pilot study, there were a few changes to my approach in this study. The most significant aspect was the time. I used about 40 minutes per participant for filling the demographic form, signing the consent forms, and for the interview instead of the 90 minutes that was anticipated. Also, I deleted one question from the interview session, which was "How helpful or unhelpful was social support systems to you?" This was because participants in the pilot study felt like it was a repetitive question that asked about their experiences with social support systems.

Study Setting

The interviews were held in Bamenda (northwest region) at Hope for the Needy

Association (HOFNA) in Cameroon and in Buea (southwest region) at Reach Out

Cameroon (ROC). I used one of the counseling rooms provided by the organizations. The

rooms had comfortable chairs and couches for the participants. There was enough room

for participants and me to place our materials (forms and recorder) for the interviews.

Snacks and water were available for participants. All the participants seemed familiar

with the organizations (HOFNA and ROC); they seemed comfortable and safe in the

environment. Before the interview started, every participant was given the opportunity to

ask any questions about the study. During this time, they also signed the consent form.

The consent form highlighted the purpose of the study, the possible benefits and risks, the

compensation of 5,000 francs CFA ($10) voucher card from Leader Price, privacy, as

well as participants' rights to the study. I further reminded participants that the face-to-

face interviews would be recorded and that should they feel uncomfortable with the

recording process, they should immediately alert me. I let participants tell me more about

themselves and why they decided to take part in the research study. This approach helped

some women feel comfortable with me while some were still rigid about sharing their

personal information and their lived experiences.

Recruitment Procedure

I conducted face to face interviews for women who had come in contact with

social support systems as a result of being abused by their partners/husband. Participants

had to meet the purposeful criteria; they had to be a victim (past or present) of IPV, had

to be over 18 years of age, and had to be female participants. They also had to be from

the Northwest and Southwest Regions of Cameroon and had to have come in contact with

social support systems like the judicial system, NGOs, churches/mosques, and the police.

As mentioned, the interviews were conducted in a 4 week span of time. After

receiving Walden University IRB approval I asked workers at HOFNA and ROC to put

up the posters in their organizations. The workers introduced me to 23 women who were

interested in the study, but only 17 qualified for the criteria. The six other participants

who qualified came after I was almost done with the eight participants I needed for the

study. When I met with the eight participants, I told them more about the study, gave

them a letter of invitation, and used the participant screener to make sure they met the

criteria of the study. Participants were then able to set up a date and time to meet with

me. I selected the first three participants for the pilot study and the remaining eight for

the main study. When participants came, they were given the demographic form and the

consent form to sign. After which the face to face interviews were conducted.

I started the interview with reviewing and completing of consent forms and

demographic forms by participants. Upon approval from participants, all interviews were

audio recorded. I assigned participants with fictitious or pseudo names.

Biography of Study Participants

The demographics below provide some information concerning the sample population

that participated in the study;

Table 1. *Demographics of Sample Population (N=8)*

Participant Pseudo Names	Gender	Age	Education Level	Number of Children	Marital Status	Region of Origin	Employment Status Do you Work?
Amanda	Female	36	High school	1	Married	Northwest	No
Anaya	Female	30	Technical school	1	Separated	Southwest	Yes
Leslie	Female	26	Advanced degree	0	Divorced	Southwest	Yes
Paula	Female	30	High school	4	Married	Northwest	No
Victoria	Female	38	High school	0	Married	Northwest	No
Sandra	Female	40	High school	6	Married	Northwest	No
Nina	Female	33	University graduate	0	Divorced	Southwest	Yes
Brenda	Female	44	High school	3	Married	Northwest	No

Table 2 shows a table of the types of social support systems victims used and the

number of times they visited these social support systems.

Table 2. *Reaching Out to Social Support Systems (N=8)*

Participant Pseudo Names	Social Support Reached	Number of Times Reached
Amanda	Hospital, parents, church, HOFNA, Police	12+
Anaya	ROC, court, police.	7
Leslie	Police, hospital, ROC	5+
Paula	ROC, family	3
Victoria	Church/pastor	4
Sandra	Church, police, HOFNA	11+
Nina	ROC, friends	3
Brenda	Church, HOFNA	4

Below is a biography of participants with their pseudo-names. The biography provides an in depth of their demographics as well as the social support systems they had visited.

Participant I: Amanda. Amanda was a 36 year old from the Northwest Region of Cameroon. She still identified herself as married but at the time of the study, but lived with her friend after recently leaving her husband. She said she did not complete high school, so indicated in the demographic form that she completed only primary school. Amanda had one child with her husband. She stated that her husband beat her up several times and she had to go to the hospital because she became unconscious. Amanda indicated that she had visited social support systems about 12 times. She had gone to the hospital, her parents, the church, her friend (who she now lived with), as well as the police.

Participant II: Anaya. Anaya was 30 years old with one child, and was fighting for custody in court with her ex-husband. She was a university graduate with a degree in English, and she was from the Southwest Region. Anaya admitted to having visited ROC, the hospital, and the court.

Participant III: Brenda. Forty-four year old Brenda was unemployed and had three children with her husband. Brenda admitted that her husband beat her several times and, as a result, she visited HOFNA and her church. She was from the Northwest Region of Cameroon with a high school diploma. Brenda explained that she constantly lived in panic and fear. She admitted that she was always stressed out and wondered what the future holds for her.

Participants IV: Leslie. Twenty-six year old Leslie was the youngest victim of the eight participants I interviewed. She recently went through a divorce but was still seeking counsel from ROC. Leslie explained that she visited social support systems more than five times in the Southwest Region. She reached out to the police, the hospital, and ROC. She showed me scars on her body that she claimed were inflicted upon her by her ex-husband.

Participant V: Nina. Thirty-three year old Nina from the Southwest Region said she reached out to social support systems three times and visited ROC and friends. Nina was divorced, but went to ROC for counseling and to also help her younger sister who was going through the same ordeal. Her sister left her marriage about 2 years ago.

Participant VI: Victoria. Thirty-eight year old Victoria did not work and reached out to social support systems in the Northwest Region. She indicated that she reached out to her church and her pastor. She also indicated she was still married to her husband and had no children. Victoria said she had attained a high school diploma.

Participant VII: Paula. Thirty year old Paula had four children. She visited ROC and tried to rely on her family; she explained it was all in vain. Paula indicated that she sought help from social support systems three times. She did not have a job, but had attained a high school level of education. Paula said she was still married to her husband in the Northwest Region but was not happy. According to Paula, her husband kept getting her pregnant, hoping that she would produce a male child.

Participant VIII: Sandra. Forty year old Sandra had six children and had attained primary school. She was still married to her husband in the Northwest Region

and was unemployed. She said she reached out to her church, the police, and HOFNA, and indicated that she had visited the social support systems over 11 times. Paula was extremely troubled about the services she received and also wondered if she would ever get help because she was "really fed up!"

Demographics/Biography of Sample Population and Data Collection

Eight women who self-identified as either victims or survivors of IPV participated in the study. Every participant filled out a demographic form that asked for their age, marital status, the level of education, the number of children, and the region of residence. I assigned pseudonyms to the participants and requested that they include how many times they had visited social support systems and which type of social support systems were reached. All the participants were females above 18years of age living either in the northwest or southwest regions of Cameroon.

Data Analysis

The first step I took in data analysis was to read all the transcripts to gain an understanding of what was presented in the data. After that, I transcribed all data as well as distinguished specific issues and themes using paragraphs, phrases, and sentences (Creswell, 2007). I used NVIVO 11.0 in organizing data and completing audio coding. I established nodes using women's experiences with social support systems. I transcribed data and analyzed using Creswell's (2007) 3-step approach as described in Chapter 3. I organized the data that were reduced into themes and nodes/codes were condensed using NVIVO. I used the data to mark subjects that appeared several times among the eight participants and distinguished into nodes. The nodes were then condensed into themes to

cover each participant's experiences with social support systems as victims of intimate partner violence.

Themes

I identified themes using the NVIVO software. I picked out the names and gave participants the opportunity to choose which name they wanted to use. The following themes were identified from the face-to-face interviews with experience with social support systems among women exposed to IPV:

1. Recollection/feelings about abusive relationships

2. Understanding social support systems

3. Reaching out

4. Experiences with social support systems

5. Coping as a victim

6. Reducing intimate partner violence

7. Serving victims and survivors

Themes and Research Questions

I used two theories in this study. They were the transtheoretical model of change (TTM) and the health belief model (HBM). The TTM evaluated participants' willingness to act on healthier behaviors, provide strategies of change for guiding the individuals through the stages of change to action and maintenance (Greene et al., 1999). The HBM evaluated participants' willingness to engage in health promotion, and self efficacy to successfully change a behavior (Carpenter, 2010; Chapin, 2011). I used the models as a guide to understand participants' perspectives about social support systems, what

motivated them to seek these services, as well as the domestic violence resources they felt were available or accessible to them. Some core constructs of the TTM and the HBM were evaluated in part with the themes and research questions.

Research Question 1

What social support systems have women used in Cameroon?

Theme 1: **Recollection/feelings about abusive relationships.** All participants described how unhappy they were and how they felt like they did not belong in the relationship, be it past or present. A lot of the participants felt stuck and did not know where to go considering they had children. Participants felt rejected by their families or believed that social support systems did not understand. Participants described unhappiness and instances that led them to seek help from social support systems. I asked the women that, "what words will you use to describe your relationship today with your partner? And can you name an instance or instances where you decided to reach out to social support systems?"

As explained by Anaya:

> I thought that I had met the man of my dreams. He seemed just right for me, after all the abusive relationships I had gone through. But now that I am no longer with him, I see that I had ignored all the signs and red flags because I really wanted to believe that he was a good man…I came to Reach Out Cameroon because I am following my case in court with a lawyer here who is trying to help me see my daughter. But it has been very hard. The judge is asking me why I have not tried to work things out with my husband, even though he is very abusive…I went to

the hospital once when my husband forced me to sleep with him and beat me so bad. But at the time, I was too afraid to talk with anyone because the nurses were all looking at me in a funny way.

Amanda described another troubling experience with her husband:

My relationship with my husband has really been unhappy…a lot of fights, he has been beating me. Several times I am actually scared of him, scared of what he can do to me. I (recently) have ran away. Actually some time back, he attacked me, he came back home angry. Maybe he had taken some beers–he's a drunkard. Most times when he came back, he is always out of order fighting me. He beats me up. I got unconscious and I was taken to the hospital where I talked to the doctors and nurses.

Sandra explained that she stayed in the abusive relationship because she wanted the best for her children:

My relationship with my husband was very, very unhappy. It's an unhappy marriage. I didn't get any happiness in this marriage. I am just raising…because I have children with him but I am not happy…my husband has been beating me several times, and I went to the police. He has other women. He comes home drunk and do [es] certain things, which embarrass my children.

Victoria described how her partner sexually assaulted her to the point where she had to leave and still got flashbacks of those moments:

I can tell you about my story in my relationship. When I was still some years back, so I go into some relationship with this man. The person I respected and

loved and cared for all my life and I believed one day we will be together forever. But here comes a situation that he goes and gets other women. So each time I used to talk about it, instead of making me understand why he was doing it, he ended up just like harassing me. I remember one day when he got drunk, he came home, I opened his phone, finding all dirty things, and I tried to talk with him. Instead of understanding me, he demands [demanded] for sex. You cannot be happy when you [someone] does that to you. When I was with him, he will tie me with a rope, by the side of the bed. I felt diminished. He then tortured me to the extent that I felt like I could not live this life anymore. I think someone I love why could you do this to me, I mean. So, I decided to go and talk to my Pastor about it because it was getting too much for me.

Brenda expressed panic and fear all the time in her relationship with her husband:

I will say our relationship is full of panic, fear, I am stressed out, and I wonder everyday what my future is or what if I have a future at all. I still live with my husband and our three children and his mother…I am suffering a lot, and I don't know what else to do. Every day he beats me, my body is full of scratches and wounds and I don't know what we can do to solve the matter.

Paula had a story of more of sexual abuse/exploitation because she could not produce a male child for her husband:

I feel lonely all the time. I am with a man that I don't love. My family says he was from a good family. But I don't love him and he knows that. My experience has not been the best; as I earlier told you, I don't love my husband, maybe that's why

he treats me the way he treats me. I live with my partner right now. We have four

kids and he makes me to keep having children because he wants a boy child. And

since I have not been able to give him a male child he keeps on putting me under

pressure so I should have a male child with him. There are times he gets to like

beat me it gives me a lot of trauma, and I don't think that this is the best way to

live and I don't think that is the best relationship ever; so I decided on going back

to my father's house.

Leslie decided to get a divorce despite the fact that she could face backlash from her

family. She said that:

Yeah I was a victim of domestic violence with my ex-husband…we are divorced

and we don't talk to each other (or the family)…There were times when I was

abused, I reached out to the police and sometimes when I was bruised, I had to go

to a hospital. My husband beat me and I had wounds and bruises on my body and

I had to seek medical attention.

All the recollections of abusive relationships prompted the participants to want to

get out assistance from social support systems.

Theme 2: **Understanding social support systems.** Even though they were a little

shy of explaining themselves, participants seemed to have a good grasp of what social

support systems means to them and how they could use it. Participants were asked, "Can

you describe to me what social support systems means to you?"

Sandra explained that they are systems that could bring her husband back to

order:

The social support, I think can help me, maybe to organizers to talk with him

(husband) or to share things with him so that we can get a good marriage.

Victoria was a little bit more explicit in her understanding of social support systems:

Social support systems is all about somebody being there for you, people around

you communicating. There for you in situations for example the police. I can give

an example. When I was in such a situation, when I was passing through what I

was passing through in my past relationship, eh, people were there for me I should

say. For example, my church, my Pastor was there for me. And yeah, that is how I

can understand social support systems.

Nina was very brief in her description, but she understood it was a vast term that meant

several things to different people:

Social support systems to me is a very vast term but I would say is someone that

is being cared for or getting assistance for others. It could be family or friends, or

the community.

Amanda and Anaya were more subtle in their definitions and also focused on examples of

social support systems:

Social support systems means hospitals, when you go to people that can help you

like doctors, nurses, maybe even the police.

Anaya explained that:

I think social support systems mean going to the church. The police, hospitals, or

talking to a doctor about your abuse or how your husband is treating you badly.

Leslie also explained that social support systems are meant to help women who were
victims of IPV:

> Social support systems is a system within a society that is willing to help people
> such as clinic doctors, hospitals, some NGOs, things like that.

Paula also pointed out the same social support systems:

> I think like a doctor, police, court, or something like a family.

Brenda further expounded that it is a place for women in a bad relationship to go and feel
safe:

> To me I think social support systems means, it means when you are in a bad
> marriage and you don't feel safe. You can go either to the police, hospital, or the
> court and anybody in fact that can help you and maybe support you.

Many of the women seemed to believe that their families could be their social support
systems, but when that failed, they looked somewhere else.

All the participants understood what social support system meant and what they
could be used for. Participants had different definitions, yet they all summed up to the
fact that the social support systems could help them in their abusive relationships.

Theme 3: Reaching out. Participants were eager to share their experiences about
their encounter with social support systems. Each participant had reached out to social
support systems from three to over ten times. Paula explained that she had reached out
first to her family and then to ROC. She explained that:

> There was a time I went to my family. My father did not ask me anything why I
> came. Then after about two days, he told me to go back to my children. So I came

back to the house. Then my friend told me to come to ROC. But I told my

husband I was going to the market. So he did not know I was going to ROC.

Amanda also had a similar encounter with her family:

I have tried to reach out to my parents. Most times I ran to my parents, but you

know they can't accept me back. You need to sort issues out with your

husband.… My husband normally fights me, friends, and parents. And they told

me (I need to) go to the police and makes a statement. I went to the police and

make a statement. I went to the police, I told them the whole story and they did

not say anything. They said they could not help me apart from me going back

home and settling my issues with my husband. They really did not give me any

support. So I went to the church. I talked to the pastors. They tried to counsel me

but they didn't give me much support. At the end of the day, all they told me was

to go to my husband.

Leslie mentioned that she had been to the police several times to report the situation at

home with her husband and to the ROC:

I have used ROC. It's an organization. Assists with battered women, women

going through domestic violence. I have also dealt with the police too. Several

times I reported my husband to the police.

Some of the participants had gone to the hospital after an encounter with their

partners and shared their experiences. Anaya explained that:

I have come to ROC. I went to the hospital once when my husband forced to sleep

with me and beat me. But I was too ashamed to talk to anyone.

Sandra on the other hand reached out mostly to the church who directed her to the police. And after the police, she decided to go to the HOFNA:

> I decided to go to the police if they can please discipline him (husband) because I talked to my church members. They told me you can't leave the marriage like that. That maybe go to the police and tell them what you are passing through, maybe you will get help. …Yes, I came to this organization (HOFNA) so that they can maybe help for what I am going through with my husband.

Victoria said she enjoyed going to church as a believer because she needed the support from her pastor and community:

> Well, first I am a believer, other than my pastor and community leader, he played a big role in my life. He told me I had to live life more than I was seeing.

Brenda explained that she had gone to her Pastor, who tried to talk to her husband. She said:

> I have been to church to talk to the Pastor… the police and today I also came to HOFNA. It's the second time I am coming to HOFNA.

Research question one was discussed. Participants were able to describe the reasons why they decided to reach out to social support systems and the type of social support systems they reached out to. Many of them felt like reaching out was the best solution for them and their children. They felt like reaching out would reduce the feeling of uncertainty in their marriage and in their lives. Table 3 summarizes the themes and information that were developed from participants in the study;

Table 3. Themes and information extracts for research question 1

Research Questions (RQs)	Themes	Information Extracts
RQ1. What social support systems have women used in Cameroon	• Relocation/feelings about abusive relationships • Understanding social support systems • Reaching out	• Explaining abusive relationships and what made them reach out. • Explaining their understanding of social support systems • Encounter with social support systems and how many times reached out

Research Question 2

What are women's experiences with social support systems in Cameroon?

Theme 4: Experiences with social support systems. I asked the participants that "what has been your experience with the social support systems you reached out to?" Nina, who had suffered IPV for 10 years, said she was castigated by society and her family:

Actually, when I was in the situation where I was abused or experienced domestic violence, I didn't have the opportunity to be able to utilize any social support systems because of the way…how in Cameroon we have like a social stigma that when you get out and look for help. But right now I got out of the situation, and I did not use any social support systems. I was just able to find ROC from a friend

and what they are doing about helping victims of domestic violence. I only reached out to ROC after the fact. But they are helping me right now with the relationship I am in.

Leslie, who was also divorced from her partner, expressed the heartbreak of going through IPV and the society shunning her because she decided to stand for herself:

> I mean, Cameroon being what it is, the woman is so constantly blamed for being abused in the home. There is no excuse. I mean sometimes when I reported to the police, I was sometimes blamed for being battered. The most sympathetic was ROC. ROC was very understanding and gave me some counseling, but nothing else was done.

Anaya explained that the only place that was somewhat helpful to her was ROC. When I asked her about her experience with social support systems, she said that:

> Not very good. Like I said, people judge you too much that you are not a good wife or might have another boyfriend and that is why you want to leave. The only place that has given me small support is here at ROC. They are very nice people here. They talk to you and try to even give you money. Give you resources on how to help yourself and even try to help in court.

Brenda explained that her husband beat her even in front of the kids and refused to see their pastor when he was summoned to church. Things, on the contrary, got worse for Brenda as she seemed extremely traumatized and sad. Brenda posited that:

> I have been to church to talk to the Pastor, and he called my husband after church service to talk to him because my husband has been beating me in front of our

children and his mother. But the Pastor told him to come see him, he refused and

things got worse at home. He (my husband) even slapped me because I told the

pastor about our business and he said if I loved my family and wanted to be in the

marriage, I will respect the boundaries and keep my mouth shut…It is the second

time I am coming to HOFNA. And the last time they told me there is nobody

available to help me. So I decided to come (today) to see the counselor. I saw her

and she talked to me for a while and prayed with me. Even though nothing has

changed, I want to, at least, know that they will be available to help me.

Other participants explained that their experiences was nothing short of horrible.

They felt like social support systems were not as helpful to them as they should.

You need to sort issues out with your husband.… My husband normally fights

me, friends, and parents. And they told me (I need to) go to the police and makes

a statement. I went to the police and make a statement. I went to the police, I told

them the whole story and they did not say anything. They said they could not help

me apart from me going back home and settling my issues with my husband.

They really did not give me any support. So I went to the church. I talked to the

pastors. They tried to counsel me but they didn't give me much support. At the

end of the day, all they told me was to go to my husband.

Sandra went to the police several times but they did not help her situation. Then

she went to her local church:

There they told me that once you get married, you have to pass through such

things. They told me that "you have children, you have to persevere because you

vowed to the church that in health, in sickness, in good, in poor, in everything you have to stay together." So the church were insisting that I sit there. They didn't sympathize with me.

Paula distressed because she was not getting help from ROC as much as she needed and she was also being sent back to her husband by her father:

Actually, apart from ROC, I think I went only to ROC. They did not like do anything to help me. They were just like giving me advice and I don't think the advice was good enough to like help me with the situation…So my father thinks am like disgracing his family name. Just sending me back to my husband. And on the part of my Mum, my Mum cannot say anything about it because she knows that she like went through the same thing I am going through now with my father. When I went to ROC…the woman said I should go back to my family and that she is going to have me see the counselor. And that if the counselor comes she is going to like call me back next week. She advised me a little bit, and that was all I had with the woman and nothing else. So for me, I don't think that was really helpful.

In all, listening to the participants was a clear indication that their needs were not met by the social support systems they approached. Despite the fact that most participants reached out to them more than three times, they felt like they were not helpful. All participants at some point in their relationship reached out to their church, the police, family, friends, and NGOs. They all expressed disappointment in the services. Table 4

summarizes the themes and information that were developed from participants in the study;

Table 4. Themes and information extracts for research question 2

Research Questions (RQs)	Themes	Information Extracts
RQ1. What are women's experiences with social support systems in Cameroon?	• Experiences with social support systems	• Participants explained their experiences with social support systems

Research Question 3

How do women cope with or endure IPV through the help of social support systems?

Theme 5: Coping as a victim. A lot of the participants felt like they were not coping with IPV as much as they thought they would with the assistance of social support systems. When I asked participants that, "How have you been able to cope with intimate partner violence with through the help of these social support systems?" Sandra explained that she was at least provided with some food:

Yeah, they help [ed] me just for coming and consoling me and supporting me with like food, I can't buy food in the house. They could help us with food; they could help me with milk for my children. That's the little things they help me with. But I see its worsening.

Paula also articulated that she had problems coping especially that her situation was still the same:

I've not really been able to cope that much because everything is still the same. First my husband will kill me if he knows that I went to ROC. Because I made him know I was going to the market. But right now, I am training to like learn a new business that is going to help me raise some money so that I can take care of myself and my children.

Brenda said the counselor she saw at HOFNA gave her some money and prayed with her. But that she could not go home with the money because her husband would think it was from a boyfriend. And that her husband is "uncontrollable" so there was no point even reporting him to the pastor of their local church:

As a matter of fact, my situation has still been the same. In fact, it's getting worse because my husband did not like the fact that I reported him to the Pastor. And even told the pastor to mind his own business and take care of his own wife.

She insisted this is not helping her cope, it has just made things worse for her and making it harder for her to leave.

From the results stated above, participants would have wanted to get more assistance from social support systems so that they could better cope with IPV. Participants believed that social support systems could provide more services for them and their children. However, that was not the case with the social support systems they visited to assist them in fighting against IPV. Table 5 summarizes the themes and information that were developed from participants in the study;

Table 5. Themes and information extracts for research question 3

Research Questions	Themes	Information Extracts
RQ1. How do women cope with or endure IPV through the help of social support systems?	• Coping as a victim	• Participants explained how coping while in an IPV relationship was extremely difficult for them.

Research Question 4

How would IPV victims use the social support systems should they get all the services they need?

Theme 6: Reducing IPV. When I asked the participants, "How would you use the social support systems to reduce intimate partner violence if you get all the services you need from them?" six of the participants said it might have made them leave faster than they did. Nina:

What would have improved if I had ROC while I was in the situation, I would have been able to seek help faster than I did and I would have been able to reach out to people faster and express to them the situation I was going through because I never talked about the situation. So when I was able to leave, I received a lot of social rejection from family and friends. That's why I moved from Limbe to Buea because they did not see the reason why I was leaving. The mental torture, the verbal, physical, everything I've been through in the relationship. I was very tolerant, I was leaving in fear and wasn't able to express myself.

Leslie also showed a similar plight but summed it up in one sentence:

>…I would have been able to get out of the relationship faster than I did.

Amanda said she now leaves with her friend but was scared because it seemed like they was no escaping for her:

> If I got all the services I needed I would actually leave my husband…and
>
> establish myself elsewhere. And I will also help other women to fight against
>
> domestic violence. I put myself in their shoes, and I know exactly what they are
>
> going through.

Paula was more specific about her needs with her husband. She felt like if he changed she would rather stay with him for the sake of their children:

> First I would like social support services to talk to my husband. They talk to my
>
> husband and let them try to make him know how bad violence is. And if there is a
>
> way they can support me financially so that I can take care of myself and my
>
> children.

Brenda was also worried about herself and the future of her children and believed that if they got more assistance from social support systems, it could benefit her and her children. She explained that:

> If they gave me all the support I need, I would maybe learn a trade with my
>
> children and I might leave my husband to continue the trade with my children, so
>
> we can, with the money, so we can live our lives without the help of my husband.

Sandra like the other participants was desperate for her independence:

If they help me, we separate and, at least, I get a house of my own, and I stay with

my children, and I get rights for my children to stay with them, it will be very

helpful to me. And we separate, he does his own thing then I continue and do my

own thing with my children.

Participants believed that if they got all the services they needed from social

support systems, it could help in reducing IPV in their homes. It could help them get the

independence they so desperately yearned for themselves and their children.

Theme 7: Serving victims and survivors. During the interview session, the

women were finally asked, "What do you think could be improved for social support

systems to help you more as a victim of intimate partner violence?" Anaya explained

that:

The government especially needs to give more rights to women. The police need

to support us. We are human beings too. We also have our feelings.

Sandra also believed that the government could intervene in their situations:

…maybe we can run to the government…And they know that there is violence

somewhere. They know how women pass through tough times. Maybe it can

educate our men to reduce that violence. I want you to reach out today and tell

those organizations and tell the people, sensitize those men especially, those men

on how to treat their wives, maybe the violence could reduce.

Victoria elucidated that:

Everybody needs to know about this, that domestic violence is real, it's

everywhere, like the church or the police people, or they should put laws, strict

laws, and they should talk to people. They should do more putting up [of]

programs to teach both men and women that nobody is a superior. Even when you

are superior, you need to be respected as a Cameroonian man. It should not be all

about like doing this and doing that and harassing your wife. That is not the best

way.

Amanda, like most of the participants, also believed that the government needed

to step up for women and believed that everyone else would follow suit:

I believe this organization (HOFNA) or maybe the church if they are reached out

by the government to maybe give them more funds, they would be able to handle

such cases. They would be able to help the women because in this our country,

women are so vulnerable. If the government handles all of them to help them to

support us women, that can help us.

Brenda stressed on societal education and engaging the community in assisting

victims and survivors as well:

I would say pretty much just enabling women, not only the victims. Like I said,

also people that are in society so they can understand that, you know if you are in

a situation like that, it's only good to get out. That's what I realized now from

ROC-helping you to know your self-worth build your self-esteem. So in that way,

because, without self-esteem, you cannot be able to continue in another

relationship. You will not be able to know the warning signs. You can still find

yourself in the same situation.

Finally, Leslie expressed her feelings about the workers who have committed themselves to helping victims of IPV:

First I will ensure that the workers are well educated from domestic violence, and I will ensure that they are trained on how to handle the cases and not to be stereotypical. Because women deserves [deserve] to go through domestic violence or be battered for any reason.

In all, the participants seemed very disappointed about the services they got from the social support systems they reached out to. This made it extremely difficult to stay in the abusive relationship for a very long time, if not all their lives. Some participants expounded that the society in its entirety needed to be educated about IPV. Table 6 summarizes the themes and information that were developed from participants in the study;

Table 6. Themes and information extracts for research question 4

Research Questions	Themes	Information Extracts
RQ1. How would IPV victims use the social support systems should they get all the services they need?	• Reducing IPV	• Participants described how they could eradicate IPV in their lives if they received assistance from social support systems
	• Serving victims and survivors	• Participants explicated how they would improve social support systems to assist other IPV victims.

Evidence of Trustworthiness

Establishing trustworthiness involves the use of transferability, credibility, confirmability, and dependability as the inquirer's equivalents for objectivity, reliability, external validity, and internal validity (Creswell, 2007). Qualitative researchers consider that confirmability, credibility, dependability, and transferability ensure the objectivity of qualitative findings (Anney, 2014; Schwandt, Lincoln, & Guba, 2007). Participants were chosen using a purposeful-criterion sample, so evidence of trustworthiness was essential. Participants were compensated with a 5, 000 francs CFA ($10) voucher for Leader Price store. The voucher was a remuneration for participants' inconvenience and time.

Participants were women either from the northwest or southwest regions of Cameroon. It therefore meant that the study was not a reflection of the entire population of Cameroon. I used member check for gathering information from the lived experiences of participants and follow up questions for strengthening validity and accuracy. Saturation was achieved when no new themes emerged from analysis of the data collection from participants. To further enforce credibility and build participant-researcher confidence, I worked directly with participants who were victims of IPV, conducted member-check interviews and collected the data. Credibility was reassured by following interview guides and making sure I focused on the research questions. I also assured credibility by keeping an open mind to the lived experiences of participants with social support systems.

I used internal validity to enhance triangulation; member checking was facilitated by participants confirming their responses during the interviews. The threat to credibility

laid mostly with netting how participants made sense of their lived experiences. To also strengthen internal validity, data gathered from the pilot study and the face to face interviews were triangulated. This was done by taking notes from the pilot study and using them to enhance the interviews. Dependability was critical in improving triangulation in that it could be relevant to other researchers who study similar populations in Cameroon. It is particularly relevant for women who are victims of IPV and have sought help from social support systems. Therefore, I made sure all interviews were audio-recorded. Data was analyzed using NVIVO software, thus, making information retrieval to be relatively easy. Dependability was also established when themes of identified in the interviews were reviewed by the committee member of my dissertation. Also, coding was immediately conducted following transcription as information was still fresh in my mind. I transcribed the interviews word verbatim to allow the exact phrases and words used by participants.

I controlled personal bias by using bracketing. This meant that I made sure I did not include my personal bias and opinions on experience with social support systems among women exposed to intimate partner violence. My focus was on questioning participants about their lived experiences with social support systems and sometimes confirmed using follow-up questions.

Summary

The purpose of Chapter 4 was to discuss the findings and themes of this study and discuss the findings from the data that were taken from the face-to-face interviews about experience with social support systems among women exposed to intimate partner

violence. The information provided was divided into pilot study, study setting, recruitment procedure, demographics/biography of sample population and data collection, data analysis, themes, themes and research questions, and evidence of trustworthiness. The interviews with participants were also discussed, giving participants the opportunity to discuss their lived experiences with social support systems.

The themes and research questions were linked together identifying the context, intervening conditions, and consequences. This strategy was used to discuss the results described in Chapter 5. The discussion of the results described in this chapter, recommendations, and conclusions will be presented in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Social support is when one has the certainty and perception that one is cared for, is assisted by other people, and is part of a supportive social system (Fanslow & Robinson, 2010). Intimate partner violence is a persistent and pervasive social problem in society that describes financial, sexual or physical violence, and psychological aggression or coercive acts by a present of a former partner (CDC, n.d.). IPV is a persistent pattern of intimidation, threat, isolation, and fear that results in emotional or physical trauma.

The primary aim of this study was to understand the lived experiences of social support systems among women exposed to IPV. It was essential to use a phenomenological approach to IPV victims' perceptions of social support systems in Cameroon. I collected data using face-to-face interviews that I recorded, including a three participant pilot study that helped model the path forward for the eight participants in the study. Data collected were analyzed using NVIVO software to help in developing themes or nodes. The themes were taken from the occurrence per interview.

The findings of this study were interpreted using the transtheoretical model of change (TTM) and the health belief model (HBM). In addition to the TTM model, Kolundzija, Gajic, Misic-Pavkov, and Maras (2011) identified processes of change that are overt or covert activities or experiences that usually encourage change about people's behaviors, thoughts, relationships, or feelings. The stimulus control is the process of the stage that was discussed. The interventions help people change their environment to control the causes of behaviors like self-help groups, environmental reengineering skills, and avoidance techniques (Kolundzija et al., 2011). The HBM posits that a range of

factors affect an individual's self reported probability of taking part in preventive efforts (Cornelius et al., 2009).

The purpose of this qualitative study was to explore the perceptions women have about using social support systems in the southwest and northwest regions of Cameroon. I reviewed the purpose of the study and I compared the findings of the interpretation to those that were examined in the literature review. Also, limitations of the study were discussed as well as recommendations for implications to social change and recommendations for further research about IPV victims' and social support systems in Cameroon. The study sought to find out if they would feel comfortable using these services should they be made available to them. The main finding in this study was that participants felt they were not given the services they needed from social support systems. They also felt that the men, the communities they lived in, and the government needed to educate others about IPV. Social support workers and volunteers need more training to better serve the victims as well as survivors.

Interpretations of Findings

This study filled an identified gap in the literature review by focusing on experience with social support systems among women exposed to IPV in Cameroon. The interpretation of the findings were presented with the research questions identified in Chapter one:

RQ1: What social support systems have women used on Cameroon?

RQ2: What are women's experiences with social support systems in Cameroon?

RQ3: How do women cope with or endure IPV through the help of social support

systems?

RQ4: How would IPV victims use the social support systems should they get all the

services they need?

Research Question 1: What Social Support Systems Have Women Used in Cameroon?

Participants had sought the help of many social support systems. As described in

the literature review, social support is a process that involves bonds of formal or informal

friendship that establish exchanges to meet the needs of people (Ferreira et al., 2012).

People who receive positive emotional and behavioral change from these individuals

often experience a sense of relief to some extent as far as their crisis are concerned

(Ferreira et al., 2012; Pedro et al., 2008). All the women, as described in the HBM, were

in the perceived susceptibility stage. The HBM suggests that a diversity of factors affect

an individual's self-reported probability of participating in preventive efforts (Cornelius,

Sullivan, Wyngarden, & Milliken, 2009). People in this construct would engage in

behaviors or activities to help reduce the risks of developing these problems. Participants

all acknowledged that IPV was a problem and decided to seek help. Participants

explained that they had gone to social support systems at least three times. Participant

Amanda said she had visited social support systems more than 12 times (hospital, church,

Hope for the Needy Association Cameroon-HOFNA, the police, and her parents). Sandra

also had visited more than 11 times (the police, HOFNA, and the church). Leslie had

visited the police, the hospital, and Reach Out Cameroon-ROC more than five times.

Leslie explained that she still went to ROC for support even after her divorce was

finalized. Anaya had visited social support systems seven times, Victoria and Brenda four

times, and Nina and Paula said they had gone three times. Intimate partner violence

survivors or victims have always reported that successfully getting out of a violent

environment has been a less stressful transition. Survivors and victims have explained

that the assistance of social support systems like public cash assistance, shelters, and

counseling made the transition less stressful (Botein & Hetling, 2010; Lyon et al., 2008;

Simmons, Farrar, Frazer, & Thompson, 2011). Social support systems are either

government or nongovernmental agencies including public health officials, police

officers, and the judicial or legal system (Taylor, 2011). They could also be informal

supports from community members/groups, family members and friends (Heaney &

Israel, 2008). The most sought social support systems were the police and the church. It

does demonstrate an inclination to use those services that could provide them with the

support they desperately need for themselves and their children.

Also, participants mentioned in the interviews that they were desperate to get

help, hoping that their situations could change. It indicated that they had all attained the

contemplation stage of the TTM Model. In the contemplation stage, the women

recognized the abuse as a problematic behavior and have some awareness of the

advantages and disadvantages of the process of change (Burke et al., 2004). IPV victims

in this stage are usually not yet ready to leave their abusers. Often because women are yet

to have control of their situations (Burke et al., 2004; Catallo et al., 2012). There are no

time periods for victims to move from one stage to another, but they may remain in the

precontemplation and/or the contemplation stages for several years (Prochaska et al., 1992). It is for this reason that Brenda, who was identified to be in the contemplation stage, recognized the problems faced by victims of IPV. However, she seemed not to have made up her mind about leaving her abusive partner. She had visited social support systems four times (her local church and HOFNA). But during the interview, she mentioned that if she got all the services needed she might leave her husband. She did not want to raise their children all by herself. Brenda was more worried about bringing up her children all by herself, without the help of her partner. This behavior ties with the literature review that, many women in a study believed that the threat of separation and lack of social support was reduced after they left their abusers (Ditcher & Gelles, 2012).

These findings were evident that participants were aware of what social support systems means, and as well as their uses. In the demographic form, they all answered, "Yes" to have been physically/sexually, emotionally/psychologically, and financially abused by their husbands or partners. Other than Brenda, they all understood the perceived severity (HBM) of being in an abusive relationship and all wanted to leave their abusers or had already left.

Research Question 2: What Are Women's Experiences with Social Support Systems in Cameroon?

According to the literature review, individual and/or group therapy and support groups are a representation of services that are supposed to help victims of IPV (Zweig & Burt, 2007). Intimate partner violence victims who develop battered woman syndrome are definitely in need of effective interventions that would satisfy their personal needs of overcoming domestic violence (Hearns, 2009).

Participants were not pleased with their experiences with social support systems. Many of the participants further posited that they received assistance from HOFNA and ROC organizations. To them, those were the only social support systems that seemed to help them to an extent. Anaya said that people judged her and said she was not a good wife. Anaya also mentioned that she had been in court because her husband had refused her to see their daughter for over a month. But Anaya was in distress because the judge insisted that she should try to work things out with her husband. Paula, who has four children with her husband, was constantly under pressure to have more children because she was unable to produce a male child. Paula stated that she had been to her father's house several times, but her father insisted that she went back to her husband because she was disgracing his family name.

Trevillion, Agnew-Davies, and Michele Howard (2013) examined a vast literature of studies that suggested that service use has increased overtime, but healthcare professionals are still unable to identify signs of domestic violence. These finding are extremely important because patients who have experienced IPV may not have any other direct contact or may have limited access to social services other than the healthcare provider (Trevillion et al., 2013). This limited or lack of access was a result of several reasons like language barriers, social norms, and inaccessibility to social support. Leslie experienced the same fate; she had been to her parents several times, but she was continually sent back to sought things out with her husband. Nina, who had been in an abusive relationship for 10 years, said she received a lot of social rejection from family and friends to the point where she had to relocate to another city to restart her life. The

findings in this study in the study also ties with the research done by the Advocates for Human Rights. As described in the literature review, the Cameroon society discriminates against boys and girls especially with the small representation when it comes to decision making and control of family resources (The Advocates for Human Rights, 2014). Men had rights and power to decide over vital social issues like marriage, healthcare, divorce, land ownership and child upbringing (CEDAW Report, 2011). These inequalities have since molded ideology, beliefs, and attitudes of women and men regarding their sociocultural issues, health, and the economy. What mainly increases the core risk factor is customary and cultural laws that make it almost impossible for women to seek help from their abusers, even if they wanted to (Teke, 2009).

According to Leslie, when she was in the hospital for the medical attention she needed, the doctors/nurses blamed her for what happened. As described in the literature review, researchers believed that social support should be extended especially to hospitals and clinics where victims usually have first contact with some kind of support after an abusive experience. Selic, Pesjak, Kopcavar-Gucek, and Kersnik (2008) and Trevillion, Agnew-Davies, and Michele (2012) posited that the relationship with patients, their doctors, and their willingness to open up if the doctors asked them should be examined. If the doctors are not keen to understand domestic abuse, they may not be of assistance to the victims, thus was the case with Leslie.

The barriers that are perceived as explained in the HBM model could prevent participants from engaging in health promotion behaviors. Participants' decisions could influence the perceived benefits and barriers of the IPV victim to either get out of the

abusive environment or remain there (Chapin, 2011). The many barriers including lack of

suitable or sufficient resources could prevent an IPV victim from either trying to change

their situation or get some assistance from social services. Participants faced barriers like

family, community (church and the police), and friends. Some of them were not working,

while, some of them were worried about their children. Anaya explained that people in

the community judged her; reason why she stayed so long in the abusive relationship.

These barriers faced by the participants were described in the literature review. My study

found out that deterring roles that affect a victim of domestic violence are as a result of

cultural norms and lack of personal resources (Kulwicki et al., 2010). Some participants

that were not working said they depended on their husbands for support. Anaya also

explained that her father always sent her back to her husband because it was a taboo for

her to leave her husband regardless of the circumstances. These barriers had deterred

Anaya's plans to escape from her husband. Anaya could be described as being in the

action stage of the TTM model of change as described by Prochaska et al. (1992). Anaya

separated from her husband and vowed to get her daughter back. She did not want her

daughter to grow up in an abusive environment. She had gone to court despite the

backlash from the judge. The HBM model further explained that individuals would take

action if they perceived any future health threats, but in Cameroon, as described by all

participants, the lack of healthcare resources prevented people from taking positive

actions (Kongnyuy, Hofman, & Van den Broek, 2009).

Furthermore, in the HBM model, the findings showed that Nina was experiencing

the cues to action stage. She saw her sister go through the same thing she went through

and was advocating for her to get help. Nina was triggered to help her sister, thus prompting an engagement in health promotion behaviors. Nina was now aware of the effects of intimate partner violence so she advocated for her sister to also get services from ROC. As described in the literature review, participants who used social support reported better mental, oral, and physical health. They also reported a lower risk of depression and psychological distress than those who were not living in a shelter (Kamimura et al., 2013). As stated in this study, while trying to help her sister, Nina is making sure she and her sister have a healthier life.

Victoria had also left her abusive relationship but was extremely traumatized to the point that it affected her new relationship. Victoria explained she still had flashbacks, was constantly traumatized, and psychologically distressed. As described by Kamimura et al., (2013), using social support could reduce the effects of mental and physical health. Since Victoria did not get enough social support while she was in the abusive relationship, she still lives with the ordeal. More so, she is embarrassed to get help, especially for counseling. It also connects with the literature review that sates that women who left abusive relationships still suffered from physical trauma, low self-esteem, depression, and feelings of fear, something that is similar to women who are still in the relationship (Haesler, 2013). In the study, women needed more social support in and out of the abuse and sometimes relied on social networks for that support, which were usually never met.

Research Question 3: How Do Women Cope with or Endure IPV through the Help of Social Support Systems?

The findings from this study were that all participants found it extremely hard to cope despite the services of social support systems because of the barriers they encountered. Leslie and Nina, who were divorced, explained that they still came to ROC because of the counseling. They explained that only ROC had been helpful to them. Drawing from the maintenance stage in the TTM model and despite the setback by the many social support systems they tried to reach out to, some participants were hoping they do not relapse into the same relationship. Leslie explained that ROC helped her a little but the other social support systems were not helpful.

Nina was able to refer her sister to ROC who was also going through IPV. Nina said she can cope with IPV now because she knows the signs and would make sure that she does not go back to another abusive relationship. Nina explained that she left her ex-husband about two years ago. As explained in the literature review, the research discovered that when victims of IPV are no longer able to cope with the abuse they experience, they would at times seek external resources especially agencies available in the community (Haj-Yahia & Cohen, 2009).

Other participants like Amanda, Paula and Sandra, were still desperate for social support. Amanda left her husband and was living with a friend. She seemed to be in the preparation stage of the TTM model. Amanda said she felt stuck, without a game plan but hoping that she could get help from social support systems. In the preparation stage, women who experience IPV recognize that the abusive behavior is problematic. At this stage, they intend to change and even develop an escape plan (Burke et al., 2004).

Victims at this stage usually do not have an effective action plan but have tried many

actions of escape (Chang et al., 2006). The findings also supported the literature that

posited that victims of IPV may decide that leaving an abusive relationship could be

problematic to them because they may not have a place to go for shelter (Botein &

Hetling, 2010). Researchers found out that IPV was one of the highest causes of

homelessness in women and children (Aratani, 2009). Over 90% of these women and

children in this study relied on domestic violence shelters or homeless shelters and foster

homes (Aratani, 2009). Intimate partner violence also affected women and children in

that many of them had to move from one place to another causing instability in the lives

of the women and children (Baker et al., 2009). Amanda was worried about being

homeless because she was temporarily staying with her friend.

Research Question 4: How Would IPV Victims Use the Social Support Systems Should They Get All the Services They Need?

Victims of IPV felt that social support systems needed to be improved or educated

to provide better services to victims and survivors. Findings from this study were evident

in that all participants explained that if they got all the services they needed from social

support systems, they would leave their abusers or would have left earlier than they did.

Sandra, at the end of her interview wondered if she would ever get assistance from social

support systems, considering her circumstances. She understood the perceived benefits

(HBM model) of leaving her abuser and getting a better life. Sandra was expecting that

social support systems would support her as well as help her cope with the abuse. Sandra

explained that she got counseling from HOFNA but was still in the abusive relationship.

One of the findings in the literature review posited that more women felt like if there

were more support for them, they would be able to cope and leave their abusers and maybe develop more resilience in fighting IPV (Aldridge, 2013). This may be the reason why some of the participants in the study sought help yet were still living with their abusive husbands or partners. Brenda also explained that she was beaten every day and had wounds and scratches all over her body. Like Sandra, she worried about getting help.

Also, I found out that five of the women were of the opinion that besides the government and the community, the men also needed to be sensitized. Sandra and Victoria explained that if the men were informed they might treat their wives better. Victoria also elucidated that the communities have to be educated about intimate partner violence so they could support abused victims in the community. As described in the literature review, services would be only useful and accessible if the women have access to them and if they would not be turned downed or shunned from their families and communities (Fanslow & Robinson, 2010).

The participants wanted a long-term goal of protecting them which was more than just talking to the men. My findings in this study tied with the literature that discovered there was a need for an intervention for men (De la Harpe & Boonzaier, 2011). The women in this study felt that even as physical abuse had reduced, the program was not working for the men because of the long-term consequences. Men according to the study needed more than just domestic violence sessions. There needed to be long-term interventions that could help both the men and women in the future (De la Harpe & Boonzaier, 2011). The government also had to be involved to provide consequences for abusing a partner as described by Nina, Leslie, Amanda, and Anaya.

Limitations

The most noted and important limitation to this study was the lack of generalization. Experiments and case studies share the problem of generalization that were completed with a limited number of people. Despite all this, academic communities have accepted generalization as ways of acquiring knowledge (Larsson, 2009). The study was limited to the participants in the northwest region and the southwest region of Cameroon. I used a purposeful criterion sample that further limited the need for generalization to this study. As described in Chapter 3, purposeful sampling has been widely used in qualitative research for identifying and selecting information-rich participants that are related to a phenomenon of interest (Palinkas et al., 2013). I asked selected participants to describe their lived experiences with social support systems as victims of IPV. It means that replicating this study would entail not just readdressing the sampling method of eight participants (three in the pilot study), but also broadening the scope of the regions identified for the study. The results of the study were cautiously interpreted and they may not necessarily apply to another setting or another population.

Also, participants were compensated with 5,000 francs CFA ($10) voucher cards for Leader Price store. The voucher cards was compensation for their time and inconvenience. The fact that the women were able to show up for the interviews considering their situations and some of their responses about educating men and society demonstrated their quest for change. Their perceptions about experience with social support systems among women exposed to IPV were limited just to the eight participants in the study. I used member check for summarizing information from participants and

asked follow-up questions when necessary to increase validity and accuracy. I used the theory/perspective triangulation for multiple theoretical perspectives to interpret and examine the data. The HBM and the TTM model were used to enhance further the internal validity. It was also used in combination with a phenomenological perspective of understanding participants lived experiences with social support systems. I assisted with member checking by confirming participants' responses during the face-to-face interviewing.

Another problem faced was time and resources constraints. Due to the time constraints of finishing my dissertation and the limited resources, I was not able to do a larger sample size. I was not able to work in other regions or organizations. These constraints however provide an opportunity for further research in the field.

The main aim of this study was to understand women's lived experiences as well as figure out what seemed to be the reason for lack of support. Therefore, despite the limitations faced as described, the study could still be relevant when it comes to discussing perceptions of experience with social support systems among women exposed to intimate partner violence in Cameroon.

Recommendations

Females in Cameroon are constantly faced with IPV, the majority of them believing it is a natural circumstance in the community (U.S. Department of State, 2010). It is, therefore, essential for IPV victims to discuss their experiences with social support systems; systems that are supposed to protect them from their abusers. As described by all the participants in this study, it was important for their partners in particular and the

community and government, in a broad-spectrum, to be educated about IPV. It was

important for communities to provide support to individuals faced with such deplorable

situations, especially those with children.

As earlier described, the lack of social support services has been recognized as a

primary link to IPV; an obstacle to seeking medical, personal, social, and legal services

as well as an important risk factor for health issues that are associated with IPV (Lyon et

al., 2008). Intimate partner violence survivors or victims have reported that successfully

getting out of a violent environment has been a less traumatic transition (Simmons,

Farrar, Frazer, & Thompson, 2011). Survivors and victims believe that social support

systems like public cash assistance, shelters, and counseling could assist them in getting

out of abusive environments (Botein & Hetling, 2010; Lyon et al., 2008; Simmons,

Farrar, Frazer, & Thompson, 2011). It is evident from this study that women are in

desperate need for social support systems. Communities and the government need to be

educated in helping these women and also men on how to avoid intimate partner

violence. The findings of this study could be offered to social support systems so they can

offer their feedback and commentaries to me. The information could be further used to

develop training sessions that could educate men, communities, and government on how

to promote the avoidance of IPV. The ultimate objective is to eradicate IPV in Cameroon

where participants are always faced with victimization.

Researchers in the public health sector should develop, design, and implement a

multi-disciplinary process and approach to continue to curb IPV in Cameroon.

Compulsory activities at governmental, social, and religious levels would be necessary.

In addition to that, more appropriate and immediate interventions for victims of IPV are required to accomplish a decrease in intimate partner violence in Cameroon.

Furthermore, a follow-up study could be performed with a bigger sample size to understand how social support systems operate as compared to other developing countries and how they can help victims of IPV. This study could help with recommendations that could potentially enhance social support systems in Cameroon. A larger sample size would provide the government and local communities with information about all regions in Cameroon as concerns intimate partner violence and the vital importance of social support systems. These evaluations of larger sample sizes could provide a larger awareness of the plight against intimate partner violence. The government, as a result, could provide an intervention for victims. This study was a tentative one, so as important as the findings are to research, there is a great need for intervention in these communities.

Intimate partner violence is perpetrated in Cameroon by numerous people in the society especially spouses, family members, parents, community members, and public authorities (United Nations, 2013). Traditions and customs are numerous like condoning a husband beating his wife, wife inheritance by a male family member after the death of her husband, female genital mutilation (FGM), and early/forceful marriage (United Nations, 2013). Intimate partner violence further exceeds as the Cameroon society discriminates against boys and girls especially in the small representation when it comes to decision making and control of family resources (The Advocates for Human Rights, 2014). Another follow-up study could be done in regards to exploring the perceptions of

cultural norms concerning intimate partner violence. These cultural norms could be considered in terms of providing social support systems to victims of intimate partner violence. Participants in this study stressed on the fact that family, friends, and even the community were not as supportive. The community; including friends and families; felt like the women had to endure whatever came their way because they had children with their partners, they belonged to their husbands or partners, they vowed "for better for worse," or their families had already received the dowry or bride price.

Also, research that focuses on experience with social support systems among women exposed to intimate partner violence in Cameroon would be helpful to enhance awareness of how women cope in abusive situations. The study could be further stimulated through comparative studies using other qualitative methods like ethnography or grounded theory.

The study will be disseminated by independent peer-reviewed colleagues in the field of research who did not participate in conducting the study. The peer-reviewed process would ensure objectivity and increase the likelihood of my study being viewed by others interested in the intimate partner violence. My study could also be disseminated to other health professionals, investigators, health professionals, and policymakers in Cameroon. A brief report of my study could be submitted to the media or professional organizations interested in the field of domestic violence. Press releases in the northwest and southwest regions of Cameroon would also be considered because it would offer an efficient mechanism to disseminate my study to the community and educate them on IPV.

Implications to Social Change

Domestic violence deters victims' abilities to practice their rights to self-determination, which affects many areas of their lives and choices (Webb, 2010). One important implication to social change that has resulted from this study is the contribution to knowledge that could help in reducing IPV in Cameroon. The study might assist in educating social support workers or volunteers to help fight and hopefully eradicate domestic violence in Cameroon.

This study also adds to the body of academic research on the unending effects of domestic violence in Cameroon. The findings from this study would hopefully encourage the need to implement and develop culturally sensitive programs to help in reducing domestic violence or intimate partner violence in family homes. An intensive effort by researchers, academia, religious, and governmental/nongovernmental organizations that would involve using all forms of media to increase awareness in the Cameroonian communities on the effects of IPV on women and even the children is needed. There is a dire need for similar campaigns to raise awareness of reducing IPV in Cameroon.

Intimate partner violence has lifelong consequences for victims, their children, and abusers. At the same time, it is reversible and preventable especially for children who are victimized. Improving interventions to assist IPV victims especially those who reach out to social support systems should be mandatory. Researchers in this field may be able to assist women through interventions, further research on the topic, and the funding and implementation of a plan.

Conclusions

Experience with social support systems among women exposed to intimate partner violence is a public health issue in Cameroon that needs to be thoroughly addressed. Participants in this study described that their needs were not met by social support systems. Five of the participants were forced to remain in abusive relationships or chastised by the community and their families for leaving their abusive partners. It is important that this social health issue be addressed especially by the government to provide better interventions for victims or survivors.

The recommendations provided in this study could be important in implementing effective public health programs that could help IPV victims get the social support they need. The programs could also be used by other African countries that experience the same challenges for victims and survivors of IPV. These findings illustrate the need to provide and identify the social support systems needed by victims and survivors of intimate partner violence. No victim should be left behind in the eradication of intimate partner violence both in Cameroon and in the world.

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Appendix A: Flyer

(Flyer for the Study that will be posted at the two organizations and given to women who come for help)

Experience with social support system among women exposed to Intimate Partner Violence in Cameroon study

This research study is for women who are victims of IPV and have had any experience with social support systems like police officers, domestic violence agencies, medical professionals, and the church. Researchers at Walden University want to learn more about the lived experiences of victims of IPV and the social support systems. The study will involve interviews at the Hope for the Needy Association (HOFNA) Cameroon in Bamenda and Reach Out Cameroon (ROC) in Buea.

The research is absolutely voluntary!

Is this study a good fit for me?

You may qualify for this study if:

1. You are over 18years old
2. You can read and write basic English language
3. You identify yourself as a victim of Intimate Partner Violence
4. During a domestic violence experience, you reached out to one or more social support systems.
5. You live in the Northwest or Southwest Region of Cameroon

What will happen if you agree to take part in the study?

1. Complete a forty five minutes face-to-face interview in a private office at any of the NGO offices
2. Complete a short demographic survey and debrief of the study.
3. No children age over 12 months of age will be allowed in the interviews.
4. The researcher will cover your identity by using a fake name and to also protect your privacy.
5. You have to agree to have the conversation recorded.

There may not be any direct benefit to you for taking part in this study. But, you may experience some emotional distress by telling your story and sharing your experiences. Your participation in this study may however help other women in the future who experience intimate partner violence. Also, 5,000 francs CFA ($10) *Leader Price* Voucher will be given to each participant who takes part, as well as snacks during the interview process.

To take part in the "Experience with social support system among women exposed to Intimate Partner Violence in Cameroon" or for more information, please contact: **Ahone Ngujede at** ▮▮▮▮▮▮▮▮, Walden University, PhD Public Health candidate.

Appendix B: Demographic Data Form

Experience with social support system among IPV victims.

Pseudo name assigned to Interviewee_____   Date: ___/___/____

1. Has your partner ever pushed you, beaten you, refused to give you money for basic needs, talked down on you, etc.?_____

2. Have you ever reached out to the police, your family, friends, the court, the hospital, or any other support for help in Cameroon? ___No ___ Yes (If yes): Which one? (specify)_____

3. How many times have you reached out to a social support system? _____

4. Do you work? ___ Yes ___No

5. How old are you? _____

6. What Region are you originally from? _ Northwest __ Southwest __ Littoral __ South __ Adamawa __ Centre __ West __ Far North __East __ North

7. Did you attend a school? If yes: what level was completed Level of education is Nursery school__ Primary school __High school __ Technical school ___ University graduate ___ Advanced degree ___ No School

8. Marital Status __Single __Married ___Divorced ___Separated __Widowed __Living with Partner/Common Law marriage__

9. Do you have children? ___No ___ Yes. If Yes, how many? ___

Appendix C: Participant Screener

Experience with social support system among IPV victims

Recruiting goals:

- Participants must be females over the age of 18 years.

- Participants must be able to write, read and speak at least Basic English.

- Must reside in the northwest or southwest regions of Cameroon

- All participants must be able to self-identify as victims of IPV

- Recruit for about 11 participants; the number may decrease or increase depending on participant identification.

Incentive

-Participants will be compensated with $10 (5,000 francs CFA) Voucher for Leader Price store for participating in the interview.

Miscellaneous

-Snacks may be offered to participants during interview process.

-Participant identification will remain confidential.

Screening Questions

Hello my name is Ahone Ngujede. I am from Walden University. I am working on a research study about your experience as a victim of intimate partner violence with police officers, domestic violence agencies, medical personnel in the clinics or hospitals, the church, judicial system, and local community leaders. Please feel free to stop me at any time if you don't want to continue in this study. I am going to ask you some questions that will take approximately 15 minutes to complete.

1. How old are you?

   - Must be at least 18 years old. If not, ineligible

2. Are you comfortable reading and speaking English well enough to do an interview?

3. What region of Cameroon are you originally from?

4. Do you consider yourself a victim of intimate partner violence?

   - *Tell Participants*: Some women may describe themselves as emotionally or physically hurt, badly treated or injured, feeling frightened and/or controlled a past or present partner.

   - ___Yes – continue

5. Have you ever used a social support system in Cameroon?

   - Police officers

   - Domestic violence agencies

   - Doctors and/or nurses in hospitals and clinics

   - Judicial system

   - Community leaders

   - The church/mosque

Potential participants' ineligible closing:

Say to potential participant: Thank you for answering these questions. I am presently looking for individuals who fit a specific criteria. According to the information you were provided, you will not be able to take part in the study. Thank you very much for your time.

Potential participants' eligible closing:

Say to potential participant: Thank you for answering these questions. Based on your answers you are able to take part in this study. So, I will like to go ahead and make an interview time and date with you. Do you have any questions for me now?

Eligible Introduction: I will like to invite you to take part in a 45 minutes interview with a female researcher from Walden University about your experience with social support systems. The interviews will take place in a private office located in two places-in Buea at the Reach Out Cameroon (ROC) and in Bamenda at Hope for the Needy Association (HOFNA). You will be compensated with 5,000 francs CFA Leader Price Voucher for your time. You will need to arrange for child care for any of your children who are less than one year old during the interview process.

Ask potential participant: Do you have any questions with what I just explained to you?

Ask potential participant: So, would you like to participate in this study?

___Yes (*continue*)

___No (*terminate-thank potential participant and end interview process*)

If yes, SAY: OK, Can we set your interview? What time and day works best for you?

DATE of INTERVIEW _____ TIME OF INTERVIEW _____

Tell Potential participant: Only a few people have been invited to participate in this study. It is therefore extremely important that if you are no longer interested in the study to please call Ahone Ngujede at ▉▉▉▉▉▉▉. I appreciate you taking your time to participate in this study. I look forward to working with you on (date) at (time).

Appendix D: Screener Questions

Experience with social support system among IPV victims

Interview Questions for Experience with social support system among IPV victims
Fictional name assigned to Interviewee_____ Date: _____ Location: ____ Estimated
total interview time: 45 minutes

Introduce Yourself
- What words would you use to describe your relationship today with your partner?
- What is your current living situation?

Experience with social support systems
- Can you describe to me what social support systems means to you?
- Can you name an instance or instances where you decided to reach out to social support systems?
- What social support systems have you used to help you?
- What has been your experience with the social support systems you reached out to?
- How have you been able to cope with intimate partner violence through the help of these social support systems?
- How would you use the social support systems to reduce intimate partner violence if you get all the services you need from them?
- What do you think could be improved for social support systems to help you more as a victim of intimate partner violence?

Closing
- Is there anything else that you want to share about your experiences with social support systems?
- Do you have any questions for me?

Thank you! The End!

Appendix E: Letter of Invitation/Information

IPV victims' experiences with social support systems

Hello:

My name is Ahone Ngujede. I am a doctoral candidate at Walden University. I want to invite you to be a part of a study that will be developed in cooperation with *Reach out Cameroon (ROC)* and *Hope for the Needy Association (HOFNA) Cameroon*. With this study, I will like to know more about victims of intimate partner violence and their experiences with social support systems mainly in the Northwest and Southwest Regions of Cameroon. You will be given a 5,000 francs CFA Leader Price Voucher as a thank you gift for participating in the face-to-face interview. The interviews will take place in a quiet and private office HOFNA (for those in the northwest region) and at ROC (for those in the southwest region).

The study may be interesting to you because it is important that you share your experience to let others learn about intimate partner violence. You may also feel some emotional relief as you will be talking to a researcher in a nonjudgmental environment. Also, the study may be able to provide social support systems more information about how to help you in an abusive relationship. Your participation is voluntary, meaning you are free to decide whether to participate or not. If you also agree to participate and later change your mind for whatever reason, you are free to do so. Your decision will not affect any services you will need to receive if need be.

If you however decide to go through with the study, you will meet with the researcher to share your experiences about social support systems. The first part will be to fill a demographic form to know if you meet the criteria of the study. If you meet the criteria, a date and time will be set to meet with the researcher in which you will fill the consent form and do the face-to-face interview with the researcher. All of these will take about 45 minutes.

I will need to know if you can read and write the English language as well as comfortable talking to me. Per your permission, your answers will be audio recorded and will be kept confidential. This means that only the researcher will be able to see your answers. Your identity will be hidden; you will be given a nickname or a fictional name. All forms filled, including the consent forms and the demographic data form will have your fictional name.

If you are interested in participating in this study, please contact me as soon as you can. My telephone number is: ▮▮▮▮▮▮▮▮. Thank you for your time and hope that you can participate in this study.

Ahone Ngujede
Ph.D. Doctoral Candidate
Walden University

Appendix F: Consent Form

Project Title: Experience with social support system among women exposed to Intimate Partner Violence in Cameroon.

You have been invited to take part in a research study that is aimed at understanding the experience with social support systems-like courts, community leaders, police officers, domestic violence agencies/support groups, doctors and nurses in the hospitals and clinics, the church and/or mosque, and even your family. The study is inviting women over 18years from the northwest and southwest regions of Cameroon. The women must have been abused by their husband or partner/boyfriend. They also must have contacted one of the various social support systems mentioned above. Social support systems are the people or the organizations you may have reached out to help you in trying to escape from an abusive husband or boyfriend. This form is part of a process called "informed consent" that will allow you to understand this study before deciding on whether to take part in it.

The Researcher:

This study will be conducted by Ahone Ngujede who is a doctoral student at Walden University. She will be your main source of contact.

Background Information:

The purpose of this study is to understand information about abused women's lived experiences with social support systems in Cameroon.

Purpose of the Study:

The purpose of this study is to explore the lived experiences with social support systems among women who have been exposed to intimate partner violence in Cameroon.

Procedures/Methods:

If you agree to be in this study;

- Information about you will be taken down. This will not include your name in order to protect your real identity.
- If you qualify to do the study, the researcher will set a date and time to meet with you for a one-on-one interview that will take about 45 minutes.
- The researcher will record all the information but if you don't want the researcher to do that, please feel free to inform her.
- The information you provide will be made available to you as well as your community leaders. The information may help community leaders understand how you feel.
- You will be asked in the interview to share your experiences with social support systems like the courts, community leaders, police officers, domestic violence

agencies/support groups, doctors and nurses in the hospitals and clinics, the church and/or mosque, and even your family.

Sample of Interview Questions:

- Below are examples of some of the questions you will be asked during the interview;
a) Has your partner ever pushed you, beaten you, refused to give you money for basic needs, talked down on you, etc.?
b) Have you ever reached out to the police, your family, friends, the court, the hospital, or any other support for help in Cameroon? ___No ___ Yes (If yes): Which one? Specify.
c) How many times have you reached out to a social support system?
d) Can you name an instance or instances where you have decided to reach out to social support systems?

Voluntary Participation in the Study:

This study is voluntary. It is your decision to take part or not to take part in this study. We will respect your decision if you decide not to take part in the study. No one will treat you any different if you decide not to take part. If you also decided to take part but later change your mind, you may stop at any time. You may also decide not to answer some of the questions if you don't feel like answering them.

Risks and Benefits of Being in the Study:

(a) Risks-There are presently no known long-term risks for taking part in this study. It is possible that you may feel stressed out or become upset with the questions while talking about your experiences. If you feel any of these and want to see someone, a counselor will talk with you. You may also decide to come early for your appointment so that you are done as early as possible and go about your day.
(b) Benefit-You will be able to share your experiences and how they have affected your daily life. During this process you may get to understand that you are not alone and that you could start healing from the abuse you have experienced with your husband or partner. Your experience may provide possible solutions to social support systems in your area that could help other women like you in the future. You will also have a better understanding of domestic violence or intimate partner violence and how to handle it.

Compensation:

You will be given a 5,000 francs CFA ($10) voucher or gift card for *Leader Price* shopping center as a thank you gift for taking part in this study. You will also be offered snacks during the interview to help you get more comfortable.

Privacy:

Any information you provide will be kept confidential. Your personal information will never be used outside of the study and the researcher will never include your real name on any report. All the information you provide will be kept in a secure place; locked in a computer file or cabinet for which only the researcher will have access to. The information will be kept for about five years as required by Walden University.

Contacts and Questions:

Please feel free to ask any questions you want about this study. The researcher will give you a copy of this consent for to keep Please let the researcher know if you want it kept alongside your records in this organization or if you are comfortable taking it home. The results of this study will also be made available to you as well as your community leaders and the organizations that told you about the study. You may contact the main researcher Ahone Ngujede at ▇▇▇▇▇▇▇ or ▇▇▇▇▇▇▇▇▇▇▇. If you want to talk privately about your rights as a participant in this study please feel free to call 001-612-312-1210.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing my name below, I understand that I am agreeing to the terms described above.

Printed Name of Participant _____

Signature of Participant _____

Date_____

Printed Name of Researcher _____

Signature of Researcher _____

Appendix G: Confidentiality Agreement

Name of Signer:

During the course of all my activities in collecting data for this study: "Experience with social support system among women exposed to Intimate Partner Violence in Cameroon," I will be granted access to confidential information that will not be disclosed. I acknowledge that this information will remain confidential and that any inappropriate release of confidential information can damage the participant.

By Signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where other can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's names are not used.
4. I will not make any unauthorized transmission, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I am officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: _____

Date: _____