What the Numbers Reveal:

Storytelling as a Community-Level Public Health Intervention to Address Sexual and Gender-Based Violence in Ntanka, Cameroon

1. Introduction

Sexual and gender-based violence (SGBV) remains widely underreported in fragile and low-resource settings not only because of stigma, but because violence is often normalised, poorly recognised, and disconnected from accessible support systems. The Ntanka SGBV Storytelling Project in Cameroon examined whether culturally grounded storytelling could reduce silence, expand understanding of violence, and increase uptake of available services.

2. Why This Study Matters

In Ntanka, a community in the North-West Region of Cameroon, preliminary research revealed that silence around SGBV was deeply rooted in social norms, economic dependency, fear of retaliation, and limited knowledge of services. Many survivors described being pressured by families to remain silent or being blamed for their experiences.

The project sought to test whether **structured community storytelling sessions** could shift knowledge, attitudes, and practices at scale.

3. What We Did

1,510	715	10	1,340	804
Households Surveyed	Community Members Engaged	Months of Sessions	Survivors Referred via CHWs	Accessed Health Services

The storytelling sessions used culturally relevant narratives to illustrate everyday forms of SGBV, consequences of silence, and pathways to care. Sessions were facilitated by trained storytellers and community health workers. Pre- and post-test data were collected to measure changes in knowledge, attitudes, and practices. Stakeholder feasibility assessments and community health worker (CHW) referral logs were also analysed.

4. Findings

4.1. Violence Was Common but Poorly Recognised

Household data (n = 1,510) showed that SGBV in Ntanka is embedded in everyday life rather than occurring as isolated extreme events. The most frequently reported experience was verbal assault, yet more severe forms were also prevalent.

Table 1: Reported Lifetime Experiences of SGBV

Type of Experience	Prevalence (%)
Verbal assault	**57.9%**
Work-related intimidation	**22.5%**
Attempted rape / kissing / fondling	**20.2%**
Prevented from attending school	**18.3%**
Unwanted sexual touching	**16.0%**
Denied opportunity for refusing sex	**14.4%**
Forced early marriage	**9.8%**
Contraceptive prevention	**8.3%**
Rape	**6.3%**
Forced prostitution	**2.5%**
Sex trafficking involvement	**2.3%**

4.2. Post-Violence Environment: Blame and Enforced Silence

Beyond the violent act itself, survivors experienced secondary harm. **10.6%** were asked by family members to remain silent, **11%** were blamed for what happened, and only **9%** sought justice and did not receive it. These data indicate that silence is socially reinforced and institutionally enabled, rather than purely individually chosen.

4.3. Harmful Norms Sustained Silence

At baseline, deeply embedded normative attitudes created structural barriers to disclosure and help-seeking. Most respondents equated SGBV primarily with rape. Psychological, economic, and early marriage-related violence were rarely recognised.

Table 2: Baseline Knowledge — Recognition of SGBV Forms

Recognised as SGBV	Baseline (%)
Rape	**72.8%**
Sexual violence	**33.0%**
Physical violence	**23.9%**

Recognised as SGBV	Baseline (%)
Psychological violence	8.7%
Early/forced marriage	6.4%
Denial of resources	3.1%
Don't know	17.5%

Table 3: Baseline Normative Attitudes Toward SGBV

Attitudinal Indicator	Baseline (%)
Did not believe child marriage (<18) is wrong	44.0%
Believed a husband cannot rape his wife	66.0%
Believed touching based on dressing was acceptable	40.5%
Would report intimate partner SGBV	30.6%
Would report stranger SGBV	47.5%
Believed they could say no to an intimate partner	44.1%

Table 4: Baseline Awareness of Available SGBV Services

Service Awareness Indicator	Baseline (%)
Aware of free SGBV treatment services	13.7%
Aware of psychosocial services	12.6%
Aware emergency contraception is available	14.1%
Aware legal action can be freely sought	25.8%

The gap between service availability and community awareness represents a major structural barrier to help seeking, compounded by the normative attitudes documented above.

4.4.   Storytelling Produced Measurable Change

Following ten months of structured community storytelling sessions (March–December 2022), measurable and significant changes were observed across knowledge, attitudes, and behavioural intentions.
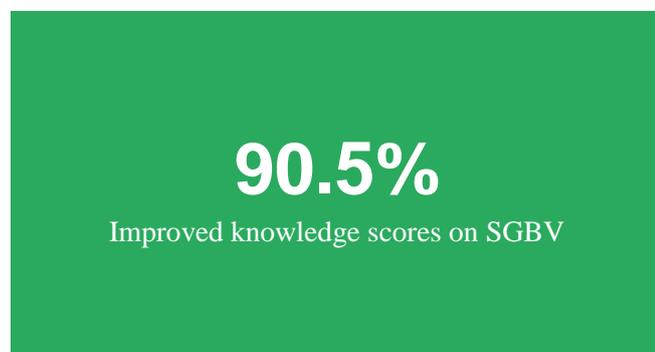
90.5%
Improved knowledge scores on SGBV

Table 5: Knowledge Improvement — Non-Physical Forms of Violence

Indicator	Baseline (%)	Endline (%)	Change
Psychological violence	8.7%	87%	+78.3
Early/forced marriage	6.4%	87%	+80.6
Economic violence	3.0%	63%	+60.0

Table 6: Pre–Post Comparative Analysis of Behavioural Intentions

Indicator	Baseline (%)	Endline (%)	Change
Would report intimate partner SGBV	30.6%	99.0%	+68.4
Would report stranger SGBV	47.5%	99.9%	+52.4
Would seek treatment	55.5%	99.7%	+44.3
Would take emergency contraception	61.0%	99.7%	+38.7
Able to say no to intimate partner	44.1%	99.3%	+55.2
Power to stop mob action	27.2%	95.5%	+68.3

The scale of change across all indicators suggests both **cognitive and normative transformation**, moving beyond simple knowledge gain toward genuine attitudinal shift.

4.5.   Service Uptake and Documented Action

Beyond attitudinal shifts, documented action increased

1,340	**804**	**23%**
Survivors referred through community health workers (CHWs)	Accessed medical or mental health services	Increase in SGBV service utilisation vs. previous years

4.6.   Feasibility and Acceptability

64 out of 64 stakeholders found the storytelling approach acceptable, and all confirmed its feasibility within households. Community health workers reported successful integration of storytelling across other health programmes, confirming that storytelling functioned as a **system-compatible intervention rather than an external imposition.**

4.7.   Detailed Quantitative Findings

Household Survey: Structural Context

The household survey (n = 1,510; analysed subsample n = 480 with complete item-level data) provides the structural and experiential baseline against which the intervention must be understood.

Sociodemographic Vulnerability

The surveyed population was predominantly young and economically vulnerable: mean age 24.7 years (SD = 14.49); 73.1% female; 86.7% unemployed. High unemployment and youth concentration indicate economic dependence and power asymmetries within households, schools, workplaces, and institutions. These structural conditions increase vulnerability to coercion and limit perceived alternatives to silence.

Table 7: Sociodemographic Characteristics — Pre-Intervention Survey

Characteristic	Value
Mean age (years)	**32.2**
Female	**52.4%**
Male	**46.7%**
Unemployed	**70.8%**
Basic or no education	**37.6%**

5. What This Means

The findings suggest that silence around SGBV in fragile settings is not simply an individual choice. It is shaped by poverty, unequal power, harmful norms, and lack of service awareness. Most victims live in a 'dark space' defined by the intersection of these structural forces, requiring deliberate policy action for change.

Culturally grounded storytelling can function as a structural public health intervention by:

- Expanding recognition of diverse forms of violence, including psychological and economic abuse
- Challenging harmful social norms around marital rape, child marriage, and victim-blaming
- Increasing community awareness of available free services and legal pathways
- Strengthening linkage to care and reducing structural barriers to help-seeking

While further research is needed to assess long-term impact, the Ntanka project demonstrates that narrative-based community engagement may be a scalable and cost-effective strategy for improving SGBV response systems in fragile environments.

6. Ethical Considerations

Given the sensitivity of SGBV within the Ntanka community, this study recognised the potential risks to participants if disclosures were misused. Ethical safeguards were central to the study design and implementation. The Internal Review Board of eBASE Africa, Bamenda, Cameroon approved ethical clearance on 17 February 2022.

Informed Consent
All participants were informed about study objectives, funding sources, intended use of findings, potential risks, and data access arrangements prior to participation.

Voluntary Participation
Participation was free from coercion. Participants could withdraw at any time without penalty or explanation required.

Do No Harm
Data collection procedures were designed to minimise distress, protect dignity, and avoid re-traumatisation of participants.

Confidentiality
Identifiable information was accessible only to the project lead and co-lead. All data collectors signed confidentiality agreements prior to fieldwork.

Anonymity
Coded descriptors (e.g., young woman, rural community, Cameroon) were used in all reporting to prevent identification.

7. Conflict of Interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

8. Funding

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