PROTECTION GUIDANCE FOR CHOLERA RESPONSE IN YEMEN

AUGUST 2017

Yemen is currently facing the world's worst cholera outbreak, which in the span of three months, has spread to the entire country except for one governorate. This is turning an already dire humanitarian situation into a disaster for the conflict-affected population, including women and men, girls and boys. As of 1 August, WHO reports a cumulative 443,166 suspected cholera cases and 1,921 associated deaths. Cholera is affecting the most vulnerable of Yemenis: children under the age of 15 account for 41% of suspected cases and a quarter of the deaths while those aged over 60 represent 30% of fatalities. Malnourished children, pregnant women and people living with other chronic health conditions are now at greater risk of death. A WASH and Health-led integrated cholera response plan was finalized and endorsed by the humanitarian community, which has since been elevated to a system-wide response in July 2017.

Not only are the vulnerable at greater risk of death from cholera, but those with specific needs may also face serious challenges if the cholera response is not delivered in a protection-sensitive manner, as well as the fact that cholera may have consequences on households that result in additional protection concerns. For example, children are not only at risk of becoming separated from their families either due to death of their parents or lack of care arrangements during treatment, but are equally exposed to the psychosocial effects of witnessing their parents dying or undergoing treatment. The domestic roles of women and girls in taking care of sick family members, cleaning latrines, fetching and handling untreated water, and preparing food, means that women and girls are at heightened risk. Behavior change campaigns at the community level have been undertaken in the affected communities but require significant time. Cholera awareness materials and treatment facilities may not be accessible for persons with disabilities, including those without visible impairments. Adding the hardship of cholera to household coping mechanisms that are overstretched may expose women and children to risks of abuse and exploitation, and recourse to negative copying mechanisms such as child marriage, recruitment into hazardous forms of labor and family separation. With some 53% of reported cholera cases being women, the long term impact on child care and psychosocial wellbeing in most communities will be enormous.

The Protection Cluster, including the Child Protection and Gender-Based Violence Sub-Clusters, are providing the following guidance to humanitarian agencies involved in the cholera response to assist them during the planning and implementation of the cholera response. This guidance includes two key principle messages:

- **Address Specific Needs of Particularly Vulnerable Groups:** Prevention and response activities should take into account the specific needs of particularly vulnerable and 'hard-to-reach' groups. Such groups include but are not limited to: children, women (in particular female-headed households), the elderly, the disabled, persons in institutions (including prisons), and the marginalized, such as *al-Muhamasheen*. This applies also to the design and distribution of Information, Education and Communication (IEC) materials. Agencies should ensure meaningful access to their services by these vulnerable groups.

- **Adopt Protection-Sensitive Responses:** Agencies should ensure that they guarantee the safety and dignity of beneficiaries, and that their response activities do not create but rather mitigate protection risks. For example, the inappropriate design and location of water and sanitation facilities

can provoke serious protection risks for women and girls. There is also a risk of accidental family separation when, for example, a parent is taken to an Oral Rehydration Corner (ORC) or Diarrhea Treatment Center (DTC) for treatment without adequate care provisions being made for the child(ren) left behind. Beneficiaries should participate in decision making and feedback/complaints mechanisms.

More detailed guidance on how to minimize protection risks to and incorporate the specific needs of children, women and vulnerable groups follows. The Protection Cluster together with the CP and GBV sub-clusters are able to offer advice and guidance, and can be contacted in the following way:

Protection Cluster:	Samuel Cheung (cheung@unhcr.org)
Child Protection Sub-Cluster:	David Sezikeye (dsezikeye@unicef.org)
GBV Sub-Cluster:	Ahlam Sofan (sofan@unfpa.org)

The Protection Cluster can assist agencies to conduct a protection assessment of their cholera response plans to help to identify potential gaps and risks for the most vulnerable including women and children.[1] The disaggregation of data by sex, age and disability is crucial to help identify those most at risk.

Identification and Inclusion of Most Vulnerable Groups at Risk of Exclusion

- Make special efforts to **identify, locate, register, and follow-up** on persons with disabilities and other vulnerable groups. Contact Disabled People Organizations, Associations of Parents of Children with Disabilities, Inclusive Volunteers Associations, as they can support with the identification.
- **Include questions** about disability issues in all of your **assessments (**e.g. using the Washington Group of Questions); **identify main-stream and impairment-related needs** in addition to **pre-existing and contextual obstacles faced** by persons with disabilities in accessing services.
- Ensure **non-discrimination** when providing services, and **promote inclusion of all vulnerable groups** including women, children, **injured persons**, older persons, and **persons with disabilities**. This includes can include promoting women and girls' participation in design of prevention and control interventions
- The World Health Organisation (WHO) estimate of "15% of the world population lives with a disability" (WHO, 2011) can be used to calculate an approximate number of adults with disabilities in any given population.
- For children with disabilities, an estimate can be calculated based on 10% of the population under 18 years of any given population (UNICEF, 2007).

[1] For example, child-related questions could include: 1) Who is caring for children left behind when the caregiver is hospitalized? The survival of these children may be at stake and they may be at risk of abuse or other harm; 2) How are child-headed households coping when the head of their household is admitted e.g. who is caring for the siblings, especially younger children? 3) Are there any children being admitted who don't know where their parents are? Or who don't have parents? What happens to these children when discharged? 4) Do sick parents ever arrive at the CTC accompanied by babies or young children? If yes, what happens to these children? While on one hand, admitting them with their mothers can put them at risk of cholera exposure, they also cannot be left without care. Is anything in place at the community level to provide care for such children? Or at clinic level to prevent the baby's exposure to cholera? 5) What are the concerns for hospitalized children – in terms of their medical/physical care (food, etc) and emotional support? What needs to be done? 6) Is anything putting children at risk of harm or exclusion in the way that the cholera prevention and response is being undertaken? What ideas do children have for improved cholera response to address their particular needs?

Awareness and Prevention of Accidental Family Separation

In a medical emergency, children can become separated from their parents depending on how the response is being carried out [or implemented]. This is devastating to children and can lead to permanent family separation, especially if the child is young. To prevent such occurrences:

- If a sick mother is admitted to the clinic accompanied by a young child/baby, obtain identity and next-of-kin information, so that if she dies, the baby's family can be traced.
- If the mother is unable to take care of her child/baby during treatment make sure that there is a caregiver for the baby.
- Liaise with the managers of the treatment center to ensure appropriate transmission prevention mechanism are in place and understood by the patient, children and caretakers.
- Never remove a sick child from a community / family without documenting next-of-kin information and keeping it with the child, so that the child can be traced back to his/her family when he/she is discharged.
- Do not remove a sick mother from her young children without ensuring that the children are left under the care of adult relatives / neighbors. Make sure the temporary caregiver knows where you are taking the mother.
- When an adult is admitted, check to see whether she/he has left children behind without having been able to make adequate care-giving arrangements. If yes, contact a child-focused NGO or Ministry of Social Welfare to provide follow up with the children.
- If you become aware of any child who has become separated from his /her parent or caregiver, urgently notify an agency that can provide immediate assistance (child protection NGO, UNICEF or any other UN agency). Babies and very young children in this situation should be given the highest priority.

Health and Hygiene Education around Cholera (signs, symptoms, prevention)

- **People** with disabilities are **not a homogeneous group** and persons with different disabilities as well as **women, men, boys and girls** may have different needs and skills. Adapt your approach accordingly.
- Information on available health services and assistance where/how to obtain it through various means are disseminated in a manner appropriate for persons with disabilities, including visual or mental impairments as well as in locations accessible for all persons, including vulnerable minorities such as the *al-Muhamasheen*.
- **Ensure** that **information** you provide is **accessible**. For example, information booklets will be of no use to a person with visual impairment, and information broadcasted on loud speakers will not reach those who can-not hear. **Use at least two forms of communication** (written, auditory) **and simple language/pictures** to be sure to reach everyone.
- Children need to get information **first hand** – this means providing information in places where children congregate: child friendly spaces (CFS), Mosques, play areas, children's clubs, children's institutions (places of safety, remand homes, orphanages), as well as during house-to-house visits;
- Raise awareness of children under the age of 5 at Early Childhood Development (ECD) centres and and CFS through **play, demonstrations and role playing**. Most children will automatically take the learning home to their mothers or other caregivers;
- **Train / involve** adolescents in peer-to-peer education and information dissemination – they are much more successful at reaching other children, than adults;
- Don't forget **about hard-to-reach children** such as child caregivers, child headed households, children living in households with disabled household heads, adolescent wives, out-of-school children including street and working children;
- **IEC materials:** Children especially those under 5 years are at different stages of development and therefore need child friendly messages that are specific to the risks children face. Messages should be appealing and attractive. The use of pictures to explain complex issues is encouraged. Coordinate with your communication specialists to ensure messages are packaged to meet children's learning and interpretation needs.
- Ensure gender sensitive preventive messages are provided to the community which would help women to take adequate measures to prevent themselves from acquiring cholera.

Cholera Treatment Centres / Hospitals / Clinics

- At Cholera Treatment Centres (CTC), hospitalized children need psycho-social support to help their recovery. Exposure to sick and dying people, or the absence of their usual caregiver will provoke fear and anxiety that could have lasting effects;
- To help support children's emotional recovery, identify personnel (consider calling on volunteers from child-focused NGOs) who can spend time reassuring them, and helping them understand what is going on. Providing children with play items such as crayons, paper, washable toys will also help them to cope with their negative experience;
- Ideally, place children in a ward separate from adults, with separate nursing care.
- Disinfect the child's items (clothing, toys, bed and linens) if discharged.
- Liaise with the medical staff at the treatment center to establish how children's items can be disinfected.
- Special attention to be provided to pregnant women and girls in CTCs.
- Ensure there is female staff presence at treatment centers so that they are accessible to women and girls.
- Ensure that services can be accessed by persons with non-mobility related disabilities (e.g. persons with impaired hearing/vision/cognitive ability/mental health) and persons with impaired mobility (e.g. persons with physical disabilities, older persons, bed-ridden individuals) where possible and resources permit.
- Uneven access to buildings (hospitals, health centres), inaccessible medical equipment, poor signage, narrow doorways, internal steps, inadequate bathroom facilities, and inaccessible parking areas create barriers to health care facilities. The toilet cahir/portable latrine should be provided for people with physical impairment.
- Consider introducing special arrangements for persons unable to access health facilities e.g. mobile health services, transportation/taxi services, facilitate accompaniment arrangements (e.g. youth groups assisting the elderly/persons with disability; community networks).
- Consider providing referrals for psychosocial support for recovering patients in need, e.g. survivors of trauma or Posttraumatic Stress Disorder (PTSD).
- Consider calling on specialized NGO staff/volunteers, case management unit in MOSAL to support health clinics in carrying out tasks such as child protection screening providing support to children who are hospitalized or otherwise seriously affected by the cholera epidemic (family death, separation, etc.

Access to Treated and Reticulated Water

- **Specific** water containers should be designed to suit the ability of a person with injury/disability (wheelchair user, mobility aids user, children, etc.).
- Develop a **social network** to support persons with injuries/disabilities to access clean and safe drinking water (including carrying empty/full water containers).
- **Monitor** the access to water for persons with injuries/disabilities.
- Ensure children who are fetching water have age appropriate buckets and jerry cans that are marked with the appropriate lines to facilitate chlorination at home;
- Women and children can be sexually abused or exploited in the process of collecting water or firewood. They should be involved in decisions regarding the location of water sources. This needs to be factored into your programming response.
- Engaging women as full and equal partners in community-based social mobilization campaigns and integrating women at the highest levels of planning and decision making in community (particularly with respect to the health needs of women, including reproductive health services) and employing women as primary distributors of emergency rations and medical supplies. Women should also be actively consulted on location of boreholes, water distribution points and distribution of hygiene supplies.
- Ensure there is female staff presence at service points so that they are accessible to women and girls.