Rapid Assessment of Protection Issues within Zimbabwe's Cholera Epidemic and Response
January 29 – February 13, 2009

Save the Children Alliance

April 2009

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Acronyms

AIDS.....Acquired Immune Deficiency Syndrome
BRDC.....Beitbridge Rural District Council
CPC .....Child Protection Committee
CPU .....Civil Protection Unity
CTC.....Cholera Treatment Centre
DSW .....Department of Social Welfare
DSWO.....District Social Welfare Officer
DMO.....District Medical Officer
DNO.....District Nursing Officer
EHT.....Environmental Health Technician
EPR.....Emergency Planning and Response
HIV.....Human immunodeficiency virus
IOM .....International Organisation for Migration
MOESC.....Ministry of Education Sports and Culture
MoHCW ..... Ministry of Health and Child Welfare
MPSLSW .....Ministry of Public Services, Labour and Social Welfare
NGO.....Non-governmental organisation
ORS .....Oral Rehydration Solution
PSWG.....Protection Sector Working Group
SC.....Save the Children
SCN .....Save the Children Norway
SC UK.....Save the Children UK
UNICEF.....United Nations Children's Emergency Fund
WASH ...Water Sanitation Health
Watsan.....Water and Sanitation
WHO .....World Health Organisation

Acknowledgements

This publication by Save the Children (UK) was made possible through the Zambezi Valley Advocacy Project supported by the Department for International Development (DfID), Disaster and Development Centre, Northumbria University and Basilwizi. The opinions expressed herein are those of the authors and do not necessarily reflect the views of these organisations.

Our sincere thanks go to the many health care professionals, Ministry staff, NGO staff, members of community groups, and children who took the time to participate in this assessment during such a busy period; and to so freely provide us with information which will help us to advocate for strengthened responses in future emergencies. In addition we would like to thank a range of people without whose support we could not have carried out the assessment. This includes staff of Save the Children (Stanford Tonderai, Emily Nyoni, John Mutenha, Mathias Masasa), as well as Agnes Nsingo (Beitbridge District Child Protection Officer), and David Maunze (who provided translation services in Binga).

Assessment Team

The Assessment Team was led by Christine Lipohar (Save the Children UK) and comprised the following people:

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Executive Summary

As of January 15, 2009 the cholera epidemic in Zimbabwe had escalated into a major humanitarian disaster, with a total number of 42,675 cases registered and 2,225 deaths, 56.4% of which had occurred within communities.

The rapid onset and escalation of the cholera epidemic resulted in a response focused on provision of life saving interventions to those infected, and interventions to prevent the further spread of the epidemic. Given the rapid spread of the epidemic and its high morbidity and mortality rates, the Protection Sector Working Group was concerned about the most vulnerable groups within the population, their ability to access prevention / response interventions, and any particular risks they might face. In mid-January the group produced a document giving practical guidance on how to mainstream protection into the cholera response, particularly to high risk groups including children, women, displaced and refugee populations, disabled and PLWHA. To complement this intervention, Save the Children Alliance undertook rapid assessments in two operational areas: Beitbridge and Binga. These two districts are characterised by their remoteness, absence of water and medical services, and high proportion of cholera-related cases and deaths. The main aims of the assessments were to evaluate the degree to which protection issues (with a focus on child protection) had been incorporated into the cholera response and to better understand the psychosocial impact of the epidemic.

Assessment methodology included focus group discussions, key informant interviews, participation in meetings, and observation. A total number of 150 people participated in the assessment: 42 community members, 61 children, 21 health care staff, and 26 additional stakeholders.

Although the assessment took place in only two geographic areas, it is likely that the issues emerging are reflective of the country wide cholera response. Further data gathering however in other cholera affected areas of the country would strengthen the findings.

Key findings:

- Key stakeholders generally felt unprepared, and unable to effectively co-ordinate the response in the initial weeks of the epidemic;
- Although a range of global guidelines exist that promote and support the incorporation of a psychosocial component into emergency health preparedness and response, this issue is being addressed largely through the good will of a few agencies and individuals rather than through a co-ordinated and integrated rights-based framework of action. Impact identified in this assessment has included:
    - The cholera epidemic is further exacerbating the already devastating psychosocial impact of HIV and AIDS in communities and families. The renewed erosion of family livelihoods may result in families adopting coping mechanisms that put their children at risk of abuse, exploitation and other harm
    - The rapid and severe nature of the illness and rules about funeral ceremonies don't give family members including children time to prepare for death or mourn in a culturally acceptable way. The long-term impact on children is enormous.
    - The care and protection of children left at home during their caregiver(s)' hospitalization, or after parental/ caregiver death is not being systematically monitored or addressed
- The high level awareness-raising around cholera has had a positive impact on knowledge levels and hygiene practices although some negative practices continue.

- Children are not being specifically targeted for awareness raising which puts them at risk of a range of protection concerns
- IEC materials are primarily written, making them inaccessible to illiterate adults and children.
- A range of preventive strategies are in place, the approach and intensiveness influenced by available resources, remoteness of locations, and medical opinion about best practice. There are concerns around Doxycyline being used as a prophylaxis
- A range of treatment, care and access challenges exist, which are especially affecting children, the elderly and people living with HIV and AIDs and other chronic illnesses
- Locally collected disaggregated statistics are not being analysed, discussed or used to rapidly inform/modify local-level responses, which puts the most vulnerable and marginalized populations (PLWHA, chronically ill, children, disabled, elderly, etc) at risk of not benefiting as fully as they could from cholera interventions.
- A range of factors exist that may be contributing to ongoing cholera including absence of women and young people in community and district level decision-making structures, absence of children's and adolescents' involvement in prevention and response activities, persistent beliefs that witchcraft is at the root of the epidemic, long distances that sick people must travel to get treatment, *"dragging their diarrhea and vomitus from village to village, ongoing migration of people,"*.

In conclusion, the cholera epidemic has taken in place in the context of a complete breakdown in essential services including water, sanitation and health care. Responses to curtail the epidemic have focused on addressing the water and sanitation situation, raising awareness about prevention and treatment, and undertaking life-saving interventions, all of which have been undertaken in the most challenging of environments. Although these interventions will address the epidemic itself, the psychosocial impact especially on the most vulnerable populations, will be much longer lasting. This has yet to be addressed, as have a number of specific age and vulnerability-related issues.

Immediate and medium term recommendations include

- Urgent response to families most affected by cholera to address their psychosocial, physical, food and protection needs.
- Analysis and use of disaggregated (age, sex, vulnerability) statistics to inform / strengthen and accelerate response at the local level
- Addressing gender imbalances on village level Cholera Co-ordinating Committees and ensuring involvement by adolescents, young people and Child Protection Committee members.
- Targeting of children directly for awareness raising and involve them in information dissemination.
- Development of pictorial IEC materials
- Strengthening of community outreach services
- Undertaking a wider and more comprehensive assessment to determine the scope and nature of psychosocial impact on the most vulnerable families
- Incorporating the psychosocial impact of cholera (and other disaster situations) into disaster planning/response processes through strengthened engagement of/with Ministry of Public Services, Labour and Social Welfare; Department of Social Welfare, and Ministry of Education, Sports and Culture; and adoption of a multi-sectoral approach that incorporates minimum psychosocial interventions in emergency preparedness and response planning.
- Incorporation of age/sex/vulnerability considerations at the planning stage to help ensure the particular needs of the most vulnerable are addressed effectively and rapidly.
- Strengthened emergency preparedness and response capacity at village, ward, district and national level; and with the involvement of women and children.

Assessment of Protection Issues within the Cholera Epidemic, and Its Response

Introduction and Purpose

As of January 15, 2009 the cholera epidemic in Zimbabwe had escalated into a major humanitarian disaster, with a total of 42,675 cases registered, and 2,225 deaths, 56.4% of which had occurred within communities[1].

Save the Children Alliance's response to the cholera epidemic is being undertaken in the districts of Binga, Nyaminyami, Beitbridge, Kadoma and Chimanimani. Additionally Save the Children are the WASH Focal Points for Binga and Kariba Rural (Nyaminyami) districts under the Cluster system, where they are collating all WASH activities, reporting to the WASH cluster on a weekly basis, and representing the organisation on the Health and Health/WASH clusters.

The rapid onset and escalation of the cholera epidemic resulted in a response focused on provision of life saving interventions to those infected, and interventions to prevent the further spread of the epidemic. Given the rapid spread of the epidemic and its high morbidity and mortality rates, the Protection Sector Working Group (PSWG) was concerned about the ability of the most vulnerable groups within the population to access prevention / response interventions, and any particular risks they might face. In mid-January 2009 the PSWG produced and disseminated a document giving practical guidance on how to mainstream protection into the cholera response, particularly to high risk groups including children, women, displaced and refugee populations, disabled and PLWHA[2] (see Annex 1) Because this document was produced on the basis of *potential* risks which might exist for these vulnerable populations, Save the Children Alliance undertook a rapid assessment in two of its operational areas to collect evidence of what the *actual* risks were. The assessment had the following objectives:

- To determine the degree to which protection issues (with a focus on child protection) have been incorporated and are being considered in the cholera response within Save the Children Alliance operational areas
- To better understand the psychosocial impact of the epidemic
- To use the information/evidence to inform (and strengthen) cholera programming within Save the Children's operational areas (in terms of prevention, treatment, post-treatment)
- To advocate more widely for improved national level cholera prevention and response within the relevant clusters

Assessment Methodology

The assessment was planned and conducted by Save the Children Alliance with representatives from both SC UK and SC Norway. The assessment was undertaken by 4 Save the Children Child Protection staff, with support from district level personnel who provided translation assistance (Tonga, Ndebele)

An assessment tool was specifically designed for the exercise[3], and was largely informed by the aforementioned Protection Mainstreaming document, as well as by the following broad definition of "mainstreaming" used by Save the Children UK in Zimbabwe:

[1] Daily Cholera Update and Alerts, January 15, 2009, *Ministry of Health and Child Welfare / Office of the World Health Organisation Representative, Zimbabwe*
[2] Mainstreaming Protection into the Cholera Response, January 16, 2009, *Protection Sector Working Group*
[3] Soft copy available

***Protection Mainstreaming**: Designing, implementing and monitoring programmes to ensure that the way we do our work is not putting beneficiaries who are already vulnerable at further risk of harm, abuse, exploitation or exclusion. This includes making sure that our own staff are not abusing, exploiting or otherwise harming children or other beneficiaries.*

The assessment aimed to gather and analyse information on the following broad questions:

- Is there anything about the design or implementation of the cholera response that may be putting the most vulnerable at further risk of harm, abuse, exploitation or exclusion? As part of this broad question, the assessment considered gender, HIV, sex, age, disability, and other factors which might render individuals or households additionally vulnerable (e.g. pregnant/lactating women, child headed households)

- What protective factors are in place?

- How is the psychosocial impact of cholera being addressed?

The tool was tested in the first location then amended appropriately. Two districts (Binga and Beitbridge) were selected for the assessment, and within each of those districts, sites were selected to ensure that data was collected from both rural and urban areas. Table 1 below summarises the locations that were piloted/assessed:

Dates	**Districts**	**Locations**	**Comments**
Jan 29		Chitunguiza	Piloting of tool
Feb 8 – 10	Binga	Binga Town	
		Rural Areas of Siabuwa, Nagangala	
Feb 12-13	Beitbridge	Beitbridge Town	
		Rural Areas of Chaswingo, Chitulipasi	

Assessment methodology included focus group discussions, key informant interviews, participation (of assessment team members) in meetings, and observation. A total number of 150 people participated in the assessment: 42 community members, 61 children, 21 health care staff, and 26 additional stakeholders (see Annex 4 for details). Methodology for children's sessions involved asking children to depict their experiences of cholera through play acting or through drawings, as a stimulus for holding discussions.

Although the assessment took place in only two geographic areas, it is likely that the issues emerging are reflective of the country-wide cholera response. Further data gathering however in other cholera-affected areas of the country would strengthen the findings.

General Situation in the 2 Districts Assessed

The following provides a brief overview of the context within the districts/sites visited.

<u>Binga</u>

Binga is a remote, poor and often inaccessible district of the country, characterised by unpredictable climatic conditions, limited access to communication, impassable roads, limited access to clean water and sanitation, high HIV prevalence and chronic food insecurity. The assessment team was told that people are resorting to measures such as exchanging a goat for 10kg of mealy meal and eating wild food which may be poisonous; while children are having to transport heavy bundles of firewood for 20 km in exchange for a plate of food.

At the time of the assessment Binga had established 4 Cholera Treatment Centres (Siabuwa, Chunge, Binga, and Pashu), the latter two of which had been dismantled. Siabuwa had scaled down its staffing complement on Feb 8, 2009, while Chunge had decamped but left a surveillance team behind.

Siabuwa clinic is an outpatient facility located approximately 3 hours' drive from Binga, 2.25 hours of which are on a dirt road ridden with potholes and ruts. The clinic has been servicing approximately 16 communities affected by cholera, within a 50 km radius east/west and a 10 km radius north/south. A 16 bed Cholera Treatment Centre, previously a delivery ward for expectant mothers, has been established about 50 metres from the main clinic.

In Binga, the district hospital has converted its paediatric ward to a cholera treatment centre with 30 beds and about 70 on standby (total 100 beds available). At the time of our visit there were no patients.

It was not until the week of Feb 9, 2009 that the MoHCW officially announced that there was a cholera epidemic in Binga after 5 out of 8 stool samples taken from 4 areas of the district, came back positive.

Beitbridge

The city of Beitbridge, bordering with Musina, South Africa is a town that attracts people from Zimbabwe and other countries, with thousands of people entering and leaving the city every day on their way to or from South Africa. The city is characterised by filth and a virtual absence of basic services, including water, health, telephone system and electrical power. Streets are strewn with rubbish and litter, there is no garbage removal system, sewage runs in the streets, there has been a severe water shortage for several months, people are living in crowded unsanitary conditions, and at the time of the assessment there had been industrial action by medical personnel for a number of months, due to the failure of government to pay salaries.

The water shortage problem stems from a malfunctioning and under-capacitated water treatment plant. ZNN had been trying to construct another plant but ran out of funds. Despite assistance from the South African government to help rectify this problem, the situation remains dire and urgent.

In terms of medical services, Beitbridge Hospital has been experiencing a severe shortage of materials and medications for a prolonged period so was already in a desperate situation prior to the cholera epidemic; for example, it has been 5 years since the hospital has had IV penicillin, and there is always a severe shortage of linen. Due to the ongoing industrial action, the hospital is not admitting any patients, it is not performing any surgery, and there is no functioning ambulance. According to medical personnel (but unconfirmed) immunisation services are virtually non-existent, and 80% of the population live in hard-to-reach places. Beitbridge also has the highest HIV prevalence in the country, at 26.6%[4]

In summary, it is in this context of large population movements (Beitbridge), crowded and unhygienic conditions (Beitbridge), absence of water and medical services (Binga, Beitbridge), and remote unreachable geographic areas (Binga, Beitbridge), that the cholera epidemic has taken place in these 2 districts, claiming 4540 victims and resulting in 160 deaths between September 2008 and January 15, 2009.[5]

[4] Epidemiological Fact Sheet on HIV and AIDS, Core Data on Epidemiology and Response, Zimbabwe, 2008 *World Health Organisation*

[5] Daily Cholera Update and Alerts, January 15, 2009, *Ministry of Health and Child Welfare / Office of the World Health Organisation Representative, Zimbabwe*

Key Findings

1. Key stakeholders generally felt unprepared and unable to effectively co-ordinate the response in the initial weeks of the epidemic

Although there was a tremendous amount of good will and intention, district co-ordination structures generally felt unprepared and unable to effectively co-ordinate a rapid response in the initial weeks of the epidemic. Key stakeholders had received training in Emergency Preparedness and Response (EPR) but too much time had passed since training had been received so rather than following existing cholera management guidelines, or applying the EPR training that had been given a crisis management approach was taken. This was exacerbated by an absence of resources to enable a rapid start up; for example supplies and drugs were slow to come in so there was an over-reliance on individuals/agencies to make donations. A reluctance to discuss the severity of the epidemic for fear of criticising the government also contributed to an initial slow response.

2. The response thus far has focused on immediate life-saving responses but has not addressed the psychosocial impact of cholera

100% of respondents stated that the cholera response thus far had focused on immediate, life-saving responses and with few exceptions no analysis or interventions were yet being undertaken in relation to the psychosocial impact of cholera illness and death on communities/families. In fact the assessment team found there has been limited to no planning, preparedness or response to the psychosocial impact of cholera at any level (national, district or community level). For example, no mention is made in either the National Cholera Control Guidelines[6] or the Health/WASH cluster plan for cholera response[7], nor is this aspect of the cholera epidemic being discussed at District or Ward level Cholera Task Force meetings.

There is also no involvement of the Ministry of Education, Sports and Culture (MoESC) or the Ministry of Public Services, Labour and Social Welfare (MPSLSW), or its Department of Social Welfare) to address psychosocial impact. The District Education Officers (DEOs) and the District Social Welfare Officer (DSWOs) do however attend district level Cholera Task Force meetings. The assessment team was told by one ministry official that it would be inappropriate for district staff to make unsolicited recommendations to their provincial level superiors, and that no action could be initiated until instructions were received from the provincial level, which at the time of the assessment had not yet taken place. Child Protection Committees (CPC), which fall under the Department of Social Welfare had therefore not been mobilised and were not taking action at any of district, ward or community levels (no CPC members for example, sit on the community level Cholera Co-ordination committees; and the cholera epidemic was only briefly mentioned at the December 2008 Binga District level CPC meeting). The assessment team was told by one respondent that during difficult times most people rely on the “power of prayer and holy water” for support.

While there has been no planning or preparedness around responding to the psychosocial impact of the cholera epidemic, there was acknowledgement at all levels that this is a serious issue, and we did find some isolated examples of attempts being made by medical staff to address the psychosocial situation for affected families, and especially for children. For example in Binga, Siabuwa Clinic is trying to make follow up visits to affected families and

[6] Zimbabwe Cholera Control Guidelines Second Edition, 2006, *Department of Epidemiology and Disease Control Ministry of Health and Child Welfare Zimbabwe / World Health Organisation*

[7] Zimbabwe Cholera Outbreaks Co-ordinated Health and WASH Preparedness and Response Operational Plan, December 2008, *Health / WASH cluster*

beginning to mobilize religious leaders to provide psychosocial support to children. Likewise faith-based groups in Beitbridge District are trying to do the same.

In conclusion, although there are a range of global guidelines[8] that promote and support the incorporation of a psychosocial component into emergency health preparedness and response interventions, in the case of the current cholera epidemic this issue is being addressed largely through the good will of a few agencies and individuals rather than through a co-ordinated and integrated rights-based framework of action.

What <u>has</u> been the psychosocial impact of cholera?

The cholera epidemic is further exacerbating the already devastating psychosocial impact of HIV and AIDS in communities and families. Several respondents expressed the view that the impact of cholera is even worse than HIV and AIDs in that its speed and severity do not give family members or communities any time to prepare for death or its impact. Families and communities are facing a rapid accumulation of risk factors:

- Children who were already orphaned by HIV and AIDs are experiencing yet another loss with the death of a caregiver to cholera

- In some cases children are losing both their parents and even additional family members within the span of a few days

- Families who are already struggling after having absorbed children orphaned by AIDs are having to take on more orphans. This is not only economically disastrous for poverty-stricken families, but is contributing to new or further separation of siblings as families divide children up amongst themselves as a coping mechanism

- Families still reeling from the emotional distress of having gone through the process of making care arrangements for orphaned children are having to start the process all over again because the identified caregivers have died

- The rapid and severe nature of the illness, as well as rules about funeral ceremonies don't give family members time to prepare for death or mourn in a culturally acceptable way. We heard that in some cases children are going to the field (e.g. to herd goats) in the morning only to come home in the evening to find that a parent or caregiver has become sick, died, and been buried all in one day. Although we were unable to identify any actual cases of this the potential is there and the long term emotional impact for a child who loses a parent under such circumstances is enormous.

- In terms of the immediate impact on children, we received reports that because individual family members are quickly following each other into the hospital as each member becomes sick, there is nothing in place to ensure the care and protection of children left behind during their caregiver(s)' absence. Children in Binga District told the assessment team "*the worst thing about cholera is being left alone while your mother is in the hospital".* Although efforts are made by community members to ensure the care of children left behind when parents are hospitalized it was confirmed in some focus group discussions that children are left completely on their own at times, because "*we are too occupied with our own lives and problems to be able to help these children" (Focus group discussion, Binga District)*

[8] Humanitarian Charter and Minimum Standards in Disaster Response, 2004 Edition, *The Sphere Project;* Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007, *Inter-Agency Standing Committee*

- There is currently nothing in place to follow up on children or other dependents when hospitalized family members die in clinics. The assessment team was told that while the social history of patients is normally taken on admission (to alert staff about care and protection issues for young children, or other vulnerable dependents such as PLWHA or disabled living in these households in the event of death), the sheer numbers of patients being admitted (or the severity of patient illness) has resulted in this procedure often being dropped. We were told of one case in Beitbridge District, in which a medical doctor attended/supervised a funeral for a husband and wife who had simultaneously succumbed to cholera, only to discover at the funeral itself that the parents had left 5 children behind with no other caregiver. Nothing was in place to follow up on those children.

- Respondents were concerned that families who have lost breadwinners will need to resort to negative coping mechanisms to survive, as is already common in many HIV affected families. This means that more orphaned children will face abuse and discrimination, and children are likely to be pulled out of school, or be forced to engage in risky activities such as transactional sex, border jumping, early marriage, and exploitative labour.

- Fear induced alienation and rejection of cholera affected families is occurring, which is further exacerbated by beliefs that they are victims of witchcraft.

The examples above reflect some of the psychosocial impact of the epidemic at the community level, but additional impacts are outlined throughout the document, including at the level of Cholera Treatment Centres. The report will also show that vulnerable groups such as women and children are excluded from activities such as awareness raising (children) or participation in community level responses such as Cholera Task Forces (women).

3. The high level awareness-raising around cholera has had a positive impact on knowledge levels and hygiene practices

One of the key strengths of the cholera response has been the high level of awareness-raising at Cholera Treatment Centres (CTCs), and at community and household level by Environmental Health Technicians (EHT's), medical personnel, NGOs and UN agencies. The exception to this has been in remote areas, where limited awareness raising had taken place at the time of the assessment.

Awareness-raising has led to an increase in knowledge about cholera transmission and prevention, as well as changes in practice (according to respondents). The assessment was not able to verify whether practice had actually changed, whether it was sustainable, or to determine whether there have been any negative repercussions related to changed practices. Information given by respondents when asked what they now do differently included:

- Leftovers are now re-heated/boiled rather than eaten cold
- Hand-shaking practices have changed
- People practice "cat sanitation" (burying of feces) where there are no toilets
- People are using aqua tabs and boiling water
- People wash their hands after using the toilet (*note – according to some respondents this was not a common practice prior to the cholera epidemic, due to a general absence of water, to do so)*

Both children and adults were able to cite the above examples of changed practices. What did not emerge however in any of the adult or children's discussions were changes in other

hand-washing practices such as before meals, after changing baby nappies, or after helping younger children/siblings to use the toilet. Children also did not give any examples of changed practices in the way they play (e.g. staying away from sewage/garbage dumps, not putting their hands in their mouths while playing, etc). Illustration 1 below depicts one child's understanding of the different ways that cholera can be transmitted or prevented.

Some negative practices which are still continuing despite the improvement in knowledge include:

- People are defecating in the bush and the rain is washing feces into the river
- Cholera-contaminated blankets are being washed upstream from water collection sites
- Cultural traditions persist such as using communal bowls/buckets for washing hands, washing bodies as part of the funeral practice, and sharing of food at funerals

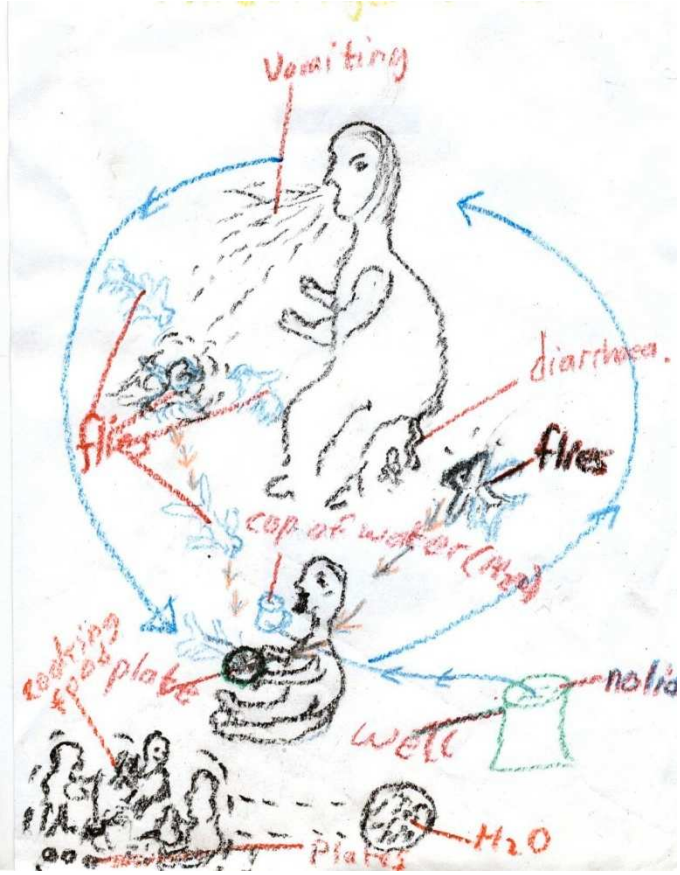


Illustration 1 – How Cholera Can Be Prevented / Transmitted (male child, focus group discussion, Beitbridge)

Gaps in the Awareness Raising Interventions

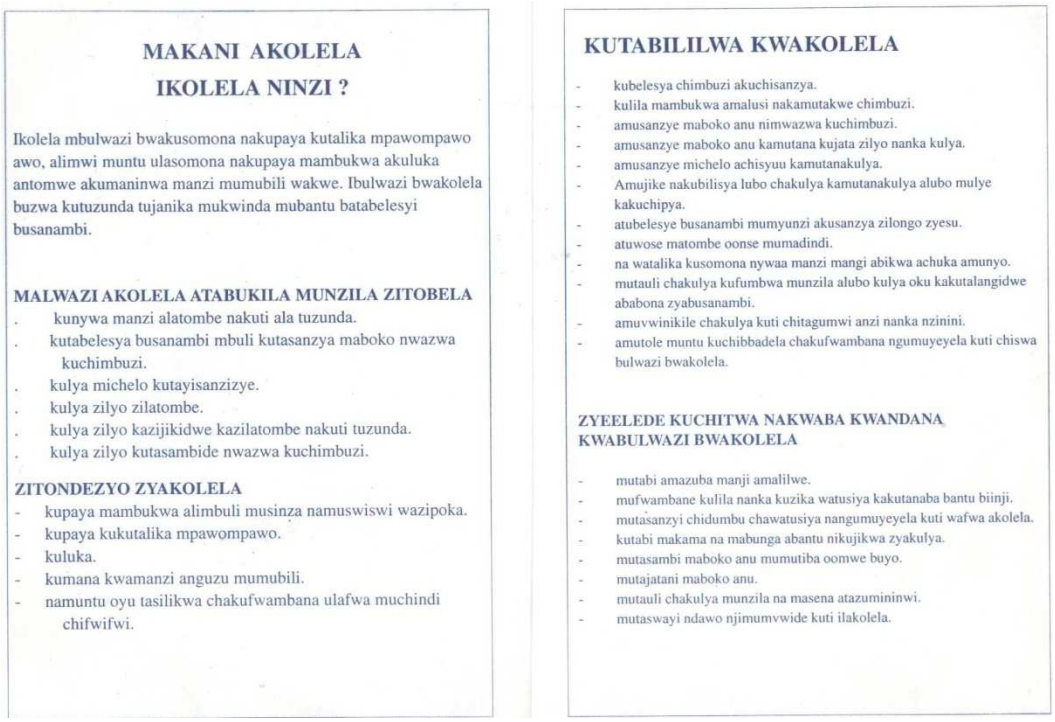
While awareness-raising around cholera prevention and response has been very strong, there nevertheless are some serious gaps:

- There has been no direct targeting of children in awareness raising interventions. While children eventually receive information through their parents, or by attendance at general community level awareness-raising, failing to target them directly means they will have limited opportunities to ask questions, raise concerns, share their own experiences, make their own recommendations, or have the confidence to undertake peer level awareness-raising.

When asked why children were not specifically targeted, the most common responses from those doing awareness-raising were that they had not thought about it, or that schools were not open so it would be difficult to reach children. A medical team in one district however was able to mobilize over 50 children for the assessment team, with less than 24 hours notice, so the closure of schools was not a barrier to reaching children. The view of the assessment team is that school closure should not be an obstacle to reaching children; in fact it is an opportunity, since they are not tied up with lessons.

Given that children are at high risk of contracting cholera during an epidemic their inclusion through specific awareness raising geared to different age groups, is essential for several reasons beyond ensuring they understand about prevention and transmission. It can provide children with a sense of control (information is power) and it gives them an opportunity to share their negative experiences, both of which are important in building resilience and helping them to cope. Additionally it puts the facilitator in direct contact with children who may already be facing protection risks as a result of cholera death or illness in their family, and enables him/her to make an appropriate referral.

- IEC materials, notably pamphlets and posters, are comprised only or primarily of written information, as per Illustration #2, below. Written materials are unattractive for children and inaccessible to illiterate people (children and adults alike). This was confirmed by respondents in both Beitbridge and Binga Districts, who stated that illiterate people had to rely on school-going children to read the information to them.



MAKANI AKOLELA

IKOLELA NINZI ?

Ikolela mbulwazi bwakusomona nakupaya kutalika mpawompawo awo, alimwi muntu ulasomona nakupaya mambukwa akuluka antomwe akumaninwa manzi mumubili wakwe. Ibulwazi bwakolela buzwa kutuzunda tujanika mukwinda mubantu batabelesyi busanambi.

MALWAZI AKOLELA ATABUKILA MUNZILA ZITOBELA

. kunywa manzi alatombe nakuti ala tuzunda.
. kutabelesya busanambi mbuli kutasanzya maboko nwazwa kuchimbuzi.
. kulya michelo kutayisanzizye.
. kulya zilyo zilatombe.
. kulya zilyo kazijikidwe kazilatombe nakuti tuzunda.
. kulya zilyo kutasambide nwazwa kuchimbuzi.

ZITONDEZYO ZYAKOLELA

- kupaya mambukwa alimbuli musinza namuswiswi wazipoka.
- kupaya kukutalika mpawompawo.
- kuluka.
- kumana kwamanzi anguzu mumubili.
- namuntu oyu tasilikwa chakufwambana ulafwa muchindi chifwifwi.

KUTABILILWA KWAKOLELA

- kubelesya chimbuzi akuchisanzya.
- kulila mambukwa amalusi nakamutakwe chimbuzi.
- amusanzye maboko anu nimwazwa kuchimbuzi.
- amusanzye maboko anu kamutana kujata zilyo nanka kulya.
- amusanzye michelo achisyuu kamutanakulya.
- Amujike nakubilisya lubo chakulya kamutanakulya alubo mulye kakuchipya.
- atubelesye busanambi mumyunzi akusanzya zilongo zyesu.
- atuwose matombe oonse mumadindi.
- na watalika kusomona nywaa manzi mangi abikwa achuka amunyo.
- mutauli chakulya kufumbwa munzila alubo kulya oku kakutalangidwe ababona zyabusanambi.
- amuvwinikile chakulya kuti chitagumwi anzi nanka nzinini.
- amutole muntu kuchibbadela chakufwambana ngumuyeyela kuti chiswa bulwazi bwakolela.

ZYEELEDE KUCHITWA NAKWABA KWANDANA KWABULWAZI BWAKOLELA

- mutabi amazuba manji amalilwe.
- mufwambane kulila nanka kuzika watusiya kakutanaba bantu biinji.
- mutasanzyi chidumbu chawatusiya nangumuyeyela kuti wafwa akolela.
- kutabi makama na mabunga abantu nikujikwa zyakulya.
- mutasambi maboko anu mumutiba oomwe buyo.
- mutajatani maboko anu.
- mutauli chakulya munzila na masena atazumininwi.
- mutaswayi ndawo njimumvwide kuti ilakolela.

Illustration 2 – IEC materials used in Siabuwa CTC

- The assessment team was unable to find IEC materials (pamphlets) in any of the CTCs visited. One centre indicated it had run out of materials several weeks earlier, and had not requested any more.
- The team was unable to determine to what degree awareness-raising is occurring in remote communities, especially in communities that do not have EHT outreach services.

4. Prevention strategies differ across geographic locations and between urban and rural areas

In addition to extensive awareness-raising, intensive efforts to increase the number of water points and a planned "blanket" distribution of household kits, prevention strategies in Binga and Beitbridge Districts are characterized by the following:

Binga

- Aqua tabs are being widely distributed. No information emerged about problems or concerns with the actual use of aqua tabs. Health care staff, however, were concerned about sustainability.
- An intensive outreach service is underway in the rural areas visited: cholera-contaminated households, once identified, are a) visited by EHTs, b) decontaminated, c) awareness-raising is carried out, and d) all household members are given Doxycycline as a prophylaxis.
- All funerals are supervised by EHT's / health personnel.
- In some communities, mass prophylaxis of Doxycycline is being undertaken to all community members over the age of 12.

Beitbridge

- Patients who are discharged from CTCs are given aqua tabs & advised how to de-contaminate their household, but are not given any supplies to do so.
- In urban areas, affected households are decontaminated by EHT's (with about 50% coverage). EHT's are not working in rural areas however, so there is no decontamination of households.
- Funerals are supervised.
- Doxycycline, as a prophylaxis, is discouraged.

In both Binga and Beitbridge, efforts are made to immediately investigate new cases of cholera, so as to determine and respond to the principle causes.

On the issue of Doxycyline, the assessment team found differing opinions amongst medical personnel about its use as a prophylaxis, ranging from its being considered a necessary intervention, to its being considered a liability. Alongside these opinions, medical personnel in both Beitbridge and Binga also expressed concerns about the negative repercussions of the "Doxycycline myth" (as it was described by one medical professional), whereby people are relying on the drug as a key preventive intervention, when they should actually be changing their hygiene practices. A concern was also expressed by medical personnel in Beitbridge that because the drug was initially being sold openly to anyone who wanted it by unscrupulous merchants exploiting the situation, they fear that it may have been consumed by pregnant women and children under the age of 12 (in whom it is contraindicated). There are concerns now about birth defects to unborn babies and bone/teeth brittleness in younger children.

In summary, a range of preventive strategies are in place in both locations, the approach and intensiveness influenced by available resources, remoteness of locations, and medical opinion about best practice.

5. A range of treatment issues and challenges exist, especially for the most vulnerable groups.

Medical personnel were asked about the challenges they faced in treating patients for cholera. The following findings emerged:

- Due to the sudden and extreme onset of the cholera epidemic, and the sheer volume of patients in some areas, the medical history of patients is often not taken (such as whether they have existing medical conditions, or are taking medication, etc.) There have been instances where this absence of information may have compromised best patient care.

- PLWHA (people living with HIV and AIDS) or other chronic illnesses have the worst outcomes if admitted as cholera patients. They require more complex treatment and a longer hospital stay but CTCs are not always prepared to deal with these cases. For example, although HIV prevalence in the country is high, CTCs are not stocked with the common drugs needed for this caseload so that both the cholera and other conditions (such as opportunistic infections) can be simultaneously treated.

- There have been insufficient / inconsistent supplies of paediatric cannulae, IV administration sets and paediatric drugs.

- Outreach services currently providing treatment and follow up of cholera patients (as well as decontamination of households), are inadequately resourced in terms of staffing, transport and supplies, to sustain the current level of intervention. For example, Siabuwa clinic has a policy of admitting only the most serious cases, and provides outreach services as a key strategy in containing the epidemic. Its staff are stretched to the limits of their capacities, trying to provide services to 17 villages within a 30km radius, some of which are so remote and impassable with motorcycles that staff must walk hours to reach them.

6. Medical personnel have concerns about their capacity to provide an adequate level of patient care.

It was the impression of the assessment team that medical personnel working in the cholera response are dedicated and committed, often working long hours and under very difficult conditions. Staff spoke of a number of challenges they face in providing even a minimum standard of patient care. While these may be ongoing concerns related generally to health care services across the country, there are also specific concerns related to the cholera epidemic. These include:

a) Food provision

The most commonly expressed concern regarding patient care was the inconsistent and unreliable availability of food. This was the case both at CTCs as well as at the household level (where outreach services exist). Insufficient and inappropriate food during illness and recovery of the most vulnerable (especially under 5's, PLWHA, and elderly) is a serious concern, as is the absence of food for CTC personnel who are working long hours without breaks. At the community level, it was thought that the absence of food is the major contributor of death for the elderly. The mortality rate however amongst elderly at the community level could not be confirmed at the CTC or hospital level due to the absence of age-disaggregated statistical analysis.

The inadequate supply of food in some CTCs means that families themselves must bring cooked food for hospitalized family members, and staff are concerned about its being badly

cooked or even contaminated. In other CTCs, staff cook the food that is brought by families or provided by NGOs or the UN, but because the CTCs do not have cooking pots or utensils clinic staff must bring their own from home.

b) Care of Children

A number of challenges emerged in relation to the care of child patients:

- The absence of "paediatric" cholera beds means that children are put into beds that are too large for them, and their legs or bodies often fall through the holes. Children also don't like being positioned so far down on the bed, and they tend to drag themselves to the top of the bed (and away from the hole).

- There is no appropriate food (e.g. formula) for infants when breastfeeding mothers who are admitted are unable to produce milk (the assessment team was notified of one case of a community level baby death which was attributed to this)

- While parents of children under the age of 10 are encouraged to remain with their hospitalized children, often times both parents and children are hospitalized at the same time so there is no caregiver presence. Young children therefore are witnessing or experiencing the violent nature of cholera illness without any psychosocial support because the nurses are simply too busy to do so.

- Sometimes children, men, women are all in same ward because there simply is no space to put them into separate wards.

- Even where paediatric wards do exist, children aged 12 to 16 years of age are put into the same ward as adults. The emotional development of children in this age group is far less than adults, and their placement in an adult ward means they are unlikely to receive a level of emotional support that is requisite to their development, as they experience or witness the harsh nature of cholera illness. Placement of this age group into adult wards is not unique to the cholera epidemic – the team was told that this is normal practice.

- Related to the previous point, while children under the age of 12 are not generally admitted/discharged in the absence of an adult caregiver or guardian as a protection measure, adolescents are not assured this same protection. Nursing staff were unable to tell us whether any unaccompanied adolescents had been admitted or discharged, but admitted there was a risk that this could occur. The assessment team was particularly concerned about this issue in relation to child headed households and adolescent migrants who might have succumbed to cholera while on their way to or from South Africa.

c) Other - there has been an insufficient supply of blankets and linens

7. Some vulnerable groups may not be able to easily access interventions

The assessment team sought to explore whether there were any vulnerable groups who had difficulty or were unable to access treatment. Responses indicated that while there has generally been strong community support to help cholera patients get treatment and to ensure the care of remaining family members, there nevertheless are concerns about some groups of people, as follows:

a) Elderly

Respondents in both Beitbridge and Binga expressed concerns about access by elderly people to prevention, care and treatment. There are a number of factors that put elderly people at risk according to respondents:

- many are already struggling with health issues and living alone/with inadequate family support, or they are caring for younger children
- they are often less meticulous about their hygiene habits due to physical/ mental capacity
- culturally, elderly people still have primary responsibility for burial ceremonies, including washing of the body
- their physical (in)capacity means they will have the most difficulty reaching a CTC, especially if they live in more remote areas

It was not possible to ascertain how many elderly people had been unable to access interventions. An analysis of age-disaggregated data in relation to community deaths and CTC/hospital admissions was not available but would give some insight into this.

b) Children under the age of 2 years

The assessment team heard a wide range of opinions about the incidence of cholera within this age group, which it felt could be leading to inaccurate reporting of cholera, as well as contributing to its transmission. For example, in one meeting attended by the assessment team where the recent deaths of several community children was being discussed, it was stated by a medical practitioner (citing WHO guidelines) that, on the basis of age alone, the deaths of those under the age of 2 (which comprised the majority), would not be documented as having been cholera related. This viewpoint was refuted by medical personnel (in another location) who cited that WHO guidance states that the “under 2” reference applies only in the context of isolated cholera cases, not in the context of a cholera epidemic. While the assessment team did not receive any information from community members that children under the age of 2 with diarrhea were being treated differently than older children, there is concern that mixed messages about this age group could lead to complacency about seeking immediate treatment, or in handling of stool and contaminated nappies; as well as inaccurate reporting (either over, or under) by medical personnel.

c) Apostolic community

The assessment team was made aware of an apostolic community that has not yet been reached for cholera prevention, due to the community’s refusal to allow entry by outsiders. This same community has a history of refusing vaccination for its children and there are concerns that its children may not be able to access cholera treatment if needed. While this is only one community, there may be others in a similar situation. This issue needs further exploring, and sensitive management. While adults may personally choose not to seek appropriate health care, refusing access to children is a violation of their rights to survival and development[9].

d) People with disability

The assessment team attempted to glean information about accessibility to prevention and treatment for children and adults with disability. Of all the respondents who participated in the assessment, there was only one (key informant) who was aware of anyone with a disability who had presented for treatment. The virtual absence of people with disability from amongst those who have required treatment (both at the level of the community as well as CTCs and

[9] Articles 6, 24 *United Nations Convention on Rights of the Child (1990);* Articles 5, 14 *African Charter on Rights and Welfare of the Child (1999)*

hospitals) is perplexing and requires further exploration. No reason could be given by respondents about this, nor are there any disability-related community level morbidity/mortality statistics to shed light on this.

e) People Living with HIV and AIDS (PLWHA)

It was perceived amongst respondents (health personnel as well as community members) that there is low cholera prevalence amongst PLWHA and their caregivers (due to high awareness levels and good hygiene practices amongst this population, as well as the fact that many PLWHA are already on long term antibiotics). The absence of disaggregated data however in relation to this caseload did not enable this perception to be confirmed. Given the long distances that people are required to travel to reach the closest CTC, it is unlikely that a person in advanced stages of AIDs who had succumbed to cholera would be able to easily get him/herself to a CTC or hospital for treatment.

f) Unaccompanied adolescents (e.g. street children, child-headed households, migrants)

As mentioned in the last bullet point of Section 6(b), the assessment team was unable to determine whether any unaccompanied adolescents (age 13-18) had been admitted to CTCs or hospitals for cholera treatment. There were no age-disaggregated statistics available and nursing staff couldn't really recall. Given the conditions in which street children, migrants and child headed households often live, the assessment team expected to find that at least some unaccompanied adolescents would have succumbed to cholera and required treatment. Their seeming absence may mean they were either unable to access care, or they were admitted and discharged as adults. The risks related to processing adolescents as adults are a concern given the special protection rights of children (under the age of 18)[10]. For example an unaccompanied minor presenting to a CTC should be supported in being reunified with his/her family and should not be discharged into a situation that could potentially put that child at risk of abuse or exploitation (such as back to the streets). Although the team did not find evidence that this had occurred, the fact that adolescents could be admitted/discharged as adults means the potential for this risk exists. .

In summary, although respondents generally felt that everyone who needed treatment was getting it, either at a CTC or through an outreach service, the assessment team was not convinced, especially given all the barriers to access that were being cited (outreach activities were delayed in starting up, shortage of ambulances/transport, distances between villages and CTCs, delays in establishment of village level ORS points, etc). The issue of access by vulnerable groups therefore needs further exploring, for example an analysis of statistics and trends related to community-level mortality (who are they and why could they not access life-saving treatment) would shed more light on which groups of people are least likely to access life-saving treatment.

8. Disaggregated statistics are not being analysed or used to inform the response

In all locations visited, age and sex disaggregated information was being documented on line listings and raw data was available at district hospitals. This information however is not being analysed, accessed, discussed or used to inform the cholera response, as has been alluded to in other parts of this report. Without accurate statistical information and analysis about age, sex and situation of people who have succumbed to cholera, it is difficult to justify or advocate for improved responses for the most vulnerable. In requesting to view statistical

[10] As per Articles 9, 19 and 20, *United Nations Convention on the Rights of the Child (1990);* and Articles 16, 23, 25 *African Charter on Rights and Welfare of the Child (1999)*

information there was often reluctance on the part of medical personnel to do so. From the various discussions the assessment team had and the few statistics it was able to view, the team estimated that about 15% of affected people are under the age of 5, that around 50% mortality is attributed to the elderly population, that PLWHA are less likely to succumb to cholera, and that women are more affected by cholera than men. These estimates however are simply best-guesses, and based on limited information. Unless locally collected disaggregated statistics are analysed, discussed and used to rapidly inform/modify local-level responses, the most vulnerable and marginalized populations (PLWHA, chronically ill, children, disabled, elderly, etc) may not benefit as fully as they could from cholera interventions.

9. Factors potentially contributing to ongoing cholera

Although a number of interventions have been put in place to prevent and rapidly respond to cholera, as described throughout this document, there are nevertheless factors which are contributing to its perpetuation. These include:

- Women and girls are highly unrepresented in community/district level cholera committees/ structures. Given the role they play in care giving and household chores, their input to prevention and response strategies is critical. While the issue of women's and girls' (non)representation in decision-making community groups is a long-standing issue not unique to the cholera epidemic and needs to be addressed as a longer term developmental issue, the impact of their invisibility in any emergency response has been well-documented and cannot be over-stated.

- Children and young people's involvement in cholera prevention and response interventions is non-existent, they have simply been excluded. Their involvement is not only vital in addressing the epidemic, but also in helping them to recover from its psychosocial effects. As with all humanitarian interventions, children in this epidemic should not be viewed as powerless and passive recipients of aid, but as an important source of energy, knowledge and creativity. Their absence from awareness-raising campaigns for example (both as participants as well as implementers), undermines the contribution they could be making towards prevention and timely identification of risk factors.

- The distance and remoteness of communities from CTCs and the absence of outreach services means patients have to travel long distances to seek treatment *"dragging their diarrhea and vomitus from village to village*" (*key informant interview, Binga District*). Some felt this was a principal reason for cholera spread.

- In some locations community members still believe that the scale and severity of illness (and death) is linked to witchcraft, which is creating a barrier to changes in poor hygiene practices. One example was given in Binga District however, whereby a community's strong belief in witchcraft as the source of the problem, had been turned around by effective awareness-raising.

- Respondents felt that ongoing migration of people was a major contributor to the spread of cholera. In most cases, when asked about the source of cholera in a particular community, respondents usually made a link to an individual or group of individuals who had arrived from a cholera-affected area. In Binga District for example, the source of cholera was attributed to an individual who had come from Chitunguiza, and had attended both a wedding and a funeral before succumbing to cholera and dying. In Beitbridge District, respondents in rural areas attributed the epidemic to people who had fled Beitbridge town in fear when cholera struck so quickly and catastrophically.

- As mentioned earlier, the mixed opinions about cholera in the under-2 age group may be contributing to its spread.

- The "Doxycycline myth" may also be contributing to perpetuation of the epidemic as described earlier in Section 3.

Conclusion

The cholera epidemic has taken in place in the context of a complete breakdown in essential services including water, sanitation and health care. Responses to curtail the epidemic have focused on addressing the water and sanitation situation, raising awareness about prevention and treatment, and undertaking life-saving interventions, all of which have been undertaken in the most challenging of environments. Although these interventions will certainly result in keeping the epidemic in check, the psychosocial impact of the epidemic, especially on the most vulnerable populations, will be much longer lasting than the epidemic itself. This has yet to be addressed, as have a number of specific age and vulnerability-related issues.

Recommendations

The following recommendations have been developed for the current cholera crisis but most could be applied to any future emergency.

In the immediate term:

1. Advocate with MPSLSW, through the Department of Social Welfare, to lead the process of identifying and responding to the needs of families most affected by cholera, as a matter of urgency and through existing structures (such as community health workers, Child Protection Committees) and existing programmes such as Home-based care, Vulnerable Group Feeding, National Action Plan for Orphans and Vulnerable Children. Consider psychosocial support [11]as well as physical, food, and protection needs.

2. Analyse and disseminate disaggregated statistics regularly to inform / strengthen response. Although information is available at Cholera Treatment Centres, clinics and hospitals though line listings, it needs to be constantly analysed and transmitted on an ongoing basis to stakeholders to enable rapid and effective response at different levels, but especially at the local level.

3. Address gender imbalances on village level Cholera Co-ordinating Committees through immediate and long-term approaches, and ensure involvement by adolescents and young people as well as Child Protection Committee members.

4. Target children directly for awareness raising and involve them in information dissemination. Schools are an important entry point for this work but school closure is not a reason to exclude children from the process. It is essential that children receive information first-hand whether they are in or out of school and whether schools are functioning or not.

[11] Note – the need for psychosocial support to cholera affected communities is also reflected in the following IFRC report - " Democratic Republic of Congo, Cholera Outbreak in Katanga and Maniema Provinces", IFRC DREF Operation n° MDRCD005 GLIDE n° EP-2008-000245-COD, 16 December, 2008. Retrieved from http://www.ifrc.org/docs/appeals/08/MDRCD005do.pdf, April 20, 2009.

5. Develop pictorial IEC materials that are attractive and can be understood by non-literate people including children.

6. Strengthen community outreach services – or increase the number of Cholera Treatment Centres, and Environmental Health Technicians. Carry out ongoing training of staff to address high turnover.

7. Advocate for the development of a common position around cholera in children under the age of 2 years; as well as a position on Doxycycline prophylaxis

8. Undertake a wider and more comprehensive assessment to determine the scope and nature of psychosocial impact on the most vulnerable families at the community level.

In the medium term:

9. Incorporate the psychosocial impact of cholera (and other disaster situations) into disaster planning/response processes. This will require

    - strengthened engagement of MPSLSW and its Department of Social Welfare, as well as the Ministry of Education, Sports and Culture
    - advocacy with the Civil Protection Unit, MoHCW and other key Ministries to take a multi-sectoral approach that incorporates minimum psychosocial interventions[12] in emergency preparedness and response planning.
    - incorporation or mainstreaming of age/sex/vulnerability considerations at the planning stage to help ensure that the particular needs of the most vulnerable populations are addressed effectively and rapidly. This might include for example:
        - Advance mapping of areas with high prevalence of HIV/AIDS and TB so that this information can be incorporated into emergency preparedness plans
        - Review and modification of current national cholera guidelines (and other guidelines), to reflect expected numbers of patients of different age / vulnerabilities, based on historical trends, to ensure pre-positioning of medical or other provisions sensitive to their particular needs
        - Using lessons learned in the current cholera epidemic to ensure pre-positioning of, or inclusion of items such as cooking pots/utensils to cholera treatment centres / hospitals in cholera kits
        - Continually analysing / responding to CTC changing needs during the period of the epidemic.

10. Strengthen emergency preparedness and response capacity at village, ward, district and national level, through training, refresher courses, community consultations etc. Ensure that women and children are included in these processes. It is a right for children to be involved in issues that affect them[13], and they are a tremendous resource in terms of their energy, creativity, knowledge and commitment.

11. Carry out a comprehensive lessons learned exercise to improve preparedness / response for the next emergency.

[12] Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007, *Inter-agency Standing Committee*

[13] Article 12, *United Nations Convention on Rights of the Child;* Article 7, *African Charter on Rights and Welfare of the Child (1999)*

Annex 1

GUIDELINES FOR MAINSTREAMING PROTECTION INTO THE CHOLERA RESPONSE

As the cholera epidemic in Zimbabwe continues, the Protection Sector Working Group (PSWG)[14], by issuing the following guidance to humanitarian agencies involved in the cholera response, hopes to promote the mainstreaming of protection.

The 2 key points that the PSWG would like to stress to those engaged in the cholera response are:

Particularly vulnerable groups

Prevention and response activities should take into account the specific needs of **and reach** particularly vulnerable[15] and 'hard-to-reach' groups. Such groups include but are not limited to: children, women (in particular female-headed households), the elderly, the disabled, refugees and asylum seekers (urban-based), persons in institutions (including prisons). This applies also to the design and distribution of IEC materials.

Protection-sensitive responses

Agencies should ensure that their response activities do not create but at least mitigate protection risks for beneficiaries. 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 a cholera treatment centre (CTC) for treatment without adequate care provision being made for the child(ren) left behind.

Conducting a protection assessment of your agency's cholera response plans will help to identify potential gaps and risks. The disaggregation of data by age and sex[16] is crucial to help identify those most at risk.

More detailed guidance on how to minimize protection risks to and incorporate the specific needs of children, women and urban-based refugees follows. The lead agencies of the PSWG are able to offer advice and guidance, and can be contacted using the details that follow below:

IOM	David Sezikeye (dsezikeye@iom.int); Diana Cartier (dcartier@iom.int)
Save the Children	(UK) Christine Lipohar (christinel@scfuk.org.zw / 011882009) (Norway) Lois Mushonga (lois.mushonga@reddbarna.org.zw / post@reddbarna.org.zw)
UNHCR	Igor Ivancic (ivancici@unhcr.org); Gavin Lim (limg@unhcr.org)
UNICEF	Allet Sibanda (asibanda@unicef.org); Elaine Bainard (ebainard@unicef.org)

Protection Sector Working Group
January 2009

[14] The PSWG consists of protection-mandated UN, NGO and humanitarian agencies. It is led jointly by IOM, SC-Alliance, UNHCR and UNICEF.
[15] The concept of vulnerability is important in identifying which groups are most at risk in crisis situations and involves an assessment of an individual's internal capacity to respond to external events. Certain persons or groups can be considered to be more vulnerable than others based on their own internal characteristics or because of society's perception / treatment of them.
[16] The PSWG is aware of the communication and human resource constraints meaning that only suspected cases and fatalities are now being reported. However, PSWG suggests that if this is possible, sex and age breakdown should be captured.

Annex 1: Children and the cholera response

Children's special developmental needs should not be overlooked in the design and implementation of interventions.

Age and Sex Disaggregation of cholera patients

- Age and sex disaggregated data of children is needed so we better understand who are affected and can better protect them. Currently there are **NO** such statistics. Ideally, disaggregate by (0-5), (6-12), (13-17) years, but at a minimum (0-5) and (6-17)**.**

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;
- 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 / neighbours. 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 (Ministry of Social Welfare, child protection NGO, UNICEF). Babies and very young children in this situation should be given the highest priority.

Health and hygiene education around cholera (signs, symptoms, prevention)

- Children need to get information **first hand** – this means providing information in places where children congregate: schools, churches, play areas, crèches, 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 crèches, **through play, demonstration, role playing**. These 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** need to be child friendly (appealing, attractive, easy for children to read and understand, developed in all languages).

Children at Cholera Treatment Centres / Hospitals/Clinics

- Hospitalised 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.

Distribution of Water Purification Tablets

- Distribute tablets to institutions housing children (schools, orphanages, etc);
- Ensure child caregivers understand how to use the tablets.

Access to treated and reticulated water

- Ensure children who are fetching water have age appropriate buckets and jerry cans;
- Women and children can be sexually abused or exploited in the process of collecting water or firewood. This needs to be factored into your programming response.

Assessment Questions to Identify Child Protection / Family Separation Issues

When carrying out cholera response assessments, remember to explore child-related issues:

- 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.
- 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?
- 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?
- 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?
- What are the concerns for hospitalized children – in terms of their medical/physical care (food, etc) and emotional support? What needs to be done?
- 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?

Consider calling on child-focused NGO staff/volunteers 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).

Annex 2: Women and the cholera response

Women are more vulnerable to cholera due to the gender roles ascribed to them

- **Women have less access to resources:** Social networks and influence; transportation; economic resources; personal mobility; control over decision-making or resources that are extremely critical to be able to save oneself from the morbidity and mortality of cholera;
- **Women are victims of the gendered division of labour:** Women are primarily responsible for domestic duties such as fetching water, preparing food, coming into contact with raw food stuff, cleaning toilets and care for sick, disabled and elderly in the family. All of their daily chores expose them to the risk of acquiring cholera;
- **Women-headed households with a double burden:** As widowhood due to HIV and migration among men is a common phenomenon in the country, there are many women-headed households in the country. Women are hence forced to play the dual role of being economically productive as well as performing domestic duties. The added responsibilities diminish women's willingness and ability to access health care. Due to the lack of male members in the family, women are often forced to attend to funeral practices exposing themselves to the risk of cholera;
- **Women as caregivers:** Moreover, gender roles dictate that women become the primary caretakers for those affected by cholera in the family substantially increasing their emotional stress and material work load and increasing their susceptibility;
- **Pregnant women and girls:** Due to their physical and emotional condition, pregnant women and girls have limited mobility and are dependent on the support of husbands and other family members. During a crisis, family disruption occurs and support mechanisms may disappear. Pregnant women and girls face greater marginalization when their dietary intake is deficient and when both ante- and post-natal clinics and supplementary feeding programmes are not in place. The likelihood of physically and mentally underdeveloped infants increases. Cholera also has a direct impact on the pregnant women predisposing to fetal deaths and complications arising out of retained placenta.

Incorporating gender issues in Cholera response

- Ensure gender sensitive preventive messages are provided to the community which would help women to take adequate measures to prevent themselves from acquiring cholera;
- 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 in location of boreholes, water distribution points and distribution of hygiene supplies;
- Special attention to be provided to pregnant women and girls in CTCs and health workers trained to handle obstetric emergencies;
- Take cognizance of the health sector collapse and the sexual and reproductive health concerns of women and girls and support sexual and reproductive health programmes for vulnerable women and girls.

Annex 3: Urban-based refugees and the cholera response

The Government of Zimbabwe in co-operation with UNHCR caters for needs of refugees and asylum-seekers. While the majority reside at Tongogara refugee camp, Chipinge District, Manicaland Province, some 1200 refugees and asylum-seekers are urban based, in particular in Harare. Refugees at Tongogara benefit from the camp based clinic in addressing their medical needs. In case of a cholera outbreak, the clinic is likely to be a centre for the coordination of the wider response in the area, including catering for needs of the local population estimated at some 2.000 residents.

Refugees in an **urban context** need to rely on the safety net provided by the ongoing response mechanisms and facilities. In that respect the following basic points should be borne in mind:

- Refugees in urban settings are mostly found in Harare (such as in Waterfalls neighbourhood and in the Avenues). Smaller numbers also reside in Mutare and Bulawayo;
- Refugees and asylum-seekers may not be in possession of identity documentation like that of Zimbabwean nationals. However, they are documented with ID Cards issued jointly by UNHCR and the Government confirming their identity, legal status and ID number. **This should not hamper their access to medical assistance as their condition may require.** The validity of identity documentation issued to refugees and asylum-seekers is recognised by the authorities;
- While refugees and asylum-seekers are expected to reside at Tongogara camp – where their medical needs are addressed through the onsite clinic – they should not be denied emergency medical treatment, in accordance with international human rights standards, when they find themselves in other parts of the country. **Refugees and asylum seekers should be rendered services and assistance on the same basis as Zimbabwean nationals as they are legal residents of Zimbabwe.**

Rendering protection and assistance to refugees and asylum-seekers is the responsibility of the Government of Zimbabwe, in accordance with the 1983 Refugees Act. Should any cases of identified cholera involve refugees, the Department of Social Welfare, the Office of the Commissioner for Refugees and UNHCR may be notified for information sharing and any special assistance related purposes (such as addressing family reunion needs, assistance to unaccompanied and separated children, women headed households, and other vulnerable cases).

Annex 4 – Participants of Meetings / Interviews / Focus Group Discussions

Binga / Siabuwa Meetings

Key informant interviews

Name	Location	Position	Date
Mrs. Tshumu	Siabuwa	Provincial Nursing Officer – has been stationed at Siabuwa clinic/CTC for past 2 weeks	Feb 8
Mr. Butale Phineas Muyamba	Binga	District Health Information Officer Assistant to the DHIO	Feb 9
Dr. Mateveke Ms. S. Mudima	Binga	Physician, Binga Hospital Nurse-in-charge, Binga Hospital	Feb 9
Sihle Mabhena Mr. Mudengwe	Binga	District Education Officer District Social Welfare Officer	Feb 9
Mr. B. Vhare Mr. M. Sabango	Siabuwa	Nurse-in-charge, Siabuwa Clinic Environmental Health Technician (from Lubimbi, seconded to Siabuwa 3 weeks ago	Feb 10

Focus Group Discussions

Type of Group	Location	Composition	Date
Cholera Task Force meeting Binga	Binga	14 (13 M, 1 F)	Feb. 9
Children from Nagangala	Nagangala	52 children - Approximately equal number of boys and girls overall, comprised of 26 children from 5 years to 12 years, and 25 children from 13 years to 17 years.	Feb 10
Community Members from Nagangala	Nagangala	20 (7 M, 13 F)	Feb. 10
Community Cholera Committee members	Siabuwa	12 (4 M, 8 F) from 7 surrounding communities	Feb. 10

Beitbridge District Meetings

Key informant interviews

Name	Location	Position	Date
Beitbridge Rural District Council Management Team	Beitbridge		
Agnes Nsingo		District Child Protection Officer (BRDC)	Feb 12
Myambo		Executive Officer Health (BRDC)	
Nsingo		Town Engineer	
Representative		Accountant	
Representative		Administrator	

Name	Location	Position	Date
Beitbridge Hospital Staff Dr. Masuka Monika Moyo Cecilia Ndlovu Chimurudza	Beitbridge	 District Medical Officer (DMO) District Nursing Officer (DNO) Matron Administrator	Feb 12
Mr. Munikwa	Beitbridge	District Psychological Services Officer, MoESC	Feb 12
Nick Van Der Vyver	Beitbridge	Head of operations – IOM (International Organisation for Migration) Centre –	Feb 13
Veronica Nicola	Beitbridge	Physician, MSF	Feb 13

Focus Group Discussions

Type of Group	Location	Composition	Date
Members of Civil Protection Unit, Beitbridge	Beitbridge	Regina Ndlovu (District head – Legal Resources Foundation Zimbabwe) Muhambi Hwata (President's office) Phiri J. (Prisons' representative), Representative – (Ministry of Public Works), Energy Mlambo (District Social Welfare Officer)	Feb 12
Staff, Chaswingo Clinic/CTC	Chaswingo	S. Noko (Nurse in charge) M. Kaweni (nurse) S. Muleya (nurse aid) O. Moyo (nurse)	Feb 13
Community members, Chaswingo	Chaswingo	10 (3 M, 7 F,) (including general hand from the CTC)	Feb 13
Children from communities in Chaswingo cachment area	Chaswingo	9 (6 M, 3 F,) aged 11 to 17 yrs	Feb 13
Staff, Chitulipasi Clinic / CTC	Chitulipasi	N. Nkomo (Nurse in Charge) V. Ngulube (Nurse) Mrs Nsingo (Nurse Aid) R Ncube (General hand)	Feb 13