

Protection, GBV and Gender Considerations in the Cholera Outbreak in Lebanon¹

This note aims to capture the key protection and gender-based violence risks as well as specific needs of women, girls, boys and men which may arise as a result of the outbreak but also as a result of outbreak response efforts. It tries to capture mitigation measures which protection and other sector interventions need to adopt to ensure interventions reduce protection risks as well as reduce exposure/transmission of the disease.

During a Cholera outbreak a number of protection risks may arise which can impact the safety, mental health and psychosocial wellbeing of individuals and communities, including: reduced access to essential protective spaces and services, disruption of care for children and other dependents (older persons, persons with disabilities) due to absence (while in treatment) or loss of caregivers, disruption or loss of livelihoods during treatment or following death especially if the primary income generator impacting the household and support network, negative attitudes and behaviours (violence, exclusion, stigma, discrimination, restriction of movement, eviction threat) toward disease survivors, families of patients and those who could transmit the disease (i.e., frontline responders), risk of heightened tension between and amongst communities and households resulting in collective movement restrictions and threats of collective eviction targeting high-risk communities, heightened anxiety, mistrust and isolation due to fear of the disease and long term physical and psychological impacts including loss and grief. As a result, protection partners need to work closely with **health, WASH and Risk Communication and Community Engagement** counterparts to reduce the risk of exposure to the disease and to prevent and respond to violence or other protection concerns that arise as a result of the outbreak.

Key cross-cutting components to be mainstreamed into the response should be: Protection including age, disability and diversity factors), Gender and Gender-Based violence including MHPSS and Conflict Sensitivity.

There are persons at heightened risk who may experience greater exposure or vulnerability² (due to their age, gender, disability, documentation status, language, gender identity and sexual orientation, and their proximity to high-risk areas, their professions, and living conditions) **and must be taken into account:**

- **Children especially under 5 years old and children with severe acute malnutrition (SAM)**, who experience higher mortality
- **Street working children and homeless individuals** who may have limited access to clean drinking water, hygiene and sanitation conditions, and limited access to information as these individuals may fall outside of prioritised 'high-risk areas'
- **Pregnant and breastfeeding women**, more vulnerable to malnutrition and higher risks of developing dangerous/fatal complications if they contract cholera
- **Immunocompromised individuals** (HIV and AIDs) and **older persons** whose immune systems are often more vulnerable
- **Women and girls, are more exposed to cholera due to the roles and status they traditionally hold** in the home and in the community as carers and caregivers
- **Specific professions** may also be further exposed, such as frontline health workers treating cholera patients or response workers who fail to follow safe food and water precautions or personal hygiene measures, shop keepers in markets, chefs/food preparers, sex workers, morgue attendants, etc.
- **Women, children and other vulnerable groups such as language minorities, persons with disabilities and older adults due to limited access to information** tailored to their needs,

¹ In previous responses around the world protection considerations have been overlooked in cholera response efforts which is unfortunate due to the long-term negative outcomes for people especially from the most vulnerable groups. This document is drafted by the PRT Core Group, GBV TF Coordinator & IA Gender specialist and drawing on available resources.

² As of Wednesday 12th October, 44% of cases which contracted cholera were under 4 years old and above 70% were women.

developmental or literacy level, about how to protect themselves and how to access treatment and support services

- Refugees/poor Lebanese **living in densely crowded areas**, remote locations, those living in poor hygiene conditions, facing water scarcity
- Refugees/migrants with **late health care seeking behaviours due to lack of legal residency, documentation** and/or who have experiences of discrimination entering health facilities/centres
- **Persons living in public institutions such as detention/prison, elderly homes, orphanages, mental health centres, shelters** who may not readily have access to enough clean drinking water and/or the available supplies or freedoms to sterilize/boil water

Women and Girls

- Cholera is transmitted principally through contaminated water and food. Women and girls have a heightened risk of coming into contact with a high infectious dose of cholera through their domestic roles, including taking care of sick family members, cleaning latrines, fetching and handling water, and preparing contaminated raw food.
- Women and girls can also face a greater emotional, physical, and socioeconomic toll during a cholera epidemic. The division of labour during a cholera epidemic can fall particularly hard on women and girls.
- The increased workload at home can result in decreased work outside of the home in terms of income generating activities and even school absence.
- Moreover, evidence highlights the emotional and physical impact of care giving for sick relatives.
- Often most of the responsibility for water purification falls on women and girls.
- Gender-based violence increases during outbreaks of infectious diseases. For instance, epidemic or pandemic control policies that enforce lockdown measures can heighten socio-economic precarity and the feminization of poverty: **known risk factors for transactional sex and sexual abuse and exploitation** but also increase family tensions and IPV;
- Traditional gender dynamics tend to disadvantage women and girls due to less decision-making authority within the household and less access to resources such as transportation for life saving medical care or potable water, particularly for female headed households who tend to be even more disadvantaged
- Female headed households have less access to water and sanitation facilities, compared to male headed households.
- Domestic migrant workers who are often women may not have free available access to water

Potential impacts of the cholera outbreak response which may create new protection, child protection and GBV risks

Health Mitigation and Response	Potential Impact
All measures	<ul style="list-style-type: none"> - Higher mortality and exposure of women and children due to gaps in gender/age sensitive health responses - Exacerbates exclusion of specific groups (pre-existing health conditions, location), - Communication materials and outreach messages are not tailored to address barriers (language, age, disability etc) and lead to exclusion of certain groups or individuals
Surveillance, isolation, oral hydration points and treatment centres	<ul style="list-style-type: none"> - Risk of stigma, discrimination, isolation, eviction, restricted movement as a result of surveillance efforts and data protection breaches in community or to media placing people at harm. - Separation of households while individuals are in treatment units particularly affecting (children, persons with

	<p>disabilities and older adults whether they are patients or dependents of patients.</p> <ul style="list-style-type: none"> - Given cholera disproportionately impacts children under 5 this group is at particular high risk of separation from caregiver during treatment - Disruption of livelihoods/loss of income which can lead to range of negative impacts and negative coping mechanisms for example IPV, child marriage, child labor, transactional sex - Exclusion of groups (hard to reach areas, inaccessibility of centres/hydration points)
Infectious preventative and control (IPC) measures	<ul style="list-style-type: none"> - Increased housework and caregiving responsibilities for women and girls, heightened exposure to violence/SEA in contact with water contractors
Safe and dignified burials, IPC measures	<ul style="list-style-type: none"> - Disruption of traditional and cultural practices
Prioritisation of cholera services	<ul style="list-style-type: none"> - Disruption of routine non-cholera services (reproductive health, MHPSS, childcare) and redirection of resources, reduced access points for reporting and protection services
In the event of School closure and community quarantine	<ul style="list-style-type: none"> - Increased burden of caregiving impacting women and girls, Increase violence, abuse, neglect of children, SEA, increased GBV (IPV, early marriage, sexual violence, SEA) - Disruption of community support networks - Disruption of livelihoods

**All these situations have a significant toll on one's mental and psychological health and wellbeing*

Mainstreaming Actions through prevention, preparedness and response

Phase	Mitigation Measures
Prevention	Provision of gender, age and developmentally appropriate IEC materials for IPC measures (and referral processes) as well as materials on PSEA key messages must be in multiple languages (incl. for refugees of other nationality, migrants) and different formats (written, visual / pictorial, and audio formats) and distributed through different access points (community centers, health facilities, schools) to enhance accessibility to information as well as to reach at-risk populations (mid-wives as an entry point for pregnant/lactating women)
	Operational communication and prevention plans should target persons at heightened risk due to their exposure and vulnerability to cholera (as listed above) , as well as be based on health surveillance data and geographic WASH hotpot mappings.
	Data on cholera should be collected, analyzed, reported using disaggregated age, sex, geographic data . Age, gender, and geographic monitoring should inform vulnerability assessments and targeting of outreach. It is important that all organizations reporting on data should be conflict-sensitive e.g., avoids stigmatizing certain communities and nationalities.
	Surveillance, investigation, and case management activities need to align with Inter-Agency and agency data protection standards, and consider protection risks (stigmatization, discrimination, retaliation, violence, eviction, etc.) as part of the data collection, analysis and sharing process keeping personal information confidential and ensuring fully informed consent for any suggested isolation or treatment practices .
	Protection sector to review existing protection monitoring tools to track trends and protection risks specific to the Cholera outbreak (i.e., stigma, at-risk groups, discriminatory measures incl. Any movement restrictions) and to monitor barriers/equal access to response and information. Findings should inform programming and advocacy across sectors.
	Joint analysis on the social stability and protection impact of restrictive measures and tensions as a result of the Cholera outbreak and the response through tensions and restrictive

	<p>measures monitoring can help to identify tension hotspots/areas at risk of escalation (eviction/restricted movement etc.)</p> <p>Protection sector partners must embed prevention and control measures in their services for children, educators, community facilitators and caregivers involved in child protection, in case management and legal services, community centres and safe spaces. Use reproductive health sector health providers including mid-wives as an entry to point to pregnant/lactating women to raise awareness on Cholera & practical steps to prevent it.</p> <p>Outreach efforts must engage communities to inform them about different gender roles in cholera prevention and response. Engage women’s groups and other community-based actors with emphasis on promoting messages and community dialogue about what family members can do to protect themselves and their family members from cholera. Encourage men and boys to participate in domestic chores. For example, helping to buy soap or cook or take care of the sick.</p> <p>Ensure women and Children at-risk (working children, street connected children) are actively involved in community activities related to WASH, RCCE and Health (e.g. community water management and sanitation committees, etc.) and involved in awareness raising plans.</p>
Preparedness	<p>Community engagement and mobilization is essential for the success and acceptance of the Cholera preparedness plan. Community stakeholders should be engaged in consultations for feedback and inputs on cholera preparedness planning (incl. youth, older persons, women groups). This is especially important in the event of treatment/isolation units and for the work of the C-RRT to dispel fears, stigma, rumors. Where required support can be sought from the protection sector.</p> <p><u>It is essential that business continuity for critical protection and non-protection interventions are maintained and that community spaces (health, safe space, centres) are leveraged to support cholera prevention and response efforts targeting high risk communities and individuals.</u> Resources directed to support cholera preparedness and response should not be diverted from critical protection activities including case management and safe spaces and partners managing community centers and safe spaces as well as in person interventions must integrate measures</p> <p>Community centres offer protection interventions, including MHPSS services, for those impacted by the disease and they contribute to the overall response efforts by expanding community entry points and networks engaged in IPC. Safe spaces and community-based protection interventions also present valuable entry points for the most vulnerable and harder to reach groups to seek and access support.</p> <p>Health, WASH, RCCE, Cholera RRTs and community health focal points should have refresher sessions on safe identification and referral training to protection and GBV services</p> <p>Key messages on PSEA / Complaint & Feedback need to be widely shared (at health facilities, frontline staff, community focal points, C-RRTs) and developed in different languages/formats to prevent risks of SEA.</p> <p>The WASH sector must ensure gender separated latrines with locks and appropriate barriers to provide for privacy and safety; and install lighting to make them accessible at night and accessible for children and persons with disability</p>
Response	<p>Cholera Rapid Response Teams should: Include female staff to ensure women and girl’s access to information and response. Explicitly identify and prioritise persons and communities at heightened risk for awareness, prevention tools and treatment. This includes those who may be more severely impacted if they contract Cholera due to pre-existing health conditions (malnutrition, pregnant/lactating mothers, AIDS), those less likely to have adequate access to information due to language or developmental barriers, and those with greater proximity to infected water sources due to their professions or traditional gender roles. Teams must be able to dedicate time to properly supporting individuals with late healthcare seeking behaviours (without documents, without legal status, remote areas, migrants, stateless etc.) and provide them with the needed reassurance, guidance and support access services. (See above listed risks)</p>

	<p>Operational response and distribution plans should target persons at heightened risk due to their exposure and vulnerability (as listed above) with critical items such as energy efficient stoves to enhance proper food handling, hygiene kits to reduce the physical, psychological, and social and economic burden on women and girls, purification tablets and other distributed WASH and Health items. Ensure that women, often deprioritized from accessing health, have equal access to diagnosis and treatment. Provide female headed households with critical items such as fuel to enhance proper food cooking and hygiene kits.</p>
	<p>WASH/health and Protection partners to monitor the impact of water shortages and cholera outbreaks on menstrual hygiene practices and ensure women and girls have access to sanitary pads and commodities for healthy menstrual hygiene, as part of the hygiene kits.</p>
	<p>C-RRT, community focal points and frontliners should ensure that information needs and concerns as well as inclusion challenges are raised and channelled to the national RCCE TF through a reporting mechanism.</p>
	<p>Cholera RRTs and other frontliner staff and community focal points involved in surveillance and response should be trained on psychological first aid to provide to disease patients, families, and contacts upon arrival.</p>
	<p>Ensure that coordination and communication between patient and families should be maintained especially for minors/persons with disabilities/older persons, risks of disconnection should be flagged and mitigated</p>
	<p>Health/MOPH should update and activate the SOP on alternative documentation requirements for access to Hospitals/PHC to ensure inclusive access irrelevant of documentation and legal residency and to share widely or through a circular across facilities and partners.</p>
	<p>Protection sector/Inter-Agency to actively advocate with telecommunication companies for a toll-free cholera hotline and to extend sim card validity timeframe beyond 5 days to address communication cost issues which may prevent calls. Known COVID hotlines should be activated.</p>
	<p>Promote the participation of women and girls in the design of prevention and control interventions. Work with partners in the GBV sub sector to meet women’s and adolescent girl’s groups in female friendly safe spaces to elicit their participation. Promote breastfeeding through women’s groups. Mobilize grassroots women’s groups in cholera prevention and response.</p>
	<p>Alternative care for dependents: Accompanying dependents, especially infants/young children/older persons/persons with disabilities unable to care for themselves with no other home-based alternative care options need to be cared for by appropriate carers trained and equipped to provide comfort and age-appropriate psychosocial care, where their health can also be monitored. Protection Focal Points must be linked up to C-RRTs and Health workers should be trained on referral pathways and good practices for alternative care.</p>
	<p>Ensure there is female staff presence in C-RRTs/treatment units so that services are accessible to women and girls. This may also help facilitate disclosure of GBV and mitigate risks for sexual exploitation and abuse. Health workers who are part of the cholera response must have basic skills to respond to disclosures of GBV and know to whom they can make referrals for further care.</p>
	<p>Due to the known psychological impacts of an outbreak on patients and families, patients should have access to MHPSS services throughout treatment especially for survivors of GBV, or other forms of violence and abuse who are affected by cholera</p>