THE NATIONAL CHILD HELPLINE (116) TANZANIA

RESPONSE DURING PANDEMICS COUNSELLORS' GUIDE BOOK

June, 2020

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ABBREVIATIONS

COVID-19	-	Corona Virus Disease
CFR	-	Case Fatality Rate
EVD	-	Ebola Virus Disease
MHPSS	-	Mental Health and Psychosocial Support
CHL	-	Child Helpline
CP	-	Child Protection
NGOs	-	Non-Governmental Organizations
UN Agencies	-	United Nation Agencies
INGOs	-	International Non-Governmental Organizations

ACKNOWLEGEMENT

This Child Helpline Counsellors Guide was developed by C-SEMA to be used a key reference guide by counsellors when attending to calls and contacts on COVID-19, EVD and any other pandemic cases affecting children.

This Child Helpline Counsellors Guide has been developed by the C-SEMA team with valuable contributions from child helpline counsellors working in the contact centres and other members of staff. They build on a wealth of knowledge and expertise acquired through years of work with children and psychosocial support counselling to children affected by violence and abuse.

The C-SEMA team would like to express its sincere gratitude to everyone who has revised and helped to develop this document, particularly staff from UNFPA Tanzania.

We also want to thank all National Child Helpline counsellors who were part of the testing phase of the guide book before the final version was realized.

INTRODUCTION.

Stressors from the COVID-19 pandemic on children and families, compounded by security, health and financial factors, increased the risks of gender-based violence and violence against children. Containment measures can further aggravate situations of children who are already exposed to abusive, neglectful and unsupportive environments. Children's sources of support outside of the family, including child protective services and school, are likely to be out of reach for some, if not all, of the time.
Measures like lockdowns, shut some children in whilst simultaneously shutting child protective services out, compromising access to social, educational and health provisions. Other children, such as children living and working on the streets or children on the move, are even more deprived and isolated from assistance, as may be the case for those living in residential care institutions or in detention.

As a response to the COVID-19 crisis, child protection actors and service providers – including government departments, (I)NGOs and UN agencies – explored how they can continue to provide support to children, families and communities remotely through the use of technology. This includes child helplines, which, over the last decade, have become increasingly important in responding to concerns raised by children and young people on a range of issues affecting their lives.

It is important to distinguish between hotlines, which are primarily used for reporting purposes and signposting (although they may also provide some limited advice and information) and child helplines which generally, provide more active support, including active listening / counselling services and referral of self-reported concerns from children and adults, such as cases of violence, abuse and neglect.

DEFINITION **OF KEY TERMS**[1]

Not all infectious disease terms are created equal, though often they're mistakenly used interchangeably. The distinction between the words "pandemic," "epidemic," and "endemic" is regularly blurred, even by medical experts. This is because the definition of each term is fluid and changes as diseases become more or less prevalent over time.

While conversational use of these words might not require precise definitions, knowing the difference is important to help you better understand public health news and appropriate public health responses.

Let's start with basic definitions:

AN EPIDEMIC is a disease that affects a large number of people within a community, population, or region.

A PANDEMIC is an epidemic that's spread over multiple countries or continents.

ENDEMIC is something that belongs to a particular people or country.

AN OUTBREAK is a greater-than-anticipated increase in the number of endemic cases. It can also be a single case in a new area. If it's not quickly controlled, an outbreak can become an epidemic.

Epidemic vs. Pandemic
A simple way to know the difference between an epidemic and a pandemic is to remember the "P" in pandemic, which means a pandemic has a passport. A pandemic is an epidemic that travels.

Epidemic vs. Endemic
But what's the difference between epidemic and endemic? An epidemic is actively spreading; new cases of the disease substantially exceed what is expected. More broadly, it's used to describe any problem that's out of control, such as "the opioid epidemic." An epidemic is often localized to a region, but the number of those infected in that region is significantly higher than normal. For example, when COVID-19 was limited to Wuhan, China, it was an epidemic. The geographical spread turned it into a pandemic. Endemics, on the other hand, are a constant presence in a specific location. Malaria is endemic to parts of Africa. Ice is endemic to Antarctica.

Endemic vs. Outbreak
Going one step farther, an endemic can lead to an outbreak, and an outbreak can happen anywhere. Last summer's dengue fever outbreak in Hawaii is as an example. Dengue fever is endemic to certain regions of Africa, Central and South America, and the Caribbean. Mosquitoes in these areas carry dengue fever and transmit it from person to person. But in 2019 there was an outbreak of dengue fever in Hawaii, where the disease is not endemic. It's believed an infected person visited the Big Island and was bitten by mosquitoes there. The insects then transferred the disease to other individuals they bit, which created an outbreak.

[1] https://intermountainhealthcare.org/blogs/topics/live-well/2020/04/whats-the-difference-between-a-pandemic-an-epidemic-and-an-outbreak/

RECENT EMERGENCIES **AND DISASTERS IN TANZANIA**[2]

Tanzania has been facing different localized natural and man-made emergencies and disasters whereby disease epidemics are among the five leading emergencies. Recent disease outbreaks that had a significant public health impact include, an outbreak of Rift Valley fever (2007) among humans in Northern and Central parts of Tanzania that affected a total of 511 cases and 144 deaths (Case Fatality Rate of 28.2%). Also, in 2009, the country was faced by Influenza A (H1N1) that affected regions including Mara, Mwanza, Manyara and Dar es Salaam in which a total of 770 cases including one death was recorded.

Additionally, the country is prone to on-and-off Cholera outbreaks whereas of latest, Tanzania had responded to cholera epidemic that took almost three consecutive years to contain, starting from August, 2015. The epidemic had affected almost all regions in Tanzania Mainland with more than 33,300 cases and 550 deaths (CFR 1.65%) reported over the entire epidemic period.

Like many other countries around the globe, Tanzania being in the tropical and subtropical areas regularly continues to battle Dengue epidemic whereas of latest, the country was affected in multiple Mainland regions including confirmed cases in Arusha, Dar es Salaam, Dodoma, Kagera, Kilimanjaro, Lindi, Morogoro, Pwani, Ruvuma, Singida, and Tanga Region with predominance in Dar es Salaam and Tanga regions. The outbreak affected 6804 people with 13 deaths recorded (CFR 0.19%).

The risk of disease outbreaks in the country has also been reported to include even those with animal – human interface like the Anthrax outbreak with the latest epidemic being reported in January 2019 from Songwe region. A total of 81 affected individuals and 4 deaths (CFR 4.93%) were reported and over a thousand animals including goats, cows and other domestic animals were reported to have been affected by the epidemic. Experience has shown that dealing with these emergencies needs a well-coordinated response in order to prevent, detect and respond to these outbreaks otherwise, longer period of containment, with multiple resources will be needed to contain such incidents at the source, with poor outcome. In June 2019, Tanzania experienced outbreak of aflatoxicosis in Kondoa, Chemba and Kiteto where 61 people were affected and 9 deaths were reported.

[2]The United Republic of Tanzania Ministry of Health, Community Development, Gender, Elderly and Children COVID-19 contingency plan - March-August 2020

OVERVIEW **OF EVD**

Key facts

Ebola Virus Disease (EVD), formerly known as Ebola Haemorrhagic Fever, is a rare but severe, often fatal illness in humans. The virus is transmitted to people from wild animals and spreads in the human population through human-to-human transmission. The average EVD case fatality rate is around 50%. Case fatality rates have varied from 25% to 90% in past outbreaks.

Community engagement is key to successfully controlling outbreaks.

Vaccines to protect against Ebola are under development and have been used to help control the spread of Ebola outbreaks in Guinea and in the Democratic Republic of the Congo (DRC).

Early supportive care with rehydration and symptomatic treatment improves chances of survival. There is no licensed treatment proven to neutralize the virus but a range of blood, immunological and drug therapies are under development.

Pregnant and breastfeeding women with Ebola should be offered early supportive care. Likewise, vaccine prevention and experimental treatment should be offered under the same conditions as for non-pregnant population.

The Ebola virus causes an acute, serious illness which is often fatal if untreated. EVD first appeared in 1976 in 2 simultaneous outbreaks, one in what is now Nzara, South Sudan, and the other in Yambuku, DRC. The latter occurred in a village near the Ebola River, from which the disease takes its name.

The 2014–2016 outbreak in West Africa was the largest Ebola outbreak since the virus was first discovered in 1976. The outbreak started in Guinea and then moved across land borders to Sierra Leone and Liberia. The current 2018-2019 outbreak in eastern DRC is highly complex, with insecurity adversely affecting public health response activities.

The virus family Filoviridae includes three genera: Cuevavirus, Marburgvirus, and Ebolavirus. Within the genus Ebolavirus, six species have been identified: Zaire, Bundibugyo, Sudan, Taï Forest, Reston and Bombali. The virus causing the current outbreak in DRC and the 2014–2016 West African outbreak belongs to the Zaire ebolavirus species.

Transmission

It is thought that fruit bats of the Pteropodidae family are natural Ebola virus hosts. Ebola is introduced into the human population through close contact with the blood, secretions, organs or other bodily fluids of infected animals such as fruit bats, chimpanzees, gorillas, monkeys, forest antelope or porcupines found ill or dead or in the rainforest.

Ebola then spreads through human-to-human transmission via direct contact (through broken skin or mucous membranes) with:

Blood or body fluids of a person who is sick with or has died from Ebola.

Objects that have been contaminated with body fluids (like blood, feces, vomit) from a person sick with Ebola or the body of a person who died from Ebola

OVERVIEW **OF EVD**

Transmission

Health-care workers have frequently been infected while treating patients with suspected or confirmed EVD. This occurs through close contact with patients when infection control precautions are not strictly practiced.

Burial ceremonies that involve direct contact with the body of the deceased can also contribute in the transmission of Ebola.

People remain infectious as long as their blood contains the virus.

Pregnant women who get acute Ebola and recover from the disease may still carry the virus in breastmilk, or in pregnancy related fluids and tissues. This poses a risk of transmission to the baby they carry, and to others. Women who become pregnant after surviving Ebola disease are not at risk of carrying the virus.

If a breastfeeding woman who is recovering from Ebola wishes to continue breastfeeding, she should be supported to do so. Her breast milk needs to be tested for Ebola before she can start.

Symptoms

The incubation period, that is, the time interval from infection with the virus to onset of symptoms, is from 2 to 21 days. A person infected with Ebola cannot spread the disease until they develop symptoms.

Symptoms of EVD can be sudden and include:
- Fever
- Fatigue
- Muscle pain
- Headache
- Sore throat

This is followed by:
- Vomiting
- Diarrhoea
- Rash
- Symptoms of impaired kidney and liver function

In some cases, both internal and external bleeding (for example, oozing from the gums, or blood in the stools). Laboratory findings include low white blood cell and platelet counts and elevated liver enzymes.

Diagnosis
It can be difficult to clinically distinguish EVD from other infectious diseases such as malaria, typhoid fever and meningitis. Many symptoms of pregnancy and Ebola disease are also quite similar. Because of risks to the pregnancy, pregnant women should ideally be tested rapidly if Ebola is suspected.

OVERVIEW **OF EVD**

Diagnosis

Confirmation that symptoms are caused by Ebola virus infection are made using the following diagnostic methods:

- Antibody-Capture Enzyme-Linked Immunosorbent Assay (ELISA)
- Antigen-Capture Detection Tests
- Serum Neutralization Test
- Reverse Transcriptase Polymerase Chain Reaction (RT-PCR) Assay
- Electron Microscopy
- Virus Isolation by Cell Culture.

Careful consideration should be given to the selection of diagnostic tests, which take into account technical specifications, disease incidence and prevalence, and social and medical implications of test results. It is strongly recommended that diagnostic tests, which have undergone an independent and international evaluation, be considered for use.

Diagnostic tests evaluated through the WHO Emergency Use Assessment and Listing process

Current WHO recommended tests include:

Automated or semi-automated nucleic acid tests (NAT) for routine diagnostic management.
Rapid antigen detection tests for use in remote settings where NATs are not readily available. These tests are recommended for screening purposes as part of surveillance activities, however reactive tests should be confirmed with NATs.

The preferred specimens for diagnosis include:

Whole blood collected in ethylenediaminetetraacetic acid (EDTA) from live patients exhibiting symptoms. Oral fluid specimen stored in universal transport medium collected from deceased patients or when blood collection is not possible.

Samples collected from patients are an extreme biohazard risk; laboratory testing on non-inactivated samples should be conducted under maximum biological containment conditions. All biological specimens should be packaged using the triple packaging system when transported nationally and internationally.

Treatment

Supportive care - rehydration with oral or intravenous fluids - and treatment of specific symptoms improves chances of survival. There is as yet no proven treatment available for EVD. However, a range of potential treatments including blood products, immune therapies and drug therapies are currently being evaluated.

In the ongoing 2018-2019 Ebola outbreak in DRC, the first-ever multi-drug randomized control trial is being conducted to evaluate the effectiveness and safety of drugs used in the treatment of Ebola patients under an ethical framework developed in consultation with experts in the field and the DRC..

Pregnant and breastfeeding women with Ebola should be offered early supportive care, like general population. Likewise, experimental treatment should be offered under the same conditions as for non-pregnant population.

OVERVIEW **OF EVD**

Vaccines

An experimental Ebola vaccine proved highly protective against EVD in a major trial in Guinea in 2015. The vaccine, called VSV-ZEBOV, was studied in a trial involving 11,841 people. Among the 5,837 people who received the vaccine, no Ebola cases were recorded 10 days or more after vaccination. In comparison, there were 23 cases 10 days or more after vaccination among those who did not receive the vaccine.

Initial data indicates that the vaccine is highly effective. WHO's Strategic Advisory Group of Experts has stated the need to assess additional Ebola vaccines.

Prevention and Control

Good outbreak control relies on applying a package of interventions, including case management, surveillance and contact tracing, a good laboratory service, safe burials and social mobilisation. Community engagement is key to successfully controlling outbreaks. Raising awareness of risk factors for Ebola infection and protective measures (including vaccination) that individuals can take is an effective way to reduce human transmission. Risk reduction messaging should focus on several factors:

Reducing the risk of wildlife-to-human transmission from contact with infected fruit bats, monkeys, apes, forest antelope or porcupines and the consumption of their raw meat is essential to prevention of outbreaks. Animals should be handled with gloves and other appropriate protective clothing. Animal products (blood and meat) should be thoroughly cooked before consumption.

Reducing the risk of human-to-human transmission from direct or close contact with people with Ebola symptoms, particularly with their bodily fluids. Gloves and appropriate personal protective equipment should be worn when taking care of ill patients. Regular hand washing is required after visiting patients in hospital, as well as after taking care of patients at home.

Outbreak containment measures, including safe and dignified burial of the dead, identifying people who may have been in contact with someone infected with Ebola and monitoring their health for 21 days, the importance of separating the healthy from the sick to prevent further spread, and the importance of good hygiene and maintaining a clean environment.

Reducing the risk of possible sexual transmission, based on further analysis of ongoing research and consideration by the WHO Advisory Group on the Ebola Virus Disease Response, WHO recommends that male survivors of EVD practice safer sex and hygiene for 12 months from onset of symptoms or until their semen tests negative twice for Ebola virus. Contact with body fluids should be avoided and washing with soap and water is recommended. WHO does not recommend isolation of male or female convalescent patients whose blood has been tested negative for Ebola virus.

Reducing the risk of transmission from pregnancy related fluids and tissue. Pregnant women who have survived Ebola need community support to enable them to attend frequent antenatal care (ANC) visits, to handle any pregnancy complications and meet their need for sexual and reproductive care and delivery in a safe way. This should be planned together with the Ebola and Obstetric health care experts. Pregnant women should always be respected in the sexual and reproductive health choices they make.

OVERVIEW **OF EVD**

Care for People Who Have Recovered from EVD

A number of medical complications have been reported in people who have recovered from Ebola, including mental health issues. Ebola virus may persist in some body fluids, including semen, pregnancy-related fluids and breast milk.

Ebola survivors need comprehensive support for the medical and psychosocial challenges they face and also to minimize the risk of continued Ebola virus transmission. To address these needs, a dedicated programme can be set up to care for people who have recovered from Ebola.

Ebola virus is known to persist in immune-privileged sites in some people who have recovered from Ebola Virus Disease. These sites include the testicles, the inside of the eye, and the central nervous system. In women who have been infected while pregnant, the virus persists in the placenta, amniotic fluid and fetus. In women who have been infected while breastfeeding, the virus may persist in breast milk.

Relapse-symptomatic illness in someone who has recovered from EVD due to increased replication of the virus in a specific site is a rare event, but has been documented. Reasons for this phenomenon are not yet fully understood.

Studies of viral persistence indicate that in a small percentage of survivors, some body fluids may test positive on reverse transcriptase polymerase chain reaction (RT-PCR) testing for Ebola virus for longer than 9 months.

More surveillance data and research are needed on the risks of sexual transmission, and particularly on the prevalence of viable and transmissible virus in semen over time. In the interim, and based on present evidence, WHO recommends that:

All Ebola survivors and their sexual partners should receive counselling to ensure safer sexual practices until their semen has twice tested negative. Survivors should be provided with condoms.

Male Ebola survivors should be offered semen testing at 3 months after onset of disease, and then, for those who test positive, every month thereafter until their semen tests negative for virus twice by RT-PCR, with an interval of one week between tests.

Ebola survivors and their sexual partners should either:

- Abstain from all types of sex, or
- Observe safer sex through correct and consistent condom use until their semen has twice tested negative.
- Having tested negative, survivors can safely resume normal sexual practices without fear of Ebola virus transmission.
- Based on further analysis of ongoing research and consideration by the WHO Advisory Group on the Ebola Virus Disease Response, WHO recommends that male survivors of Ebola virus disease practice safe sex and hygiene for 12 months from onset of symptoms or until their semen tests negative twice for Ebola virus.
- Until such a time as their semen has twice tested negative for Ebola, survivors should practice good hand and personal hygiene by immediately and thoroughly washing with soap and water after any physical contact with semen, including after masturbation. During this period, used condoms should be handled safely, and safely disposed of, so as to prevent contact with seminal fluids.
- All survivors, their partners and families should be shown respect, dignity and compassion.[3]

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https://www.who.int/news-room/fact-sheets/detail/ebola-virus-disease

OVERVIEW **OF COVID-19**

Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. Most people infected with the COVID-19 will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness.

The best way to prevent and slow down transmission is to be well informed about coronavirus, the disease it causes and how it spreads. Protect yourself and others from infection by washing your hands or using an alcohol-based rub frequently and not touching your face.

Coronavirus spreads primarily through droplets of saliva or mucus droplets from the nose when an infected person coughs or sneezes, so it's important that you also practice respiratory etiquette (for example, by coughing into a flexed elbow).

At this time, there are no specific vaccines or treatments for COVID-19. However, there are many ongoing clinical trials evaluating potential treatments. WHO will continue to provide updated information as soon as clinical findings become available.

Prevention

To prevent infection and to slow transmission of COVID-19, do the following:

- Wash your hands regularly with soap and water, or clean them with alcohol-based hand rub.
- Maintain at least 1-meter distance between you and other people.
- Avoid touching your face.
- Cover your mouth and nose when coughing or sneezing.
- Stay home if you feel unwell.
- Refrain from smoking and other activities that weaken the lungs.
- Practice physical distancing by avoiding unnecessary travel and staying away from large groups of people.

Symptoms

COVID-19 affects different people in different ways. Most infected people will develop mild to moderate illness and recover without hospitalization.

Most common symptoms:

- fever.
- dry cough.
- tiredness.

Less common symptoms:

- aches and pains.
- sore throat.
- diarrhoea.
- conjunctivitis.
- headache.
- loss of taste or smell.
- a rash on skin, or discoloration of fingers or toes.

OVERVIEW **OF COVID-19**

Serious symptoms:
- difficulty breathing or shortness of breath.
- chest pain or pressure.
- loss of speech or movement.

Seek immediate medical attention if you have serious symptoms. Always call before visiting your doctor or health facility.
People with mild symptoms who are otherwise healthy should manage their symptoms at home.
On average it takes 5–6 days from when someone is infected with the virus for symptoms to show, however it can take up to 14 days.

How is the coronavirus transmitted from one person to another?

The coronavirus is transmitted by people already infected with the virus who cough or sneeze without covering their mouth and may even be transmitted simply by talking. The tiny droplets are invisible to the eye, but they float in the air and can easily be inhaled by people. These droplets can also land on surfaces close by where the person has sneezed or coughed.

When we touch surfaces where droplets of coronavirus have fallen and then we touch our eyes, nose, or mouth, the virus can enter our body and lead to us contracting COVID-19.

The coronavirus is also found in the faces of infected people and can be transmitted if we don't wash our hands carefully with soap and water after going to the toilet.

A person may start to feel sick 1 to 14 days after being infected; many feel sick 5 or 6 days after infection.

In many cases, people who have been infected display NO SYMPTOMS. This is dangerous because despite the lack of symptoms, they can infect their families, friends and everyone with whom they come into contact.

It is very important to start preventative measures IMMEDIATELY and help others to do so because we can't be sure if the coronavirus is already in our community.

OVERVIEW **OF COVID 19**

Who are the people at risk for contracting COVID-19?

The coronavirus spares no one! All human beings are at risk: women, men, youth, elders, wealthy people, local authorities, people in good or poor health, kings, queens, people of all religions, presidents, sports personalities, movie stars, farmers, workers, drivers, students, Africans, Asians, Europeans and Americans -

All of us can contract COVID-19!

Experience has shown that COVID-19 can be an extremely serious disease and lead to death, particularly for people over 60 years old or people with underlying problems - such as heart, lung or kidney disease, diabetes or hypertension. People who are in these vulnerable groups or who smoke are also at greater risk.

OVERVIEW **OF COVID 19**

What are important preventative measures we need to take?

One of the best ways to prevent COVID-19 is to wash our hands very often and carefully with soap for at least 20 seconds. If soap is not available when we are outside our homes, we can use a hydroalcoholic solution to disinfect our hands.

Note:

- The coronavirus is very fragile. The only thing protecting the virus is a thin layer of exterior fat. That is why using soap or detergent is so important. The foam created by soap or detergent breaks through the fatty layer. This is why we need to rub our hands carefully with soap - for at least 20 seconds or more - and make sure there's lots of bubbles. By dissolving the layer of fat, we destroy the coronavirus!

- Using a solution of one-part bleach and five parts water also creates a solution which immediately dissolves the coronavirus.

How can we wash our hands in order to kill the coronavirus?

- Wet your hands with water and put lots of soap on your hands.
- Rub your hands together to make lots of bubbles.
- Wash the back and front of your hands very well.
- Rub between your fingers.
- Wash underneath your fingernails.
- Rub your hands with soap for at least20 seconds.
- Rinse your hands with water.
- Dry your hands with a clean towel or paper napkin.

Many COVID-19 experts encourage everyone to wear a mask, especially when someone needs to leave their home and go outside for a short time. This is important since people can be infected with the coronavirus 14 days before having symptoms related to the COVID-19.

My mask protects you! Your mask protects me! Encourage everyone to wear a mask!

Advice for wearing a mask:

- Wash hands well with soap or an alcohol-based disinfectant.
- Before putting on a homemade mask, wash the mask thoroughly with soap and water.
- Cover the mouth and nose with the mask and make sure there is no space between the face and mask.
- Avoid touching the mask when using it; if we touch our mask, it is important to wash our hands again with soap or an alcohol-based disinfectant.
- On arriving home, we need to remove the mask from behind (the virus might be on the front of the mask) and place it in a bucket of water mixed with soap or detergent. The mask then needs to be washed well with soap and dried in the sun.
- Wash hands with soap or an alcohol-based disinfectant.

OVERVIEW **OF COVID 19**

What are important preventative measures we need to take?

Greeting others is a sign of respect and acknowledgement of another person in African societies. We can continue to greet other people but without shaking hands with them. We also need to stand at least 2 meters away from another person.

If people wash their hands in the same bowl of water before eating, one person risks spreading the coronavirus to everyone else who is washing their hands. Using a plastic teapot prevents transmission of the disease to everyone.

If people eat from the same bowl and someone has contracted the COVID-19 without knowing it, they risk infecting everyone else who eats. If possible, providing everyone with their own separate small bowl is the best way to keep the whole family safe and healthy.

Drinking water or other beverages from the same cup or dipping the cup in the same clay drinking pot can transmit COVID-19 to everyone if a member of the family has been infected by the coronavirus.

Drinking tea from the same cup without washing the cup with soap between each serving can also contaminate all of those drinking. If possible, it would be better for each person to have his own tea cup to protect himself and others from being contaminated with the coronavirus.

What should we do if someone manifests symptoms of COVID-19?

If people have symptoms of cough, sore throat, body aches, shortness of breath, or a general feeling of discomfort, they should immediately isolate themselves from other people. They should not go out and should not be in direct contact with anyone else. They should call the appropriate health service in order to be tested for coronavirus.
If a person or a group of people has been in contact with someone who has tested positive for coronavirus, the person or the group of people should be quarantined and should no longer be able to move about freely. There should be a waiting period of 14 days in order to make sure they have not been infected with the virus.

Emergency Toll Free numbers to seek help;
116 - The National Child Helpline
199 – COVID-19 Hotline

MHPSS CASE MANAGEMENT RESPONSE: **KEY ACTIONS**

Mental Health and Psychosocial Support for child protection is part of the essential services that should not be stopped suddenly during a pandemic, but which requires adaptation to the new emergency. With increased caregiver stress, and crowded living spaces where families are confined, children are at heightened risk of abuse, neglect, and exploitation. In addition, children may experience the death of their caregiver or may be separated from their families for multiple reasons, including public health containment measures associated with COVID-19. As these risks are often hidden and out of sight within communities, it can become even more difficult to identify vulnerable children without visits or other forms of follow-up by caseworkers due to new COVID-19-related restrictions. Thus, continued support for the most urgent cases within the existing caseload must be available through adapted measures, along with appropriate responses for new child protection risks and concerns generated by the pandemic.

This section builds on existing response action from several countries and case management task force agencies. It provides considerations for adapting MHPSS and CP interventions to the COVID-19 pandemic and to better understand the important role of case management in any emergency.

CASE MANAGEMENT RESPONSE: **COUNSELLORS SAFETY AND WELL-BEING**

C-SEMA management will provide safety protocols to be followed at all times during working hours both physically at the CHL contact centres and whenever working virtually from home.

Enable caseworkers to structure their time around additional caring responsibilities and to take time off for sickness.

Share resources for managing stress and maintaining emotional wellbeing with staff (i.e. a simple self-care exercise per day, materials/links, or phone numbers for accessing psychological support, etc.).

Work with case management teams to determine the best ways of maintaining motivation and team cohesion remotely.

C-SEMA management will ensure a staff rotation system to ensure that staff are able to rest and dedicate time to their own home life situations.

Prioritizing the physical health, safety, mental health and psychosocial wellbeing of the counsellors' team is paramount. All CHL counsellors MUST adhere to safety standard procedures provided by C-SEMA's management.

All CHL Counsellors	All CHL Counsellors MUST: • Be equipped with hand sanitizer and follow national safety guidelines (e.g. wearing a mask). • Wash/sanitize their hands frequently before, during, and after work. • If "thermoflash" thermometers are accessible and considered appropriate to use, check temperatures several times during work. • Follow and promote social distancing (safe distance of 2m, or per National guidance) and, if possible, with technical advisors/specialists, consider which types of cases could be managed in this way without compromising confidentiality. • Stay at home if you feel sick and seek medical attention if you have a fever, cough, and difficulty breathing.

KEY ACTIONS STRUCTURE

MANAGING CASES.

For all cases	• National Child Helpline Team Leaders and/' or Supervisors should review and prioritize all open cases with child helpline counsellors in a 1-on-1 scenario whenever possible. This can also occur remotely if a 'stay at home' order is in place or in-person. Assess high risk cases, using the following questions to guide the re-prioritization discussion: • What is the current situation of the child? Have there been any minor or major changes that affect the child and/or their caregivers as a result of the pandemic? • What is the likelihood that the child's safety and wellbeing will worsen due to the current crisis? (Determine specific risks and document, if possible.) • What type of support does the child require and how will caseworker and child safety be considered for each action prioritized? (Document in case plan, if possible.) • Work with trusted community members, volunteers, or child protection committee members to provide follow-up only if safe and relevant. • Create or update safety plans for the child and/or caregiver and/or trusted adult. • Determine what resources are needed to implement adaptations proposed (i.e. phone credit, psychosocial support (PSS) materials, movement permits, referral service pocket cards, etc.). • Allocate a back-up caseworker to cover cases so that if the primary caseworker falls ill or is not able to continue providing services, the back-up caseworker is prepared to support. • If case management services are modified during COVID-19, document the adapted service delivery modality and include it as an annex to the case management standard operating procedures (SOPs).
For high risk cases	• Maintain case management support for all high-risk cases. If governments place restrictions on movement, case management teams and country leadership may need to advocate with authorities for permission to safely access high risk cases or identify who within the government or another child protection agency can provide immediate support. • Consider introducing the back-up caseworker to the child and/or trusted adult in case there is a need to handover high-risk cases temporarily while the primary caseworker recovers from being sick, needs to go on leave to care for someone sick, or cannot continue to provide case management services due to COVID-19 restrictions (this could include no privacy if working from home, no mobility, etc.). • Decisions will need to be made by the supervisor and caseworker around how the back-up caseworker can safely access case information during the coverage period.
For medium and low risk cases	• Medium and low risk cases should be reviewed and prioritized based on assessed needs; caseworkers' availability and contact information should be shared with the child and/or caregiver and/or trusted adult. Provide phone follow-up if required and explore community safe support options.

KEY ACTIONS STRUCTURE

MANAGING CASES.

For high risk cases	• Coordinate with authorities and ensure cooperation with restrictions on movement and travel, while also advocating to ensure services still reach children most at-risk of violence, abuse, exploitation, and neglect. • Coordinate with government bodies and humanitarian country teams to understand the scope and scale of the impact of COVID-19. • Coordinate with health actors to respond appropriately and timely to child protection issues and risks generated by COVID-19. • Coordinate – through Case Management Working Group/Task Force and/or child protection coordination group, if any is established.
Community collaboration and engagement	• Work closely with existing community-based child protection groups and focal points who already have the trust of the community to identify and refer new cases. • Ensure community-based groups/focal points have agreed upon communication channels and know how to contact a case worker and/or case management team.

INFORMATION **MANAGEMENT**

Documentation	• Ensure case registration is done properly • Simplify forms if information is to be collected and shared urgently • Verify and ensure continued safe storage of sensitive documentation especially if counselors/caseworkers are working remotely.
Information sharing	• Establish clear and confidential communication channels for continued documentation of cases and track trends in child protection concerns during the outbreaks. • Share updated information about referral processes with child protection and health actors.
Data protection	• Treat medical information about a child or family member as sensitive data and apply the highest standards of data protection. • Avoid using identifiable information or discussing sensitive issues if gathering information by phone or other means with limited data security. • Revise Data Protection Agreement to include modalities of working from home for Child Helpline counsellors and supervisors.

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[4]The Alliance for Child Protection in Humanitarian Action, COVID-19 Child Protection Case Management Guidance, June 2020

PRINCIPLES **OF CASE MANAGEMENT**

No.	Principle	What does it mean?
1	Do No Harm	Ensure that actions and interventions designed to support the child (and their family) do not expose them to further harm.
2	Priorities the Best Interest of the Child	The "best interests of the child" broadly refers to the child's well-being and provides the basis for all decisions and actions taken, and for the way in which service providers interact with children and their families. Any action/decision taken upon a child must be in the child's best interest.
3	Ensure Accountability	Accountability refers to being responsible and taking responsibility for one's actions.
4	Based on Sound Knowledge of Child Development & Child Rights	Assessments and interventions must be made on the basis of knowledge about child development within their family and cultural context and of child protection.
5	Child's Right to be Heard and Views Taken Seriously	Children have a right to be consulted and have their opinions sought and taken into account in decisions that affect their lives according to age, maturity and developmental ability.
6	Provide Culturally Appropriate Processes and Services	CHL should recognize and respect diversity (for example ethnic, cultural, linguistic and religious) in the communities where they work.
7	Seek Informed Consent and/or Informed Assen	Informed consent is the voluntary agreement of an individual who has the capacity to give consent, and who exercises free choice. To provide "informed consent", the child must be able to understand, and take a decision regarding his own situation.
8	Respecting Confidentiality & Sharing Information on a Need to-Know Basis	Confidentiality is the mandate governing sharing information on a need-to-know basis. It is the process whereby information is protected from falling into the wrong hands and ensuring it is accessible only to those authorized to access it. This means that a CHL or Social Welfare does not share information about a client unless is it necessary to do so, for example at a case review session.
9	Working in a Non- Discriminatory Way	Avoid treating a child differently because of their individual characteristics or groups he belongs to (for example, sex, age, socio-economic background, race, religion, ethnicity, disability, sexual orientation, gender identity or any other diversity). This also means making sure women and girls are treated equally to men and boys.
10	Act with Integrity	CHL should act with integrity by not abusing their power or the trust of the child or the family. The CHL should work in collaboration with the children and families they are supporting and make sure their clients understand the process by providing them with good information. They should also listen to children and families and consider their wishes when undertaking the assessment and developing the care plan.
11	Family-centred Approaches	The CHL should look at children within the context of their families.[5]

[5]Adopted from - National-Integrated-Case-Management-System-Framework_June-2018.pdf

TIPS TO CHL COUNSELLORS **ON ATTENDING TO CRISIS CALLS DURING PANDEMICS**

What are important preventative measures we need to take?

• If you are working remotely, and are not in the office or child helpline call centre, make sure you are somewhere quiet where you will not be disturbed so that you can concentrate on the call and have a private, confidential conversation.

• Make sure you have a strong and stable phone and/or internet connection to ensure a steady flow of the calls. If the signal is weak or fluctuating, you will need to explain this early on in case the call connection is lost.

• Make sure that you have easy access to contact numbers and details for other referral services and up to date information regarding response in case of a pandemic or any other emergency, including any guidelines from relevant agencies, regarding rules around social distancing, curfews, etc.

• Double check that you know how and when to contact your supervisor or other colleagues (as agreed) for support and assistance, where needed.

• Ensure that you are aware of all standard procedures, such as how to deal with security threats, case management, making referrals, etc., and if/when confidentiality can be broken.

• If you are working remotely, make sure that any records that you make are kept secure and cannot be accessed, even accidentally, by anyone else.

When Taking Calls:

Providing support on the phone is very different to speaking to someone face-to-face. Although the normal 'cues' which help us communicate, such as body language, are not available, in a strange way a telephone call can also feel much more intense and intimate. This is often because callers' phone at times of distress – immediately and without time to prepare themselves. Emotions can feel very 'raw'.

At the Start of Calls:

• When answering, be clear about who you are so that the caller can feel confident they have the correct number, and to invite them to speak. You could say something like 'Hello, this is X from Y. How can I help you?'

• Some callers have a lot to say because they have worked themselves up to make the call. Let them speak and try not to interrupt with too many questions. You can always track back later and clarify points, or probe further. Other callers may find it difficult to speak and may need encouragement – for example 'I'm pleased you felt able to call. I would like to be able to help.'

• As soon as possible, check that it is safe for the caller to be speaking to you. You could say something like 'Is it safe for you to call now?' or 'Are you somewhere you can speak in private?'

• In addition to calls from children and families, you may also receive calls from others who are calling on their behalf or who are worried about a situation regarding a child. If the call is not about a child/family, then try to provide information or signpost them to a more relevant organisation.

TIPS TO CHL COUNSELLORS **ON ATTENDING TO CRISIS CALLS DURING PANDEMICS**

• You will want to build rapport with the caller, so while keeping confidentiality and the need for information in mind, do not launch straight into asking questions about permissions for referrals, or consent to speak to others or start probing for lots of information such as date of birth, address etc.

These details can be checked later on in a call once you have established a relationship. Ask too soon and the caller may get frightened and hang up!

Dealing with Test Calls

By now, you may be familiar with 'test calls' from your time working at the helpline. This is when a child or adult contacts a helpline about something seemingly straightforward, or even trivial. This is often to try out the service, so it is important to respond appropriately and not to imply that time is being wasted or the call should not have been made. Children may also make prank calls, especially if they are bored and unable to go out and socialize with friends. Prank calls from children should be seen as a test for the service, and responded to with respect.

Turning the focus back on the child by asking questions like 'How do you feel about that?' or 'How do you think I can help you?' will often quickly end such calls. Prank calls can also be used as a way of raising awareness, for example by asking questions such as 'Do you know why we set up the helpline?' and then providing accurate information.

Unfortunately, adults may also make prank calls. Sometimes these are because of boredom or mental health problems, and can be aggressive or even sexually offensive in nature. It is pointless getting angry or engaging with such callers. They just take up time and emotional energy so it is a good idea to close them down as soon as possible by saying something such as 'This is a child helpline for children and families who are experiencing problems. I am going to end the call now so that I can keep the line free for someone who needs to speak to us.' Then end the call.

Throughout the Call:

• Use all your active listening skills, and do not be afraid of silences, as callers may need time to answer questions or process their thoughts. Remember that the caller cannot see you (unless using video calling), so saying things such as 'I am still here when you want to talk' or 'I will just sit quietly while you think about that question' can help maintain the connection and also encourage the caller to continue talking.

• Often callers might want and ask for specific information (e.g. how to access a service). Even if this seems like all they want, it is always wise to confirm that it is all they need and remind them that they can call again at another time. It is not uncommon for callers to 'try out' a service or for the presenting problem not to be what they really want to discuss. You could say something such as 'Is that all you need right now?.....remember you can always call again if you want to talk about anything else….'

• Keep in mind that not all children (or adults!) have names for their emotions. People can also have contradicting feelings. All of this can lead to feelings of confusion, sadness and anger. Empathic listening without being judgmental, and without jumping to conclusions or making assumptions, can help callers to process their feelings and structure their thoughts.

• Make sure to assess safety on every call - where is the caller now, what is happening for them and/or the person they are calling about? Who is around that can be a protective influence?

TIPS TO CHL COUNSELLORS **ON ATTENDING TO CRISIS CALLS DURING PANDEMICS**

At the End of the Call:

• Before ending the call, especially if safety is a concern, you must get agreement to make a referral (with permission) and/or develop a safety plan and/or confirmed follow-up. This might be a specific arrangement, or, if not a severe case, simply to reassure the caller to contact when necessary.
• If it is a life-threatening situation – e.g. in case of abuse or suicide – you should discuss, with your supervisor, If it is a life-threatening situation – e.g. in case of abuse or suicide – you should discuss, with your supervisor on the best and quickest way of making a referral for the safety and best interest of the child.
• After the call has ended, make sure to complete records as you would when you are in office and make any referrals/follow-up calls.
• If you have been distressed or overwhelmed by the call, seek support from your supervisor and / or colleagues before taking another counselling call. Remember that your mental health is of the utmost importance especially during this time so that you are better equipped to serve your clients.
[6]

[6]The Alliance for Child Protection in Humanitarian Action, Child Helpline International, Child Protection Area of Responsibility and UNICEF. Technical Note: Child Helplines and the Protection of Children during the COVID-19 Pandemic, Version 1,

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