Collective service

CASE STUDY

CASE STUDY: RAPID QUALITATIVE ASSESSMENTS (RQAS) AS A METHODOLOGY TO IDENTIFY BARRIERS AND ENABLERS OF HEALTH-SEEKING BEHAVIOURS DURING THE CHOLERA OUTBREAK IN MALAWI

INTRODUCTION

Since March 2022, Malawi has been battling the largest outbreak of cholera experienced in country over the last 20 years. The Malawi Ministry of Health (MoH) and its partners, including the Collective Service, have scaled up cholera response activities, including surveillance and laboratory support; reactive oral cholera vaccine administration; case management; Water, Sanitation, and Hygiene (WASH) services; and Risk Communication and Community Engagement (RCCE) programming.

As the outbreak escalated into 2022, it was imperative for a rapid synthesis of socio-behavioural evidence to be performed to identify gaps and opportunities by using socio-behavioural evidence related to RCCE as part of a comprehensive cholera response in Malawi and across the East and Southern Africa region (ESAR).

This was a key recommendation of a joint WASH, Health and RCCE assessment undertaken by UNICEF in three affected districts of Malawi in September 2022, in order to avert escalation of the outbreak during the impending rainy season. The rapid collection of social and behavioural data was determined essential to better understand community knowledge, perceptions and behaviours related to cholera transmission, prevention and treatment.

In December 2022, a rapid data synthesis was completed on social, behavioural and community dynamics related to the cholera outbreak in Malawi to inform the design and delivery of effective communication and engagement strategies to put communities at the centre of the response.

WHAT IS CHOLERA?

Cholera is a bacterial infection caused by the bacterium Vibrio cholerae, which affects the small intestine and leads to severe dehydration and acute watery diarrhea.

Cholera is highly contagious and can spread rapidly through populations with inadequate sanitation and hygiene. Without proper treatment, cholera can be fatal within hours due to the rapid loss of fluids and electrolytes. To prevent and control cholera epidemics, access to safe water, adequate sanitation facilities, health and hygiene promotion, effective disease surveillance, and early warning systems are essential. Communities are central to epidemic preparedness and response and are the best placed to detect and contain cholera epidemics. Community-led actions can save lives and reduce the impact of the disease.

These recommendations also included ways to improve community engagement during the cholera response particularly through the Case Area Targeted Interventions (CATI) model, which was a cornerstone of the WASH recommendations for the cholera response. The brief provided suggestions and recommendations on the use of socio-behavioural evidence related to RCCE as part of a comprehensive cholera response that would fill current gaps and needs for the response.[1]

TWO OF THE KEY RECOMMENDATIONS PROVIDED, INCLUDED THE FOLLOWING:

- **Prioritise qualitative data collection.** Most of the available data used [to inform the response] included quantitative methods; there is little qualitative data on factors [regarding] underlying health seeking practices. The collection and triangulation of such qualitative data would however, provide a deeper understanding of socio-behavioural factors influencing cholera control.

- **Understand barriers to heath-seeking [behaviours].** People tend to seek treatment at formal health facilities when showing signs and symptoms of cholera. However, the high case fatality rate indicates that several barriers persist, including disbelief in the existence of cholera and structural barriers to care. To support timely referral, it is important, first, to identify where and among which population groups cholera scepticism persists and second, to map structural barriers, particularly in high-risk areas and among high-risk population groups. This mapping will be essential to formulate localised approaches to barriers, such as by setting up additional cholera treatment units (CTUs).[2]

Based on the recommendations to fulfill the need for qualitative data collection regarding the health-seeking behaviors of communities, as well as the recommendations from the September 2022 assessment, the Collective Service conducted a series of RQAs in Lilongwe (January 2023) and Salima (March 2023) districts to determine the barriers and enablers to communities seeking care for cholera-like symptoms.

The Lilongwe District was chosen because it was one of the top three districts with the highest cholera case counts throughout the current outbreak, with a major urban area. At the time of the RQA, the case fatality rate in Lilongwe was over eight per cent and healthcare facilities were facing attacks, causing closures. While not included as one of the districts with the highest case counts, Salima district is a lake district, where "...fishing communities are a particularly high-risk group as people living on the lake use it as a source of drinking water, defecation, cooking and bathing".[3] As a lake district, Salima was, at the time of writing, one of the most vulnerable districts during the rainy season due to the double impact of Cyclone Freddy in March 2023.

RAPID QUALITATIVE ASSESSMENTS FOR DETERMINING HEALTH-SEEKING BEHAVIOURS OF COMMUNITIES

Based on a request from the Ministry of Health in October 2022 for RCCE support, the Collective Service has been building the capacity of government and partners at national and sub-national levels to provide coordinated RCCE services through strengthened community feedback mechanisms, operational social science training and support, and shared data intelligence and analysis to support communities during this cholera outbreak. This work included two RQAs conducted in January and March 2023, to assess the health-seeking behaviours and referrals of communities towards cholera treatment centres, as well as feedback gathered through U-Report and a quantitative household survey and data synthesis.

Rapidly assessing the health-seeking behaviours and referrals of communities towards cholera treatment centers during the cholera response, was key for making timely recommendations to response pillars to inform their operational activities.

RQAs are an essential tool for understanding community perceptions and behaviours related to cholera. Rapid Qualitative Assessments or Rapid Qualitative Research draws on primary data collected through observational activities, in-depth interviews and focus groups discussions, are typically conducted over the course of a few days by a small team, and seek to answer operational research questions useful for informing emergency response operations.[4] These assessments provide valuable information about the social, cultural, and behavioral factors that influence the transmission of cholera within a community. By identifying the beliefs, attitudes, and practices that contribute to the spread of cholera, RQAs can inform the development of targeted interventions that address the specific needs and challenges of the community.

1. Niederberger, E. et al, Social, behavioural and community dynamics related to the cholera outbreak in Malawi. December 2022. https://www.rcce-collective.net/wp-content/uploads/2023/01/Cholera-synthesis_Malawi_Collective-Service.pdf
2. Ibid., p.17.
3. Sauvageot, D., et al. Oral cholera vaccine coverage in hard-to-reach fishermen communities after two mass Campaigns, Malawi, 2017. https://pubmed.ncbi.nlm.nih.gov/28803712/
4. Johnson, G. et al. Rapid qualitative methods during complex health emergencies: A systematic review of the literature. National Library of Medicine. August 2017. https://pubmed.ncbi.nlm.nih.gov/28787628/

Malawi Red Cross Society (MRCS) staff conducting RQA data collection activities as part of focus group discussions with religious leaders in Area 25, Lilongwe.
@ UNICEF, East and Southern Africa Region, Malawi

Using the social behavioural data and community feedback gathered by the Collective Service through the RQAs, partners understood the community needs and were able to take the appropriate steps and actions required to fill the gaps for the appropriate health interventions needed, providing an informed response within communities. This included informing emergency response and interventions by RCCE partners as well as those working in other pillars of the response; addressing myths, rumours, or misinformation about health interventions; and responding to other community needs, such as access to vaccines. Using data, evidence, and community feedback that became available following the RQAs, partners implemented an informed response that resulted in positive health outcomes.

The Collective Service, in collaboration with the Ministry of Health in Malawi, has been working diligently to strengthen the capacity of partners to support local communities to improve health-seeking behaviors in response to cholera.

RQAs CONDUCTED IN LILONGWE AND SALIMA DISTRICTS:

In January and March 2023, the Collective Service partners conducted nine Rapid Qualitative Assessments within communities located in Lilongwe and Salima districts, Malawi to: 1) understand community barriers and drivers of the cholera outbreak at the sub-district level, and 2) to assess health-seeking behaviors and referrals towards cholera treatment centers. Discussions and questions used informed and were drawn from the Cholera Question Bank developed by the Collective Service partnership with the Social Science in Humanitarian Action Platform (SSHAP) at the request of the East and Southern Africa Region (ESAR) RCCE Technical Working Group to support countries facing cholera in the region.

- **Lilongwe District:** A RQA was completed following six focus group discussions on cholera and COVID-19 vaccines, which took place in communities with cholera hotspots around Lilongwe 28-30 January by Rachel James (UNICEF/Collective Service) with the support of the Malawi Red Cross Society. The focus group discussions were organized to focus on the following groups: 1) Women: 10 women ages 24-50 (mothers and grandmothers) from the community near M'buka Primary School (Area 36); 2) Youth: Male and female youth aged 17-24 from the community near M'buka Primary School (Area 36); 3) Local Leaders: Male and female (mostly male) local leaders from the community near Mtandile; 4) Older persons (aged 53-71): Male and female from the community near Mtandile; 5) Health workers (aged 23-58, mostly female), Health Surveillance Assistants (HSAs), clinical nurse and vaccinators in Bwaila District Health Office, Chimwala Health Centre; 6) Religious leaders: All men from different religious groups including Christian and Muslim in Mgona.

- **Salima District:** The RQA was conducted by Ginger Johnson (UNICEF/Collective Service) with the support of the Malawi Red Cross Society and Center for Development Communications, and focused on four locations within Salima District, Malawi: Salima City Center, Khombedza, Mchoka and Ngodzi. Primary data collection was conducted over 4 days in March 2023 (5-8 March, 2023). Data collection sites were selected according to the following factors: 1) consistently high cases of cholera since October 2022; 2) reports of high rates of 'community deaths', primarily in hard-to-reach areas of the district (anecdotal evidence); 3) geographical location of having both lakeshore and rural communities; 4) combination of both Christian and Islamic communities; 5) relatively more accessible even during prolonged rains (i.e. feasible to conduct a rapid study during the rainy season); and 6) location of a Cholera Treatment Center (CTC) within 10-12km.

KEY FINDINGS, RECOMMENDATIONS, AND ACTIONS

The following is a summary of the findings and recommendations from the rapid qualitative assessments performed. These findings and recommendations have been shared with the Malawi Ministry of Health, partners, other response pillars and stakeholders to discuss and use to inform their response and activities in communities when addressing social behavioural factors influencing health-seeking behaviours. Actions taken by these partners in response to the recommendations have been summarized in the tables below.

KEY FINDINGS IN LILONGWE DISTRICT:

Knowledge of Cholera

- **There are generally high levels of knowledge** in the community around how cholera is transmitted, how it can be prevented and how severe it is, especially amongst women (of all ages) and youth.
- **There are high levels of awareness** regarding the need for safe water and how to treat it, the need to use clean latrines, the need for proper waste disposal, and for handwashing with soap.
- **Communities know about the need to take ORS,** but many people don't know where to get it, they think it is only available through health facilities, and they think that it is too expensive.
- **Participants are aware of the need for safe water** and know how to treat it. When chlorine has been given to them by health workers they reported using it until it is finished and then they returned to boiling water or drinking unsafe water. Buying safe water (Waterguard or from water kiosks) was generally seen to be unaffordable. Participants reported that the MOH had told them their well was unsafe, and yet continued to use it due to lack of alternatives.

Health Facilities & Health-Seeking Behaviours

- Misinformation around COVID-19 vaccines has resulted in low trust in health facilities causing the sick to avoid health facilities when they have cholera.
- Strong beliefs were expressed that if you go to a health facility you will die or be killed.
- People reported that if you have other conditions, such as malaria, you should not go to the health facility as you will be diagnosed (correctly or incorrectly) with cholera.
- Families will only take their family members to a health facility if they are very sick due to fear and being unable to remain at health facilities.
- HSAs report being concerned about their safety, particularly after attacks on health facilities.
- Participants overall stated that they trust community leaders to give them information about COVID-19 and cholera, as well as religious leaders and MOH messages through radio.

Oral Cholera Vaccine (OCV)

- There are some rumours and concerns around OCV and questions as to why there is only one dose available when it is usually two (related to conspiracies around poison and COVID-19 vaccines).
- There is very high willingness to take OCV, especially from the communities who have many cases
- Few people report having had OCV offered to them aside from community leaders and HSAs who were more likely to have access to safe water and sanitation.

Safe and Dignified Burials

- Family members are not involved in current burial protocols, do not see the body and report being generally unable to see the funeral. Community leaders have communicated that no food is allowed to be eaten at funerals.
- The awareness of this process is very high with varying levels of consent by communities, including reports in some places that the participants are very much in favour of these practices due to high levels of fear of transmission, while in other places this is seen to be a key reason for not seeking health care when sick.
- Participants (including HSAs) report concerns around the respectful treatment of bodies and whether or not there is organ harvesting taking place.
- HSAs report working in CTUs and engaging in a range of tasks including decontaminating bodies and carrying them to the grave without remuneration (and perhaps adequate training).

EVIDENCE-BASED RECOMMENDATIONS ACTIONED BY THE RCCE PILLAR/MOH

INSIGHT	OPERATIONAL RECOMMENDATION	ACTION
KNOWLEDGE OF CHOLERA	Efforts should move from focusing risk communications on basic prevention **to focusing on using ORS and seeking assistance in health facilities (as well as the use of safe water/soap once they are available**). Community engagement should focus on the aforementioned points, and on collecting and addressing community feedback that is related to concerns about health facilities. This includes addressing issues regarding safe burials, family access to patients, and providing information on the CTC service experience.	Development of community feedback mechanism and training of partners to collect CF on critical concerns. Adaptation of Risk Communication materials to address key concerns (i.e. MOH Press statements on SDB, OCV, focus on ORS and access to health services) With support from the Collective Service MoH , MRCS, UNICEF and WHO are leading on all processes
KNOWLEDGE OF CHOLERA	Focus community engagement activities on men due to 1) the higher risk for men of getting and transmitting cholera, and 2) the lower health service uptake of this population.	FGDs have taken place targeting men and religious leadership to raise awareness of health-seeking behaviours (HSBs). HSAs need to participate in religious and cultural activities so that they are well received by communities and so that HSAs can transmit key messages regarding HSBs. Partners supporting engagement with traditional and religious leaders are ADECOTS, INCOS, DCT, and Norwegian Church Aid.
KNOWLEDGE OF CHOLERA	Move away from basic messaging focused on informing communities and instead, engage in two-way communication to address specific concerns.	Encouraging the design of response activities to include community engagement: dialogues, night cinema, street theatre, for example. Encouraging the use of local radio stations has been very effective and can be prioritised to share messages and to host call-in sessions for communities to interact with health workers.
KNOWLEDGE OF CHOLERA	In hotspot areas, communities should be provided with the means to prevent cholera through access to safe water: water kiosks; Waterguard or chlorine distribution; soap or cash transfers for purchasing of soap.	Information shared with additional pillars. A mix of interventions included access to free/cheaper safe water through water kiosks or chlorine distribution. CATI teams provide hygiene kits with soap and chlorine to households and neighbours. UNICEF and WHO are doing the CATI approach and partners - ADECOTS, INCOS, and DCT -are leading for UNICEF, while HPO is directly supporting WHO.
KNOWLEDGE OF CHOLERA	Communities should be provided with ORS and encouraged to go to the health facility as soon as they have symptoms.	Oral Rehydration Points (ORPs) were set up in hotspot areas and volunteers were trained to provide key messaging about seeking health care along with free ORS. It is recommended that ORP teams increase awareness raising in hotpot communities and have a clear plan to hand over ORS to local facilities or community health workers. This plan should be communicated to communities. Easy and affordable access of ORS needs to be prioritised consistently.
OCV	Provide update key messaging around why OCV is currently only one dose.	MOH Press Statements have included revised key messaging around OCV and dosing. Multiple media outlets have been used, which are accessible to all groups. Local radios, billboards in public places, flyers, use of key informants and local leadership are important for reaching remote and hard to reach areas.
OCV	OCV teams need to reach remote areas.	More outreach teams, especially in remote and hard to reach areas, need to be prioritised. MoH Health Education Services (HES) is developing messaging that all partners are using regarding OCV.
OCV	Provide OCV in hotspot communities.	Information shared with other pillars and microplanning to reach hotspot communities took place. WHO and UNICEF are leading in supporting MoH in microplanning exercises. Hotspot districts are being prioritised on a rolling, weekly basis as the cholera emergency continues.

INSIGHT	OPERATIONAL RECOMMENDATION	ACTION
HEALTH FACILITIES	• Train health workers to provide quality, patient-centred care. • **Improvements in case management should be communicated**, especially in hotspots, to **assure the communities** that quality care will be provided. • **Demystifying the CTC experience** by providing overview of what takes place would be helpful.	WHO adapted the training of surge health workers to address key issues. WHO trained the HOPs for all districts. Information on the CTC experience is provided in community dialogues with questions answered. Survivor stories shared with communities. UNICEF communications departments is documenting the stories and WHO has started this work as well.
HEALTH FACILITIES	• **Community engagement through trusted channels** (community leaders, religious leaders, HSAs, Red Cross volunteers) to encourage communities to **share their concerns and to continue to access health facilities** for all medical concerns. • **Collect and address concerns in community feedback** around misinformation and concerns with local health services. • Undertake **rapid qualitative assessments with families of cholera cases** who did and didn't decide to seek healthcare when sick to better understand reasons for decisions around health seeking.	Community Engagement activities provided through trusted channels with community feedback collected. All the UNICEF partners are engaging trusted channels and local radio stations for information dissemination. Training for partners on community feedback, including development and implementation of community feedback mechanisms. Subsequent RQAs are being implemented to understand key issues.
SAFE & DIGNIFIED BURIALS	• Review safe burial protocols together with communities and consider where it would be possible for family members to be safely engaged, such as through the use of PPE, virtually or by having a trained witness such as a community or religious leader who is trusted to monitor the process and communicate with the family. Consider the use of body bags that have a transparent window so families can see the face of the deceased. • Communicate acceptable options with families so they are able to choose which is most appropriate. • Provide information to communities to update them on options for their being in the burial process to increase trust in health facility management of the deceased	Video explainers on SDB developed by MRCS, which is supporting MoH, which is leading on SDB. Discussions continuing regarding the criteria for the SDB process. Revision of MoH press statement on SDBs taking place, to be more compassionate. Safe burials protocols should not only be limited to burial teams, but should include more partners so they are aware of the revised and can promote these as they engage with communities.

KEY FINDINGS IN LILONGWE DISTRICT:

Knowledge of Cholera

- Reoccurring questions discussed by almost all participants were focused on why the pattern of cases in Malawi 2022-2023 is so different from past experiences.

Health Facilities & Health-Seeking Behaviours

- The highest reported rate of health-seeking behaviours at a health facility are amongst women with ill children (who are easier to transport). Organizing travel for ill adult patients experiencing severe cholera symptoms presents more challenges.

- Health-seeking behaviors for adult males and for persons 40+ years of age (e.g. due to higher rates of illiteracy and/or lack of health promotion advice provided in school) is reported as the lowest among population groups.

- Belief in cholera as a real and severe illness is clear. Trust in health facilities is evident – when persons have had a prior positive experience of receiving affordable care before the current outbreak. Delays in HSBs, as communicated both by families with a recent history of cholera, and the wider communities in which they reside, is primarily about lack of access and affordability.

- Delayed health-seeking behaviours for cholera-related signs and symptoms is not about the refusal of treatment, but instead, it is related to access to care and inability to pay for transport. There is a need to encourage positive health seeking behaviors by communicating that 1) treatment at a Cholera Treatment Centers is free, 2) CTCs are taking basic measures to ensure patient privacy, and 3) patients inside the CTC will be updated regarding their treatment.

- Lack of privacy within CTCs is seen as a major issue by patients and families with experience of cholera. More prominent among women.

WASH

- The challenge regarding the use of a latrine, drinking safe water and washing hands isn't due to a lack of knowledge, but instead, is related to the hardships of daily life, which make these tasks and recommended behaviours more difficult, timewise and financially unrealistic (e.g. when purchasing soap is not as high of a priority as buying food).

- Collapsing of latrines during the rainy season due to the sandy soil is a consistently identified problem for the district. Communities have been sensitized to the need for household level latrines and want to have personal latrines, but their construction needs to be improved to withstand environmental challenges and in consideration of the inability for many families to pay for supplies (e.g. cement) to erect more permanent structures.

- Several responders and healthcare professionals in Malawi describe a multitude of theories and assumption about the primary sources of transmission within their respective areas (e.g. unsafe burials in Lilongwe, contaminated water sources in Salima, guardians entering CTCs to bring food to family members in Blantyre).

Integrated Emergency Response

- Staff hired for one specific type of project know that they cannot focus on another issue unless the "donors support and approve." Local NGOs and CBOs need strong national and international advocates to help support this position as they do not always feel comfortable discussing issues of funding and prioritization with "high-level donors who expect results on the single issue they care about."

- Current vertical programming and/or single-issue donors to Malawi – e.g. COVID-19, polio, malaria – should prioritize the multiple emergency events the country is facing and consider an integrated approach to emergency preparedness and response.

EVIDENCE-BASED RECOMMENDATIONS ACTIONED BY THE RCCE PILLAR/MOH

INDICATOR	RECOMMENDATION	ACTIONS
HEALTH-SEEKING BEHAVIORS	• Messaging and community engagement activities to target men in particular for seeking medical assistance. Use of female and child/adolescents (e.g. those who are in school and receiving health promotion messages) as motivators/champions for change. • Messaging and community engagement activities directed towards specific religious groups with known history of avoiding health facilities and/or vaccination, to focus on: 1) use of common household ingredients (salt, sugar) for treating symptoms of cholera ("they will take it as long as you do not call it medicine"), and 2) continued emphasis on referral to a health facility for severe illness ("when they are weak [ill, dehydrated], they will go"). • Delays in seeking care at a treatment facility (as communicated both by families with a recent history of cholera, and the wider communities in which they reside) is primarily about lack of access and affordability. Need to move beyond only providing messages to seek care (especially for high-risk and hard-to-reach communities). The greatest need now is for implementation of rapid solutions to facilitate free transport for those in need, and ensuring community leaders have the appropriate phone numbers they can call to request transport assistance. • Uptake of referrals to cholera treatment facility would also be improved by: 1) communications which emphasize that regardless of the type of health facility a CTC may be attached to (public, private, hybrid) treatment for cholera is free, 2) supporting facilities to provide basic privacy measures inside tent facilities (especially for female patients), and 3) amplifying positive experiences of survivors for encouraging others to seek care.	• Findings shared with the Incident Management Team, RCCE sub-committee and other forums. Services and other support advocated for and offered with the MoH and other partners. • UNICEF, WHO, and Africa CDC working to ensure that men participate in community meetings and dialogue sessions. Messaging was shared related to visiting CTUs. • In-depth discussion and advocacy is needed for the promotion of home-based solutions. ORS is more than a home-based solution and therefore there is a need to ensure the proper use of ingredients. It is recommended to not use the home based solution messages. • Community engagement meetings and advocacy with local leaders continued for the arrangement of transportation and handling of cholera patients

INDICATOR	RECOMMENDATION	ACTIONS
CREATING AN ENABLING ENVIRONMENT	• Emphasize evidence-based behaviors which inspire individual agency (active role), are tailored to local context, and are realistic/feasible to accomplish, especially among the poorest populations who experience the burden of cholera related cases and deaths. Messages which emphasizes a behavior which is not realistic to achieve (e.g. purchasing ORS when shopkeepers are price gouging), are more likely to result in confusion, anger and rejection of public health safety measures. • Community engagement activities such as dramas, plays and cinema are more effective at grabbing (and keeping) attention than distribution of IEC materials. Further, use of such types of community engaged activities demonstrates the extra care taken to reach people where they live which is (in itself) a demonstration of care, empathy and the importance of the topic being discussed. That is, persons are more likely to pay attention to what you have to say when they see the effort you have taken to bring them the message in person and engage in dialogue to discuss the issue. • Existing safe and dignified burial (SDB) protocols for prior outbreaks in the ESAR region need to be adapted for Malawi context and subsequent training provided for local burial teams. Suggested elements to include in adapted SDB protocols include: informing community leaders as soon as death occurs, appoint a 'family delegate' to witness the burial, hold a 'ceremony of speeches' on the day of burial to explain to wider community why usual burial and ceremony proceedings did not/cannot occur, continue to repeat these same cholera prevention messages at subsequent events while the outbreak is ongoing (e.g. weddings or other ceremonies) to reinforce consistent messaging.	• Partners were trained on implementing evidence based RCCE activities. • All partners have focused on two-way dialogues, door-to-door visits and distribution of communication materials for interpersonal counselling. • Safe Burial Procedure was shared with the RCCE sub-committee chairperson for the advocacy with the Ministry of Health and for discussion with the religious leaders.
INTEGRATED EMERGENCY RESPONSE	• UNICEF, WHO, IFRC and other influential international organization need to advocate to high-level donors on the importance of supporting integrated emergency response programming. Single-issue funding and human resource allocation in-country (e.g. for COVID only, for polio only, for malaria only) are not creating an enabling environment for the level of coordination needed to deal with Malawi's ongoing, concurrent crises. • Emergency response planning must not neglect the importance of preparedness and community readiness – if community engagement is only being conducted during an emergency response, it's too late. E.g. if public health responders are only seen as caring about people's health during an emergency (and only during specific types of emergencies), trust in response actors decreases and the likelihood for long-term behavior change is reduced. • If integrated campaigns are the new 'normal', then integrated RCCE messages need to be drafted and piloted which are relevant to local contexts and histories (e.g. how best to conduct a COVID vaccination drive simultaneously with a campaign encouraging use of chlorine when high-risk populations are refusing treated water for fear it contains the COVID vaccine?).	• Based on the qualitative and quantitative feedback received, UNICEF and partners are developing standardized and localized cholera prevention activities and messages. • Messages are shared through the RCCE sub-committee and other platforms for partners to share using different communication channels
WASH INFRASTRUCTURE	• Immediate steps need to be taken to build a sustainable WASH infrastructure. Within the context of the 'rainy season' (specifically) and effects of climate change (more broadly), existing WASH structures in Malawi are – quite literally – being washed away. This was described by multiple respondents in relation to sandy soil paired with the inability to pay for more permanent building supplies (such as cement). • Given the extent (geographically, duration) of the current outbreak, water quality tests need to be conducted and the primary routes of contemporary transmission need to be determined for prioritization of interventions. UNICEF, WHO, IFRC and other influential international organizations can advocate for and support the national government in these efforts.	• Findings shared with the WASH cluster • WASH emergency response is focused on rehabilitation of the WASH infrastructures at the flood affected areas and cholera hot spots. • Advocacy efforts took place with government and partners for the continuous water quality tests in the risk and flood-affected areas.

CONCLUSION

The implementation of Rapid Qualitative Assessments has proven to be an essential methodology for understanding the barriers to, and enablers of, health-seeking behaviors in response to the cholera outbreak in Malawi. These assessments have provided valuable insights into the social, cultural, and behavioral factors influencing the transmission and prevention of cholera within communities. By identifying the knowledge gaps, attitudes, and practices that contribute to the spread of the disease, RQAs have guided the development of targeted interventions and communication strategies tailored to the specific needs and challenges of the community.
The findings from the RQAs have shed light on several key issues, including the need to improve access to Cholera

Treatment Centers and to essential supplies, including oral rehydration solution; the need to address misinformation and low trust in health facilities, especially among specific demographics (men 40+ years of age); and the need to enhance community engagement and involvement in the response.
The recommendations derived from the RQAs have been actioned by the RCCE pillar, the Ministry of Health, and partners leading to the implementation of various initiatives such as the distribution of free ORS, the establishment of Oral Rehydration Points, the training of health workers to provide quality care, and the development of community feedback mechanisms, and enhanced messaging regarding health-seeking behaviors, such as access to CTCs and OCV.

Furthermore, the RQAs have highlighted the importance of engaging with key stakeholders and influencers within the community, such as community and religious leaders, in promoting behavior change and supporting cholera prevention and control efforts. By leveraging data, evidence, and community feedback, the RCCE pillar and its partners have been able to deliver an informed and community-centered response, resulting in positive health outcomes, increased vaccine uptake, and enhanced trust in healthcare workers.

Overall, the use of RQAs has significantly contributed to the design and implementation of effective cholera response programs in Malawi. By gaining a rapid and comprehensive understanding of community perceptions and behaviors, these assessments have played a critical role in ensuring that interventions are appropriate, acceptable, and sustainable, ultimately reducing the burden of cholera in the affected communities.

The collective efforts of the Collective Service, the RCCE pillar/ MoH and other partners, have strengthened the capacity to address the socio-behavioral factors influencing health-seeking behaviors and have paved the way for improved cholera response strategies in Malawi.

> **"Originally we were not using ORPs, but following the outcomes of the RQA and the community feedback received on the importance of this resource, the Ministry of Health developed and established the ORPs and used community engagement to ensure that communities were aware, and understood the importance of, this resource."**
>
> *Mavuto Thomas*
> *Health Educations Services Deputy Director*
> *Ministry of Health, Malawi*

The RCCE Collective Service enables collaboration between a wide range of organizations engaged in policy, practice, and research to strengthen coordination and increase the scale and quality of RCCE approaches, while also supporting a coordinated community-centered approach that is embedded across public health and humanitarian response efforts. This is a partnership between the WHO, UNICEF and IFRC, which leverages active support from the Global Outbreak Alert and Response Network (GOARN), and key stakeholders from the public health and humanitarian sectors.