Rapid qualitative assessment of community perceptions towards cholera – summary findings and recommendations

Authors: Sophie Everest and Loveness Chimombe, UNICEF

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Introduction

As of 12th November 2023, Manicaland province has been one of the worst affected provinces during the current cholera outbreak. To date, a total of 3088 suspected cases have been recorded from Manicaland, representing 43% of the total number of suspected cases across the country. Due to the high disease burden in this province, UNICEF, supported by the provincial and district-level Ministry of Health offices as well as Mercy Corps, AWET and Zimbabwe Red Cross, decided to conduct rapid qualitative assessments in three affected districts to better understand transmission dynamics and community perceptions towards causes of cholera, prevention measures and treatment.

It was estimated by clinical staff that approximately 75% of people in the communities around the CTCs visited were from the Apostolic community.

Methodology

The rapid qualitative assessment focused on three cholera treatment centres (CTCs) in two districts: Mutare rural and Buhera. Primary data collection was conducted over 2 days in between 8th – 9th November. Data collection sites were purposively selected according to geographical locations in rural or otherwise hard-to-reach locations which had been recording consistently high cases of cholera since the outbreak started in February this year. The CTCs visited were:

- Zvipiripiri health facility (Mutare rural) 08/11/2023. 36 confirmed cholera cases (2 currently in admission), no deaths at the CTC, 10 community deaths (4 children, 10 adults).
    - Meeting with clinic staff
    - KII cholera patient (55-year-old female who recently attended a funeral of someone suspected to have died of cholera)
    - Community Focus Group Discussion
- Odzi health facility (Mutare rural) 08/11/2023. Since 26th October the clinic has had 14 patients (11 confirmed cases, 1 negative and 2 pending), 1 CTC death and 2 community deaths.
    - Meeting with clinic staff
    - KII cholera patient (25-year-old male, artisanal miner)
    - Group discussion with community leaders and village health volunteers (7 male; 8 female)
- Chipondamidzi health facility (Buhera) 09/11/2023.
    - Meeting with clinic staff
    - KII with district community health nurse
    - Group discussion with community leaders and village health volunteers (11 male; 6 female)
    - KII cholera patient (mother of 15-month-old child whose father recently recovered from cholera)

The link to the data collection tool can be found here.

All participants provided their informed consent prior to participation.

Limitations

Due to time pressures, it was not possible to meet with community members in their villages. Instead, the district health department, supported by Awet, Mercy Corps and the Zimbabwe Red Cross, asked people to come to the CTC for group discussions. This meant it was not possible to speak to cholera survivors outside of the CTC setting, and therefore questions about how they perceived the care they received, and the after care at home, were not asked due to the likely response bias in answers that survivors may have given in front of clinic staff. Additionally, it was only possible to speak with Apostolic community members who were comfortable physically visiting the CTC, although village health workers did provide insight into the beliefs and perceptions of those who do not access treatment at clinics. It is recommended that strategies to engage directly with Apostolic communities need to be developed and implemented with trusted actors, as well as with cholera survivors, in their villages or homes to generate more insight into the beliefs and perspectives of these groups.

It is possible that interviewees expressed answers they perceived to be appropriate or socially desirable responses, although interview and discussion questions were asked across participant groups (clinic staff, village health workers, community members and leaders, cholera patients) in order to triangulate responses.

Given the small sample size of the study, summary findings and recommendations cannot be extrapolated to a wider country context. However, insights provided in Manicaland hotspot districts do suggest the need for similar rapid qualitative studies in other districts, particularly in urban areas, to inform response strategies.

Findings

1. Beliefs about drivers of cholera and signs and symptoms

Causes

- Belief in cholera as a real and severe illness is clear, particularly amongst communities where infection rates are higher.
- Understandably, a lot of respondents said that their first reaction to having the symptoms of cholera is to assume it's a 'normal' case of diarrhea that can be treated with home remedies aimed at stopping the diarrhea. We must recognise that we are asking people to significantly change their behaviours during a cholera outbreak and explain that whilst a cholera outbreak has been declared these enhanced health seeking behaviours are critical to saving people's lives.
- There were generally high levels of knowledge that cholera is spread through poor water, sanitation and waste management across all stakeholder groups. The lack of safe drinking water sources was repeatedly highlighted, with communities relying on river water or shallow wells as boreholes are either not within walking distance or are broken. These structural barriers are preventing safer hygiene and sanitation practices from emerging and forcing communities to adopt behaviours that they know are risky.

- There was some mention of the belief that witchcraft causes cholera, although this didn't seem to be a widely held view. The belief that it is caused by witchcraft is due to the similarity between the symptoms from food poisoning (i.e. the belief that someone intentionally is poisoning the victim's food or drink and therefore 'bewitching' them) and cholera. This seemed to be more commonly believed for sporadic cases rather than in communities where there had been multiple households affected by cholera.

Transmission

- Transmission at funerals, tombstone ceremonies and other religious gatherings, through handshaking, preparing and communal eating of food, lack of sanitation and hygiene facilities, was also regularly highlighted as a high risk. However, many community members stated that the by-laws which have banned the practice of cooking and sharing food during funerals are not being adhered to because these practices remain encouraged by many religious leaders, who expect to receive a portion of the meat from the food prepared by the mourning family. There is therefore little incentive on their part to support the ban on preparing and sharing food during funerals. Village health workers highlighted that when they get the buy-in from village heads on curbing the size of religious gatherings and the communal sharing of food that this has a big impact on whether religious leaders in turn support these measures. However, village heads stated that they often feel raising these issues with religious leaders is often too sensitive a topic. The provincial ministry of health office in Manicaland have taken action on this issue by recommending to environmental health officers (whose role it usually is to supervise burials) that families find alternative ways to appreciate their religious leaders by providing an equivalent donation (e.g. money or a chicken which can be slaughtered and eaten at home). This initiative should be actively supported by response partners working with environmental health officers.
- The movement of people between Buhera and Mutare, either for economic activity or cultural events such as funerals, was also frequently cited as a risk. In Mutare rural, Buhera was considered a hotspot district and many respondents stated that this is where the cholera outbreak had originated from and cases were being imported into Mutare rural as people moved between the two districts.

Signs and symptoms

- Awareness of cholera as a diarrheal disease which can attack suddenly was high across all stakeholder groups.
- Typically people will try to treat their symptoms at home for 2-3 days before there is a recognition that this is something more serious than 'normal' diarrhea
- Village health workers highlighted how beliefs amongst some parents around the causes of a sunken fontanelle (the soft spot on a baby's skull) are resulting in risky treatment practices. A sunken fontanelle can be an indicator of severe dehydration, necessitating urgent rehydration as a treatment. However, some parents are instead applying salt to the inside of the baby's mouth and apply pressure with the thumb to push up the roof of the mouth to try and reduce the depression in the skull. More understanding regarding how parents explain the illness of the sunken fontanelle and what causes it is needed to understand why they go down this treatment

route so that strategies can be developed to help encourage rehydration as an immediate treatment.

- IParents also highlighted that it was often difficult to distinguish between 'normal' diarrhea in children which would be treated at home, and that of cholera, meaning that children are often taken to the CTC later after developing symptoms than adults are.

2. Beliefs about prevention

Risk perceptions

- The Apostolic community are stigmatised in both districts for their attitudes towards biomedical preventative and curative measures, and this risks further marginalisation which will likely drive people further away from seeking health care if not addressed. Attitudes towards biomedical solutions within the Apostolic community seem to vary, and there was a general perception amongst clinic staff and community health workers that health seeking behaviour had increased during the current cholera outbreak compared with an outbreak of measles last year. This was perceived to be due to increased risk perceptions towards cholera and how quickly it can kill both children and adults.
- Typically there are lower risk perceptions towards cholera in non-hotspot areas compared with areas with higher case loads. As there are high levels of movement between districts for economic activity as well as for cultural events such as funerals, this poses a risk where people moving into hotspot areas are not aware of the cholera risks. Culturally, families will often wait to bury their loved ones once relatives have had the opportunity to travel for the funeral. This will also pose a significant risk over the Christmas period when families will be travelling across the country to spend time together and will celebrate through communal cooking and sharing of food.

Water treatment and storage

- In general, communities said that they do not have regular access to either Waterguard or Aquatabs to treat their water. There have been sporadic distribution of NFI items by response partners working in the area but these have not been regular enough to maintain supplies at household level. Whilst the CATI approach is being used, there are rarely NFIs given out to targeted households due to lack of available stock.
- There also seemed to be openness amongst some Apostolic members to treating water with Waterguard. Aquatabs were said to be less accepted as these come in pill form, and therefore associated with medicine. However, there were also reports of Apostolic communities using Waterguard as a way to bleach their religious clothing instead of as water treatment, suggesting that continued community engagement strategies for this community group are needed.
- Boiling of water appeared to be a practice more commonly followed by households whose main source of drinking water is from a shallow well rather than households who collect their drinking water from nearby rivers. There is a Shona proverb *mvura haina n'anga* which translates to *water has no purifier*. The meaning of this is that water, particularly from a flowing river, purifies itself. Consequently, there is a widely held belief that river water cannot be contaminated and that the source of water drunk by the ancestors cannot make people sick. As the river is also the

place where many caregivers come to wash the bedlinen and clothing of those sick with cholera, or even to bathe patients, this presents a significant risk.

- It was widely accepted that water storage at home was often leading to transmission. Village health workers mentioned that in the homes they visited it was rare to see drinking water being stored separately from water for other uses and that hands were frequently dipped into drinking water storage containers as people did not have access to cups with long handles.

Sanitation practices

- The availability of household latrines varied greatly, and open defecation is particularly prominent during large religious gatherings or events and amongst those working in the agricultural or artisanal mining sectors. Village health volunteers explained that they had been visiting households without a latrine to teach families how to build temporary pit latrines from locally available materials which can be used whilst the family save up to build a more permanent structure. However, community members stated that it was often too difficult to manually dig pit latrines in the dry season when the soil is too hard. Community leaders in Buhera also have taken the initiative to support families to setup cooperatives so that households can support each other with construction costs. Whist these are impressive examples of communities taking action into their own hands to find solutions, more needs to be done to address the structural barriers of access to sanitation facilities.
- Apostolic communities do not use physical buildings or structures to pray or conduct religious ceremonies so it is common practice to practice open defecation whilst attending church gatherings. Groups do tend to gather for prayers in the same outside areas – they do not move from place to place – so there could be opportunities to explore establishing latrines where groups often congregate which are collectively funded by the members.
- Community members explained that when someone is sick with diarrhea the common practice will be to dig a shallow hole (and in the dry season this is really just scratching the surface) next to the homestead where the patient can relieve themselves because they are too sick to reach the latrine or go in the bush. The faeces is often covered over with ash (which makes people think that it has been disinfected) and soil. When the rains arrive this is likely washed into the shallow wells where people are collecting their water. Some people did understand that this was risky but said they did not have another option.
- Some community members mentioned that they ration water in order to make it last longer. This includes recycling water that has been used to clean dishes and laundry so that it can be used the following day for the same activities. Some people also stated that frequently washing hands was often considered a waste of precious water.

Role of village health workers

- Village health workers play a critical role in their communities and are seen to be the eyes and ears for clinic staff in the community. They play a wide role in delivering education on cholera prevention and treatment, providing lifesaving ORS and referrals to CTCs, and helping to create an enabling environment for protective behaviours to emerge through the provision of soap (when available) and advice. They are often the first port of call when people become ill and are key in preventing dehydration before patients reach the CTC. They also play a critical surveillance and reporting role, helping to raise alerts to clinics when outbreaks occur.

- Increasingly, due to the pressure put on environmental health workers caused by the increase in cholera cases, village health workers are also making death notifications and overseeing burials, as well as disinfecting the homes of cholera patients.
- Despite their key role, village health workers repeatedly highlighted that community members will often follow the advice and guidance of their religious leaders above the advice from village health workers. When the advice is conflicting, the religious leaders have significantly more influence in decision making. One village health worker explained that, following a community death from cholera, she had worked with the family and religious leader and agreed that there would be an immediate burial after which mourners would return home without cooking or sharing food. When she returned to the family's home the day after the funeral she learned that the religious leader had called back mourners after she had departed and they had continued with the traditional preparation of communal food.
- In some of the more peri-urban areas around Odzi which are closer to the town of Mutare there's a perception amongst communities that they already have high levels of knowledge around cholera and therefore they're less inclined to accept advice or engage with the village health workers. However, cases are increasing in Mutare urban areas. We may need other means of engaging with these populations beyond door-to-door campaigns from village health workers.

3. Vulnerable groups

- The Apostolic community were widely mentioned as being particularly at risk from cholera but there was a general feeling amongst community health workers and clinic staff that engagement on cholera prevention and treatment with this group is slowly improving health seeking behaviours. Although religious leaders will not make public statements in support of prevention or treatment of cholera, there is an attitude that those seeking care for cholera will be forgiven for this perceived sin by the leadership. However, fear of being caught receiving biomedical treatment and the stigma of being a cholera patient are still highly prevalent factors which delay health seeking. Women in particular face an increased caregiving burden during cholera outbreaks, as in other humanitarian crises and disease outbreaks, and much of the time it is the male head of household who decides whether women can use water treatment in the home or seek care for sick loved ones.
- Artisanal miners, and other informal workers such as agricultural labourers and vendors (in particular the districts of Odzi and Chiadzwa), should also be considered a high-risk group because they do not have access to sanitation or hygiene facilities whilst working. They are also more likely to have to eat out regularly and therefore rely on food vendors at the markets or by the roadside. Knowledge and awareness of the causes of cholera appeared to be lower than amongst other groups. This may be due to the fact that artisanal miners are usually young men who live in temporary structures close to the mining areas and therefore do not regularly come into contact with village health workers. Their lifestyle is often quite nomadic as they move to new mining areas often on a weekly basis, making outreach strategies difficult. This group is heavily impacted by the loss of income incurred from receiving medical treatment at the CTCs and are therefore more likely to seek spiritual healing or home remedies first.
- Communities and households who rely on river water as a primary source of drinking water are at high risk due to perceptions that river water purifies itself. Community leaders and village

health workers widely recognised that rivers are a major source of contamination but alternative sources of safe drinking water are often not available. This was deemed to be particularly risky during the dry season where water remaining in the rivers was scarcer and dirtier. More needs to be done to raise awareness that clear water is not equivalent to clean water.

- Children, particularly the under 5s, are also at higher risk. Children often get high temperatures, vomiting and diarrhea so these symptoms do not immediately trigger health seeking behaviours amongst caregivers to the clinics. For example, when children are teething, diarrhea is a common symptom and the expectation is that it will pass in due course. There's also a worry about the amount of time the caregiver will have to spend at the CTC which diverts them from attending to other children and other duties or income generation activities at the home.
- The elderly are also an at-risk group. There are more elderly people in the rural areas than in the urban areas and they are heavily impacted by the long distances to the CTCs if they suffer from reduced mobility. Grandparents often take on caregiving responsibilities in the home and there is a risk they are expected to attend the CTC if a child falls sick.

4. Beliefs about treatment

Home remedies

- It is common practice amongst the Apostolic community to use home remedies to treat the symptoms of cholera. Treatments being used include mixing vinegar, bicarbonate of soda and salt together and drinking the solution, as well as eating toothpaste or porridge, or putting the patient in a bath of cold water due to the belief that water can be reabsorbed into the body. Bathing patients sick with cholera is often done in the river, posing a significant contamination risk. Other remedies include dissolving ash into water and drinking the solution, in the belief that ash (which is often used for disinfecting hands) will disinfect the internal organs from the cholera bacteria. Some Apostolic schools, such as St. Noah's in Manicaland, have claimed to have done spiritual research on the causes and cures of cholera and have recommended some of these home remedies as appropriate treatment options.
- Spiritual healers are also giving those with symptoms stones which are used to cast out evil spirits. Once this treatment fails to cure the symptoms, this often triggers the patient to seek help at the CTC.

Health seeking behaviours

- Physical access and the distance to CTCs is also a major barrier, with some communities living 20-25km away from the nearest CTC. This places significant constraints on the family to find the money to pay for a cart for transportation.
- Not all the clinics across Mutare rural and Buhera have CTCs, meaning that some clinics with sporadic cholera cases have to refer patients to another clinic once they arrive. These patients must then travel even further at their own expense to access the CTC.
- There are some excellent examples of community-led solutions to overcoming access constraints to the CTCs. Staff from Mercy Corps shared an example of an extended Apostolic family who had suffered 10 cholera deaths amongst members living in the same village. The family decided to provide transport to anyone from their community needing to access the CTC

by driving patients in their car. Hiring a car to transport someone who is sick to the CTC is often prohibitively expensive – some estimates were that it would cost an entire cow – so often people are forced to rely on carts. Mercy Corps provided the family with funding for fuel and supplies to disinfect the car between trips. In addition, 3 men from the family offered their time for free to conduct waste management activities in the village, which Mercy Corps supported through provision of PPE.

- Being seen at the CTC is a major barrier to accessing healthcare amongst many Apostolic community members, who are fearful of the repercussions from religious leaders if they are caught. Clinic staff explained that they are often called directly to the house of an Apostolic community member to provide treatment in the home rather than at the CTC, and that they will attend in plain clothes instead of wearing uniforms identifying them as health workers. However, whilst this is often the approach taken for more milder cases, clinic staff did stress that when faced with severe cholera symptoms which often occur at an alarming pace, it is often the case that members of the Apostolic community do seek assistance (although often delayed) at a health facility with the expectation that they will be forgiven by religious leadership afterwards.
- Loss of income during stays at the CTCs is also a significant barrier in accessing treatment, particularly for those working in the informal sector who rely on a daily payments to support their families
- Stigma of cholera remains a significant barrier in accessing timely health care. Cholera is often seen as a dirty disease, where those who fall sick are often judged by their neighbours for maintaining poor hygiene and sanitation practices. Village health workers explained that often people sick from cholera will approach them asking for ORS and complaining of headaches and feeling weak. They will often not mention diarrhea as a symptom due to the embarrassment. Village health workers have to find diplomatic ways to probe the symptoms without causing shame in order to ensure that the patient is referred for the appropriate treatment.

Oral Rehydration Points (ORPs)

- There does not currently seem to be a strategy of establishing ORPs outside of health facilities in Manicaland. Some cholera patients explained that they had had to travel over two hours to reach the CTC, either by foot or on a cart.
- Village health workers said that ORPs were generally considered less visible than CTCs and therefore would likely be used by Apostolic communities. There is a perception among some members of the Apostolic community that they cannot prepare ORS themselves but if it's prepared by someone else and given to them then this is more acceptable.
- Clinic staff highlighted that since the current outbreak of cholera started, more patients have been turning up to the CTCs with homemade sugar and salt solution. However, there is confusion around the quantities of sugar and salt to use.
- Village health workers in Chipondamidzi were under the impression that there was a policy in place stipulating that ORPs could only be established in communities with 35 confirmed cholera cases or more. This was raised with district health officials who were not aware of such a policy. A review of the current ORP strategy is urgently needed for Manicaland province to establish a clear way forward in scaling up the availability of immediate treatment and referrals to CTCs through ORPs.

Patient care

- Clinic staff were unanimous in highlighting issues with availability of clean water for patients as well as lack of medicine to treat cholera. Solar powered boreholes were broken, or electricity supply was unreliable, which is forcing clinic staff to either take unsafe water from shallow wells in the community or travel long distances to the nearest borehole. When electricity is down the staff are often forced to use candles at night because they do not have torches. Ciprofloxacin, the recommended antibiotic used to treat severe cases of cholera, was either out of stock or in very low supply at all of the CTCs visited.
- The issue of food was raised by clinic staff, cholera patients and community health volunteers. The ministry of health has issued a ban on visitors for cholera patients to reduce the risk of contaminated food being brought into the CTCs or of visitors becoming infected at the CTC before returning home. This has put strain on the clinics who must now provide the food for patients. Some CTCs were allowing visitors to bring raw food items to the CTC which staff then prepare on site, but patients generally said the food was not enough or to their preferences. Staff mentioned that food supplied by the district often runs out so if patients' families are not able to provide the raw items to the clinic then they are often using their personal money to buy food.
- Cholera patients and community members often referred to time spent at the CTCs as being 'detained'. One patient referred to feeling 'locked-in' at the CTC. None of the patients had had their treatment plans clearly explained to them and none knew when they would be discharged or how long their treatment was intended to last for. This makes it very difficult for patients to plan care for children or elderly relatives at home or to manage the loss of income during time spent at the CTC. This, alongside the fact that patients are not allowed visitors, is causing anxiety and a feeling of being isolated amongst patients. Improving the patient experience at CTCs could help to encourage more timely health seeking behaviours.
- One female community member explained that she and her 2-year old child had been sick from cholera but the husband decided that only the mother would be admitted to the CTC and the child would be treated at home because he anticipated that she would be kept at the CTC for too long if both she and the child went together, as once she recovered she would be expected to remain at the CTC as the child's caregiver. Eventually the clinic staff convinced the husband to allow the child to be admitted and both survived. Many parents highlighted how much strain was placed on the family when a parent, particularly the mother, was admitted to the CTC and the family was left without options for childcare for those remaining at home.
- There were also positive experiences of the CTCs shared during the discussions. One father explained that his two sons had become sick and were admitted to the CTC. They made a full recovery and were discharged within 3 days. He explained that he often went to the fence of the CTC to talk to his children (there was no acknowledgement that this is also a risky practice) but expressed how happy he was with the care given by the staff and now talks to parents and caregivers to take their children to the CTC as soon as symptoms start. With his permission, UNICEF recorded a short video of his testimony that can be used for dissemination through village health workers and community leaders.

Pillar	Issue	Recommendation
WASH	Lack of WASH infrastructure	This is the biggest structural barrier affecting communities' ability to adopt safer and healthier sanitation and hygiene practices. Immediate steps need to be taken to build more sustainable WASH infrastructure particularly amongst communities reliant on rivers and shallow wells for their primary source of drinking water and where rates of open defecation are highest. In the immediate term, the WASH pillar should focus on restoration of contaminated boreholes in hotspots.
WASH	Water quality testing	Without systematic water quality testing done to identify the location of contaminated water sources it is very difficult to focus RCCE activities to target the riskiest practices and behaviours. Water quality tests need to be conducted and the primary routes for transmission need to be determined for prioritisation of interventions
WASH	Access to water treatments	Without access to appropriate water treatment options communities are unable to keep themselves safe despite being aware of the risk posed by the ongoing use of contaminated water sources. We need stronger partner coordination to map out communities who have been underserved by NFI distributions in order to increase availability of water treatment, water storage and soap at household level. CATI teams need access to NFIs to distribute so that they provide a full package of support to households alongside cholera education and disinfection. Water subsidies could be an effective strategy to control the outbreak, but would need to be available beyond just hotspots to ensure that community tensions are not created.
WASH, Case Management + RCCE	Awareness of and perceptions to water treatments and rehydration	More dialogue sessions are needed with Apostolic communities to see what suggestions they have for finding common ground to appropriate water treatment options, given that some consider aquatabs to be medicine and therefore unacceptable. These dialogue sessions could also help to clarify whether ORS is acceptable amongst the more ultra-conservative groups, for example, as well as to understand perceptions towards IV fluids, as these only contain natural ingredients. This would also shed light on attitudes towards administration of these treatments (e.g. intravenous vs oral) as well as preferences towards the administrator or providers of the treatments (e.g. health staff or religious leaders). These sessions could also help to clarify whether there's leeway amongst the leadership to get permission for some water treatments and rehydration. It would be worthwhile to recruit a local social science researcher from the academic community in Zimbabwe to assist with this.

		Additionally, targeted awareness raising with communities who rely on river water as their main source of drinking water should be conducted to improve understanding of how contamination of water occurs and to encourage boiling of water where possible and/or use of water treatment options to mitigate this risk.
Case Management	Availability of medicine and supplies at CTCs	Clinic staff reported acute shortages of essential medicines and supplies (e.g. access to safe drinking water) needed to effectively treat cholera patients. The case management pillar should consider ways in which to work with the provincial and district ministry of health offices to map out stock and asset inventories at the CTCs and put plans in place to help address gaps identified
Case Management + RCCE	Treatment at CTCs	Cholera patients often referred to feeling 'detained' at the CTCs, largely due to the ban on visitors and a lack of information provided to them around their cholera treatment plans. More needs to be done to inform communities about what kind of treatment is given to cholera patients, how long treatment typically lasts, and why the ban on visitors is currently in place. This could be done through: - Generating and sharing cholera survivor testimonies of their positive care experiences at the CTCs, and answering common questions about treatment - Communication refresher trainings for clinic staff to ensure they are equipped with skills to talk to patients about their treatment plans and answer questions - Reviewing and updating existing village health worker / community health worker training packages to ensure they have knowledge about what happens at the CTCs - Arranging 'go and see' visits for village heads and religious leaders at the CTCs where clinic staff can show them how care is provided and common questions can be answered - Community meetings where community members can ask questions directly to clinic staff - Radio chat shows where clinic staff (perhaps along with cholera survivors) talk about treatment and listeners can call in to ask questions - Developing leaflets for patients whilst recovering at the CTCs on cholera treatment strategies and aftercare when discharged. These would go hand-in-hand with regular Q&A sessions with family members who may be living nearby.
Case Management	Access to ORPs & CTCs	• A clear ORP scale up strategy needs to be developed and operationalized, particularly in hotspot districts. More information is needed on community perceptions of ORS and ORPs in order to inform this strategy. Potential options might involve installing ORPs at the house of the person who usually treat the sick, or there is sometimes a dedicated person in the community where people bring their sick to be prayed for, for example. Traditional birth attendants are trusted, particularly among women, and could also engaged to provide ORS and referrals to CTCs for sick patients. This could also be supported by demonstrations around the preparation of ORS and sugar and salt solution, as well as the use of water filters and boiling of water etc. All of these strategies

		should be guided by a 'listen and learn' participatory approach where workshops with community leaders are held to make decisions about the specific locations and services of ORPs to ensure buy-in at community level. Cholera patients frequently had to travel long distances to reach the CTCs, usually using transport they had to pay for. This poses a significant barrier to accessing timely treatment. Options for covering the costs of transport for patients, or an ambulance-based referral system, particularly in rural areas, should be explored. In more urban contexts, exploring working with local drivers (taxis or combis) to draw up a referral and transport scheme should be considered.
Case Management + RCCE	Children	Parents face a difficult dilemma in recognizing the difference between diarrhea, which children often suffer from, and the early onset symptoms of cholera. Treating dehydration in children quickly is critical. It may be worthwhile updating or developing advice and guidance for parents on steps to take when children become sick, as well as a targeted messaging campaign highlighting that as long as a cholera outbreak is ongoing, all cases of diarrhoea – including 'normal' diarrhoea, should be treated with ORS and an immediate visit to the clinic. This should be targeted at all high risk groups including young children, the elderly and frail, pregnant women or those with underlying health issues including HIV.
IPC	Mass gatherings	Specific community engagement strategies need to be developed with the Apostolic community which focuses on working hand-in-hand with religious leaders to identify solutions which are trusted and respectful of beliefs and customs but keep people safe during funerals and religious gatherings. This could include activities such as enabling religious leaders to develop action plans with village heads for how they will prevent the spread of infection at events they are supervising, which response partners and district ministry of health offices should commit to supporting
IPC + RCCE	Festive season	The upcoming festive period poses significant risks to cholera transmission, as families will be travelling long distances across the country to congregate in large groups and share food together. A clear communication strategy needs to be developed and implemented with provincial health departments and religious leaders to talk about ways families can stay safe over the festive period.
IPC + RCCE	Food vendors	Regular outreach activities should be targeted at market areas/food providers on safe food preparation and storage, and at mobile worker camps.
RCCE	Supporting locally-led solutions	This research highlighted many excellent examples of communities taking action to fight cholera. Supporting community action planning should be a critical component of the RCCE strategy for the cholera response in Zimbabwe. This will enable key stakeholders – including religious leaders and village heads – to come together to discuss the main cholera risks in their communities and agree on a way forward to

		implement localised solutions. This requires cross-pillar coordination so that all response pillars can support the implementation of these action plans.
RCCE	2-way engagement	Messaging on cholera needs to move away from generic advice on handwashing and drinking clean water as these do not reflect the hardships of daily life and the structural barriers that people face in adopting these practices. Advice which cannot be implemented will just lead to confusion, anger and rejection of public health safety measures. The RCCE pillar should be utilising community insights (e.g. community feedback analysis or social science research) to generate evidence-based engagement strategies on critical behaviours. This should be delivered through localised forms of community engagement activities e.g. community drams, plays, mobile cinema with Q&A sessions, radio listening shows etc., and not through 1-way IEC materials.
RCCE	Evidence generation	Rapid qualitative assessments are a useful way to generate insights on transmission dynamics and attitudes towards preventative measures and treatments for cholera. The RCCE pillar should coordinate with other pillars to generate community insights for more effective and dynamic decision making on key issues or hotspot areas which are reflective of contextual factors (e.g. historical experiences, political and socio-economic issues)
RCCE	Perceptions of village health workers	More research should be done to find out more about how village health workers are perceived in different community groups within communities. For example, to understand whether they are trusted, or perceived as arms of the authorities who spy or report on people, or who want to spread the 'gospel of biomedicine' and will discriminate against those who don't subscribe to a biomedical world view. This is essential in planning the delivery of interventions, especially as the current response relies heavily on village health workers as the bridge between the response and affected communities
RCCE	Community-led solutions	The RCCE pillar and partners should start drawing up best practice examples around community-led solutions to tackling the outbreak to help demonstrate that communities are not passive recipients of response interventions but can play a vital role in halting transmission. Examples should also be documented around successful strategies to improving health-seeking behaviours, particularly amongst the Apostolic community, in order for learning to be documented and shared.