Zimbabwe Cholera Outbreak

A rapid qualitative assessment report and recommendations on Oral Rehydration Points

Partners: Zimbabwean Ministry of Health; Welt Hungerhilfe; UNICEF; Apostolic Women's Empowerment Trust (AWET)

December 2023

Introduction

As of the 11th December 2023, there has been a total of 11,448 suspected cholera cases across 54 districts in Zimbabwe. Data has indicated that there is a high rate of community deaths, and in rapid qualitative assessments communities have highlighted that they face significant physical barriers in accessing the Cholera Treatment Centres (CTCs). Communities have reported that the closest CTC can be 20km away from their home, resulting in the need to use expensive or time-consuming transport options which many people cannot afford.[1] Oral Rehydration Points (ORPs) have so far been mainly established at the CTCs themselves, and not at community level. This means that access to life-saving rehydration treatment and referrals to the CTCs remains a critical barrier to those with symptoms.

Learning from the outbreak response in neighbouring Malawi demonstrated the importance of ensuring that communities' perspectives and opinions about the location and services provided by ORPs in their communities were central to decision making. Consequently, partners of the Zimbabwe RCCE pillar and case management pillar collaborated to conduct a rapid qualitative assessment to ascertain community perceptions towards Oral Rehydration Solution (ORS) and ORPs, in order to inform the ORP scale-up strategy in Zimbabwe.

Methodology

The rapid qualitative assessment focused on the urban settings of Chitungwiza (St. Mary's and Zengeza) and Harare (Kuwadzana and Glenview). Data collection was completed between 29th November and 5th December. Data collection was purposively selected based on partners' project areas where there were consistently high cases of cholera being recorded. It is recommended that further assessments are conducted in rural locations to compare findings and develop an appropriate ORP scale-up strategy for rural contexts. The assessment consisted of:

- Chitungwiza
    - 1 FGD with community health promoters conducted by Welt Hunger Hilfe (10 participants, all females aged between 35 and 65 years old) held at St Mary's polyclinic
    - 1 FGD with community members in a hotspot community conducted by Welt Hunger Hilfe (10 participants, 8 females and 2 males aged between 25-65 years) held at Zengeza 1 pre-school
    - 4 Key Informant Interviews (KIIs) conducted by Welt Hunger Hilfe
        - Matron, adult female in St Mary's
        - Businessman, adult male at Zengeza 2 shops
        - Pharmacist: adult male at Zengeza 1 shops
        - Care giver, adult female in Zengeza 1
- Kuwadzana (community location)
    - 1 FGD with community members in a hotspot community (7 men and 5 women) conducted by AWET and UNICEF
    - 1 community feedback session with behaviour change volunteers (14 women and 7 men) conducted by AWET and UNICEF

[1] UNICEF, rapid qualitative assessment Manicaland November 2023

For more information, please contact lchimombe@unicef.org

Glenview (Glenview Poly Clinic)

- 1 FGD with City Health Promoters and community members (vendors, small and medium scale entrepreneurs, religious leaders (4men and 7 women) conducted by UNICEF and AWET

The link to the qualitative assessment topic guide for ORPs is here.

All participants provided their informed consent prior to participation.

Limitations

Data was collected in urban settings only, so the findings cannot be extrapolated to rural contexts in Zimbabwe. It is recommended that partners conduct a similar assessment in rural areas, such as in Manicaland or Masvingo, where cholera cases remain high.

Given the small sample size of the assessment, summary findings and recommendations cannot be generalised. However, insights provided can be used to guide more localised response strategies for ORP scale-up.

Findings

1. Knowledge and use of ORS

- All study participants reported that they had heard about oral rehydration solution. Most community participants highlighted that they used sugar and salt solution (SSS) at home, rather than purchasing ORS sachets or travelling to the clinic to pick them up. Instructions for how to make SSS have been printed on the back of children's routine immunization cards for many years and therefore knowledge is relatively high among women
- All participants indicated that ORS or SSS is used to rehydrate a person suffering from diarrhea symptoms. The perception was that ORS or SSS is *"for regaining strength"* in someone who has lost strength and energy from diarrhea and vomiting. Many participants indicated that ORS or SSS would not be administered immediately but only if the sick person had at least 3-4 loose stools or if the symptoms were severe and the patient was on the way to the clinic
- Community participants stated that they would often give the sick individual warm water to *"cleanse the system"* first and if that didn't stop the symptoms then ORS or SSS would be used
- When asked how to make SSS at home, there were mixed responses within the community participants about the correct quantities and measurements to use. Particularly, confusion came from whether it was 6 or 8 teaspoons of sugar or 1 or half a teaspoon of salt per litre of water or whether it was 750ml or 1 litre. Some participants said they would check with the community health worker first before making it at home.

2. Access to ORS

- In terms of where to get ORS, the first and most cited response was from the pharmacy. The clinic and hospital was also mentioned by some respondents. Participants were unanimous in saying that they would make SSS at home if they couldn't access ORS
- There was a mixture of responses as to whether is it easy or difficult to access ORS
    - The matron from Chitungwiza indicated that it was easy to get ORS at the clinic since it was free. She however indicated that at times they will be out of stock
    - Community health promoters indicated that ORS is only free in times of outbreaks and thus easy to access during emergencies only. However, when there is no outbreak, the group expressed that it is difficult to access ORS, mainly because of a $14 user fee at clinics.

For more information, please contact lchimombe@unicef.org

- Some community respondents indicated that ORS is easy to access when one makes its home (as SSS), while many indicated that it can be difficult for vulnerable or poorer households because of the cost of sugar, clean water, gas/electricity or firewood to boil the water, as well as forgetting the dilution proportions
- Some respondents indicated that it was easy to get ORS at the pharmacy because it only costs 50c per sachet, but others highlighted that the number of sachets one needs to treat a sick person at home may be many and this results in high costs
- All community members highlighted that, considering the severity of the disease, they wish that ORS could be more freely accessed at no cost

- Participants agreed that there were no religious restrictions or beliefs which would prevent people in their community from using ORS or SSS, but that preparing it at home was likely to be more acceptable amongst the ultra-conservative Apostolic sects. ORS prepared in a clinical setting by a nurse or health staff member would be less likely to be accepted by some ultra conservative groups.

3. Knowledge and perceptions of Oral Rehydration Points (ORPs)

- Most people highlighted that ORPs are available at the clinics, but some said that they have also started to appear in public places, *"we saw them at Zaname shops, we were taught how to wash hands and received ORS"*
- Information on what people say about ORPs was largely positive although some recommendations were heard:
  - *"They are good they help to strengthen a patient who is not able to reach a CTC"*
  - *"People who accessed ORPs recovered"*
  - *"ORPs help save lives"*
  - *"People are happy about them, they are grateful for the assistance because sometimes people do not have sugar or clean water to make the solution at home"*
  - *"The ORS was free therefore helped many sick people"*
  - *"Patients tend to drink more ORS at the ORP compared to the way they drink at home. So the ORPs are more effective since patients are encouraged to drink and are monitored"*
  - *"At home, a patient may refuse to drink ORS or cannot finish one cup of ORS but at the ORP, patients could finish 3 cups"*
  - *"The ORS at the ORP was cool and it also helped to revive the patient"*
  - *"People complained that the ORPs were put for a few days, and when others were referred to the ORP, they were already gone"*
  - *"I visited the ORP with a child suffering from diarrhoea and was given 2litres of ORS, my child recovered"*
  - *"It* [the ORPs] *was a good initiative but they only lasted for a few days*"
  - *"My child fell ill at school during exams time and could not leave school, his father rushed to an ORP at Zengeza 2 shops and was given ORS, he took it to the teacher, and the teacher helped my child drink the ORS. He was able to continue writing his exams"*
- The unpredictability of how long ORPs outside of the clinics would be available for was noted by several of the participants, indicating that communities are not being involved in decision making around where ORPs are established or for how long they will provide services
- In Kuwadzana and Glen View, respondents indicated that they were not aware of any ORPs which had been setup in their community during previous outbreaks, and that the only way to access ORS previously was at the clinics
- There was consensus that ORPs should be installed in the community. The following were the reasons cited:
  - Immediate access to ORS to rehydrate a person suffering from diarrhea since some will be too weak to reach a CTC or have money for an ambulance or transport. Similarly, it ensures treatment is more accessible for the elderly or those with disabilities

For more information, please contact lchimombe@unicef.org

- Mitigation of the financial challenges in procuring sugar and gas/firewood to make own SSS at home, as well as lack of access to clean water. Sugar is expensive and water sources in the community are perceived as unsafe
- People who are reluctant to seek help at the clinic can just go to an ORP which is less visible and can help to mitigate stigma
- ORPs also serve as a good referral point for people to go to a CTC, thus promoting early health seeking behaviour
- It can enable informal workers who may not be able to spend the time accessing a CTC, such as vendors, to access essential treatment
- It will help to reduce congestion at the CTCs where waiting times are often long

4. Community perspectives on ORP locations

- The following locations were suggested to be a suitable location to setup an ORP because of centrality, easy access and good visibility
    - Shopping centers (there are often 'outreach points' providing primary health services which could also be used for ORS provision)
    - Marketplace
    - Clinics, Hospitals
    - Ground B, ward 8 open space
    - Schools
    - Churches (particularly as churches often have boreholes where people are able to collect water so there is already a precedent set for seeking health/WASH services)
- The following people were cited as needing to be involved in decision making around the location of an ORP:
    - Councilors
    - Environmental health personnel and nurses
    - Community health workers
    - Church/religious leaders
    - Police
    - School heads
- Respondents also cited that there are often community WhatsApp groups where information about availability and locations of ORPs can be shared, as well as common questions or concerns could be responded to. In Kuwadzana, for example, there is a residents WhatsApp group with over 400 people. In person community meetings and letters issued to the community health workers to give to influential leaders were also mentioned.

5. Community questions or recommendations on ORPs

- *"People who man ORPs should receive training"*
- *"People who man the ORPs should be provided incentives"*
- *"To promote community engagement, ORPs can be manned by local people from the community"*
- *"Provision of mobile toilets at an ORP"*
- *"Wide sharing of information about the location of the ORP, as some community members do not know where ORPs are stationed"*
- *"Provision of many ORPs to improve access"*
- *"Provision of ORS sachets to community health promoters since community members visit them to access treatment"*
- *"May ORS sachets be given to people to keep in their homes, since diarrhea may come unexpectedly"*

For more information, please contact lchimombe@unicef.org

- *"In addition to ORPs, if we could get aquatabs to treat our water because the water we drink is not safe"*
- *"Provision of visibility to people manning ORPs so that community members can easily identify them"*
- *"Provide hygiene education at water points especially handwashing to avoid contaminating the spout and handles"*
- *"Promotion of health seeking behaviours since some members of the community believe we live because of the grace of God"*
- *"Promoting quick decision making to visit a health facility since sometimes we remember when the patient is now very severe"*
- *"There is need for privacy to protect patients who visit a CTC"*

6. Recommendations for cholera response pillars

1. Work closely with the Risk Communication and Community Engagement (RCCE) pillar to ensure that community leaders and community representatives are engaged early on to decide upon ORP sites that are acceptable, accessible and do not pose a risk of community transmission
2. ORPs are an essential mechanism for delivering community health and hygiene education, as well as listening to common questions, concerns and beliefs. A feedback mechanism should be set up across the ORP network so that these community insights can be collected, analysed and acted on. The RCCE pillar can support with this
3. Regular information about the location of ORPs, their opening times and services available should be shared through trusted 2-way communication channels (such as residents WhatsApp groups), where communities can also have questions and concerns responded to
4. Communities should also be involved in decision making around the criteria for establishing and decommissioning ORPs and clear communication should be shared widely to let people know when an ORP is being closed, why, and where they can go to get ORS once the ORP is closed

For more information, please contact lchimombe@unicef.org