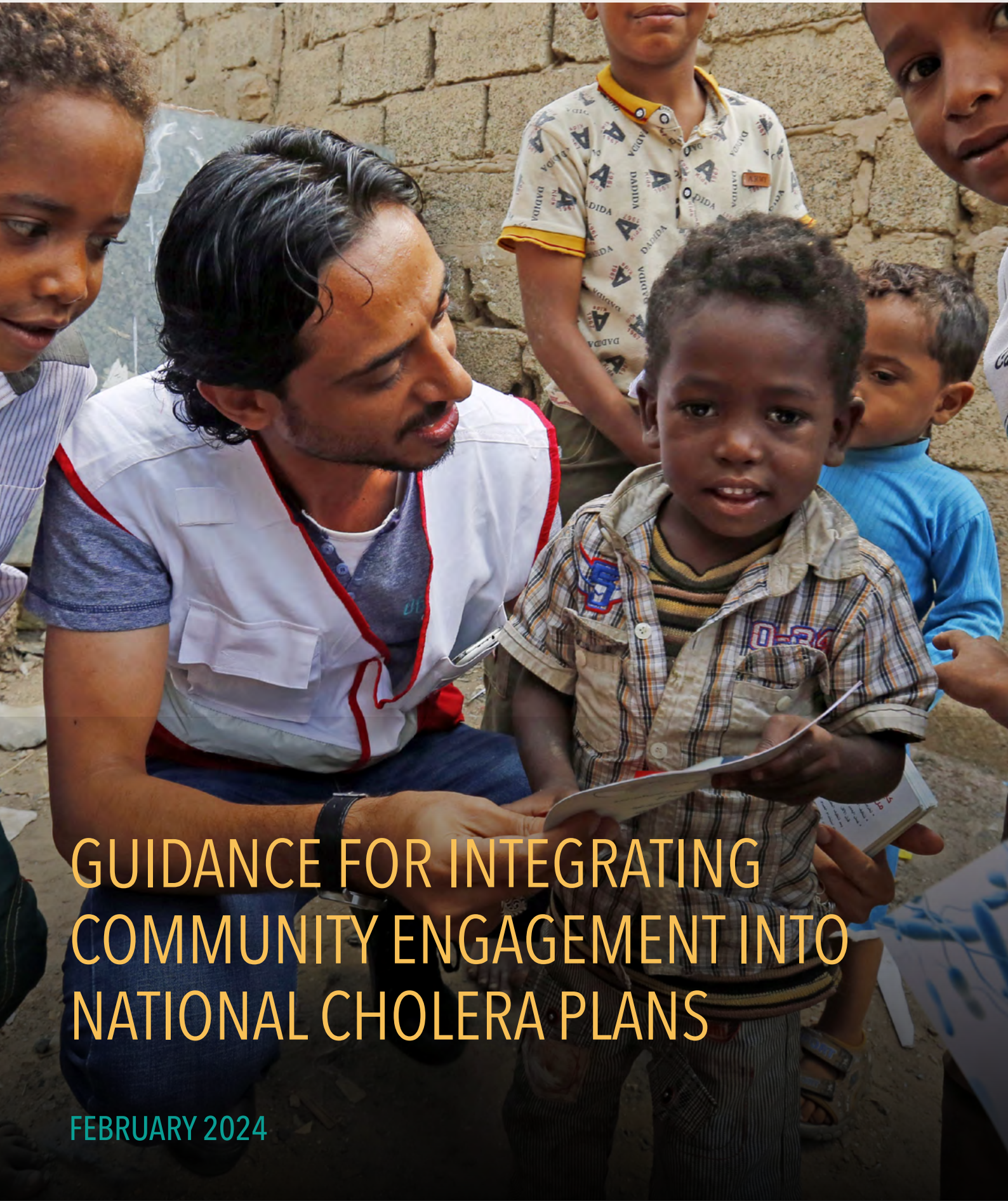
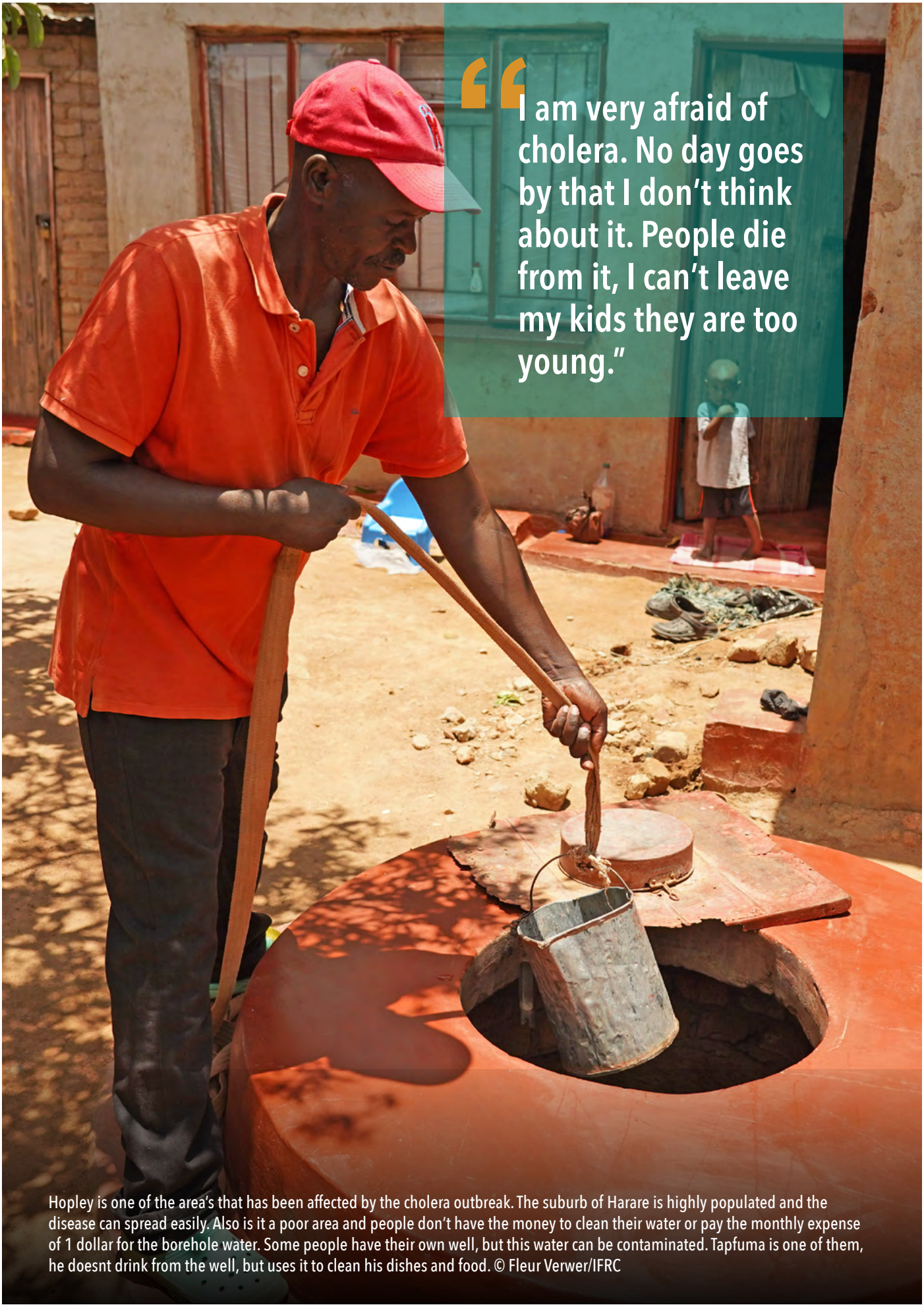
GLOBAL TASK FORCE ON
CHOLERA CONTROL



GUIDANCE FOR INTEGRATING COMMUNITY ENGAGEMENT INTO NATIONAL CHOLERA PLANS

FEBRUARY 2024



Hopley is one of the area’s that has been affected by the cholera outbreak. The suburb of Harare is highly populated and the disease can spread easily. Also is it a poor area and people don’t have the money to clean their water or pay the monthly expense of 1 dollar for the borehole water. Some people have their own well, but this water can be contaminated. Tapfuma is one of them, he doesnt drink from the well, but uses it to clean his dishes and food. © Fleur Verwer/IFRC

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Cover Photo: YRCS volunteer Majed sits among a gathering of children at the slum quarter, teaching them protective healthy ways against cholera infection and telling them how to wash their hands with soap before and after eating.© IFRC

Layout: René Berzia – Ink Drop

ACKNOWLEDGEMENTS

This guide was developed to contribute to the Global Task Force on Cholera Control Interim Guiding Document to Support Countries for the Development of their National Cholera Plans. It focuses on the integration of community engagement approaches.

The GTFCC would like to acknowledge the collaborative efforts of those involved in the development and review of this strategy and to thank them for the time and expertise shared. In particular, the GTFCC would like to acknowledge the International Federation of Red Cross and Red Crescent Societies (IFRC), which has led and financially supported this work. The core contributors, namely Sophie Everest, UK Health Security Agency, Public Health Rapid Support Team; Mónica Posada, IFRC; Innocent Kommwa, IFRC; and João Rangel de Almeida, WHO, deserve special thanks.

An IFRC surge team with a household water treatment delegate did an assesment in the area to check the quality of the water.
© Fleur Verwer/IFRC

The GTFCC would like to thank the Risk Communication and Community Engagement Collective Service that offered a convening platform and facilitated collaboration among agencies and key partners.

Thanks are also given to those who took part in the advisory group, interviews, and consultation that helped to shape the guide, including Kate Alberti, WHO/GTFCC; Ombretta Baggio, Alexandra Machado, IFRC and Emmet Kearney, IFRC/GTFCC Country Support Platform; Leilia Dore, WHO; Maria Falero Cusano and Mariana Palavra, UNICEF; Eva Niederberger, Anthrologica; Ginger Johnson, Collective Service/UNICEF; and Diane le Corvec, Collective Service/IFRC. A final word to acknowledge the contribution of all GTFCC working groups and their chairs who technically validated this document.

Training for trainer on cholera sensitization.Here training on mapping. © Julie Garlenq /IFRC

EXECUTIVE SUMMARY

This guidance has been developed for use by those involved in designing, developing and implementing a National Cholera Plan for Control or Elimination (NCPs) at country level. Five pillars form the basis of effective cholera control strategies:

- Surveillance and reporting
- Case management
- Use of oral cholera vaccine
- Water, sanitation, and hygiene
- Community engagement.

Within NCPs, community engagement should be considered both a technical function in its own right and a cross-cutting approach contributing to achieving the outcomes of the other four pillars.

This guidance provides practical advice on how to integrate community engagement across the pillars

It also outlines the role of community engagement throughout the four phases of NCP conception and execution: inception, development, implementation, and monitoring and reporting. It complements and aligns with the Global Task Force on Cholera Control (GTFCC) Interim Guiding Document to Support Countries for the Development of their National Cholera Plan.

Below is a summary of suggested activities to successfully integrate community engagement approaches into each phase of the NCP conception and execution:

Phase 1: Inception

- Establish or strengthen a working group for community engagement (with clear terms of reference), which includes local and international NGOs, UN organizations, Red Cross and Red Crescent Movement, local academic partners, civil society organizations (CSOs), community-based organizations (CBOs) and faith-based organizations (FBOs), as well as other organizations working on hygiene promotion, community engagement, social and behaviour change, or social science in health[1]
- Ensure representation of community engagement in all pillars and working groups to promote integration of this work across the response
- Ensure social science data (including community feedback) informs the priority areas for multisectoral interventions (PAMI) mapping and that communities can validate findings
- Work together with other pillar leads to conduct a multisectoral situational analysis and ensure consideration for capacity (both staffing and funding) to deliver on community related aspects within each pillar

1. *Community engagement representation at government level will differ in each country context. It's important to include representatives from the Ministry of Health and/or the government's water management structures in community engagement coordination mechanisms. This could be a specialist within a health promotion department, for example. In some cases, risk communication may be separated from community engagement. This may require the involvement of multiple departments from within and outside of health (e.g., Ministry of Social Affairs).*

Phase 2: Development and Phase 3: Implementation

- Surveillance and reporting
  - Contribute to community-based surveillance (CBS) activities and outcomes which empower the community to support the early identification, reporting, and referral of suspected cases or deaths during the outbreak
- Case management
  - Integrate community-led trust-building activities in the public health response to cholera so that treatment services are accessible, trusted, and meet priority needs
  - Support staffing capacity within relevant government departments to implement RCCE activities in oral rehydration points (ORPs), cholera treatment units (CTUs) and cholera treatment centres (CTCs)
- Use of oral cholera vaccine
  - Integrate community-led trust-building activities in the public health response to cholera so that vaccination are accessible, trusted, and meet priority needs
  - Generate and use community data to create evidence-based strategies which enable protective behaviours to emerge in support of OCV uptake
- Water, sanitation, and hygiene (WASH)
  - Include community perception indicators in WASH baseline surveys to identify barriers to the uptake of healthier and safer practices. Use this to inform the design of WASH programmes
  - Enhance participatory approaches to design and implement locally led actions to reduce open defecation and improve rates of handwashing, safe water usage, food hygiene, and environmental sanitation (as well as to fully engage in broader investments and improvements in WASH services)
- Community engagement
  - Ensure communities, particularly vulnerable and marginalized groups, are empowered to act and actively participate in cholera-related processes (prevention, preparedness, and response)
  - Develop a contextualized community engagement strategy to enable successful integration of community-centred and participatory approaches across the response

Phase 4: Monitoring and reporting

- Integrate community engagement indicators for specific pillars into monitoring and evaluation frameworks. Ensure communities are regularly consulted on whether they feel listened to and trust response actors, and implement remedial action plans if levels of participation and trust do not meet agreed targets
- Ensure participation of the community engagement pillar in the analysis of the evolution of the epidemic, as well as cholera PAMIs, so that community data can be used as part of an integrated outbreak analytics approach

Collectively, these actions are critical to ensuring that community knowledge and perspectives shape the design, delivery and evaluation of NCPs, enabling the objectives of each pillar, and the overall goal to end transmission of cholera, to be achieved.

PURPOSE OF THIS GUIDANCE

This guidance document is for those involved in designing, developing, and implementing NCPs. Its **focus is on integrating community engagement across all pillars and establishing community engagement as a pillar in itself**. Within NCPs, community engagement should be considered both a technical function in its own right and a cross-cutting approach contributing to achieving the outcomes of the other four pillars.

This document highlights key community-centred activities and tools, specific to cholera prevention, that may be used throughout the four phases of NCP conception and execution. It is a practical guide, with signposting to useful tools to work in partnership with communities and all response pillars.

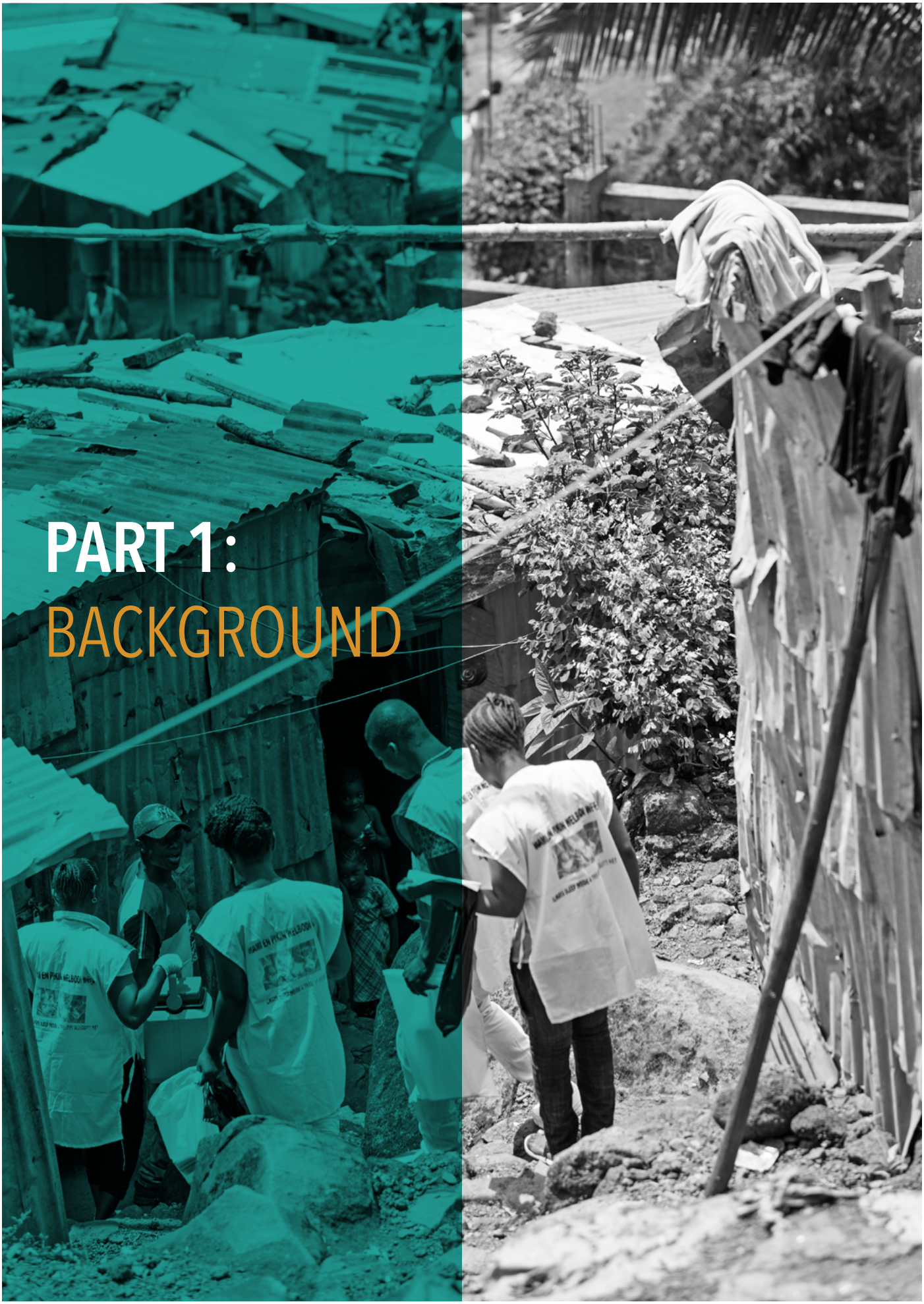
An NCP is a dynamic, multi-year and operational document used by cholera-endemic countries or countries experiencing recurrent cholera outbreaks to prepare for and implement long-term prevention and control interventions. It is endorsed by ministries, government agencies, and institutions at the national level. For acute cholera outbreaks, the guidance for emergency cholera outbreak preparedness and response should be used in conjunction with this guidance. Annex 1 contains a plan template for the community engagement section of an NCP that can be used if no national template exists.

Malawi Red Cross Society volunteers carry water from a borehole to a cholera treatment centre outside Mangochi in south-eastern Malawi. Chlorine is added to the water to help the volunteers keep the centre - which lacks running water - disinfected and contain the spread of cholera. Malawi's cholera outbreak, which started in March 2022, has spread to all 29 districts of Malawi and is the worst such outbreak in decades. © Victor Lacken/IFRC

AUDIENCE FOR THIS GUIDANCE

Cholera prevention, control, and management requires concerted efforts from all sectors, including those outside of the health sector. This document is relevant for all partners involved in the conception and excecution of NCPs at national and subnational levels, including those working in health, WASH (including water, sanitation, solid waste and hygiene), environment, agriculture and nutrition, education, security, gender, child protection, local governance, and trade and industry (including local traders' groups). This includes government ministries (including NCP pillar leads); national and international non-governmental organizations (NGOs), UN organizations, Red Cross and Red Crescent Movement, civil society organizations (CSOs), community-based organizations (CBOs), faith-based organizations (FBOs), academic institutions, media practitioners, and media institutions involved in cholera prevention, control, and management activities.

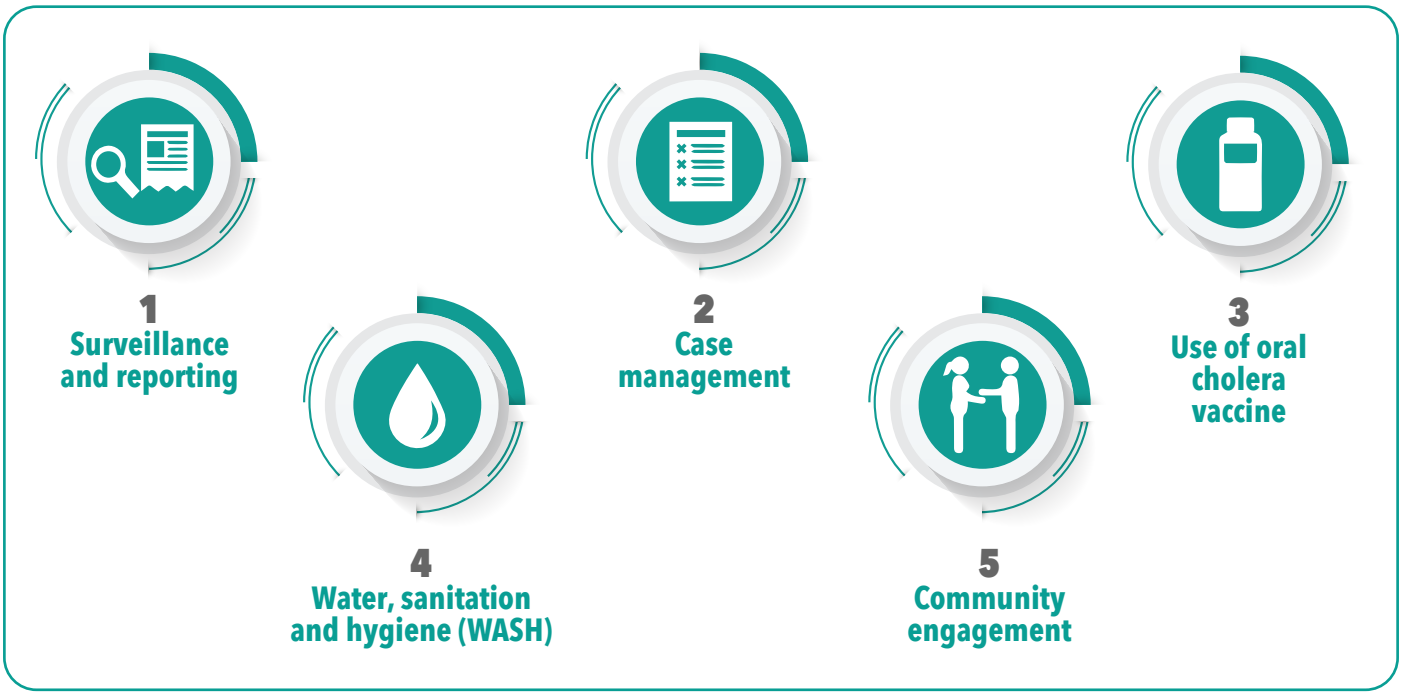
Cholera in Sierra Leone. Makeni regional Hospital, district of Bombali. Wara Fonah, 4, was admitted to cholera ward because of high fever and vomiting. Parents suspected that she was suffering from cholera but after the checkup by a doctor the diagnosis was possible malaria. It is common that patients suffer from multiple medical conditions at a same time or are given wrong initial diagnosis.© Jarkko Mikkonen/Finnish Red Cross



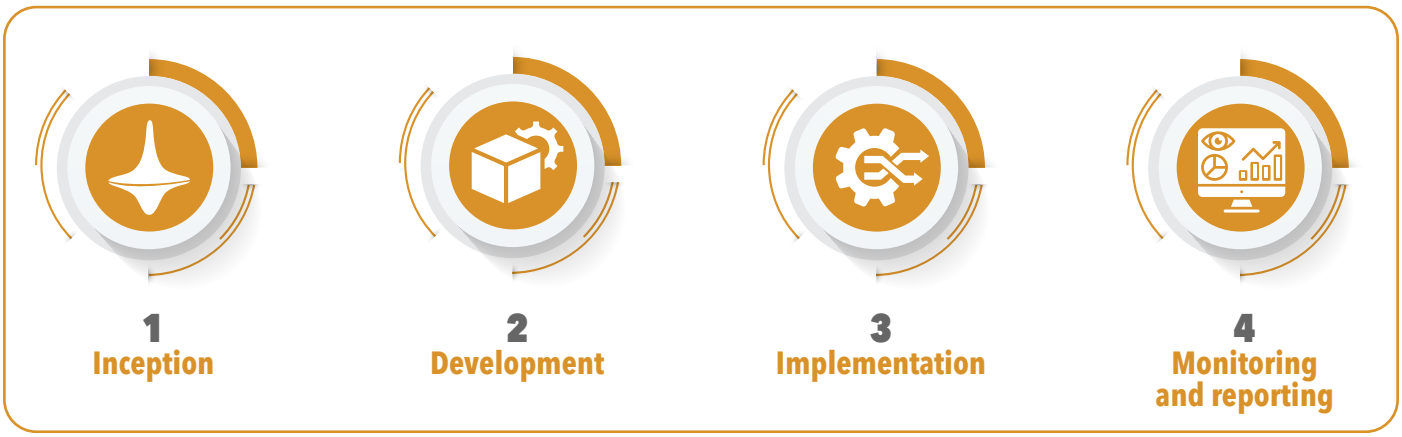
PART 1: BACKGROUND

In 2017, the Global Task Force on Cholera Control (GTFCC) launched a new global strategy called *Ending Cholera: A global roadmap to 2030*.[2] The aim of this strategy is to reduce cholera deaths by 90%, with as many as 20 countries eliminating cholera transmission by 2030. In addition, the GTFCC has produced the *Interim Guiding Document to Support Countries for the Development of their National Cholera Plan*.[3] This guidance on integrating community engagement into NCPs aligns with and complements the GTFCC *Guidance on Development of NCPs*.

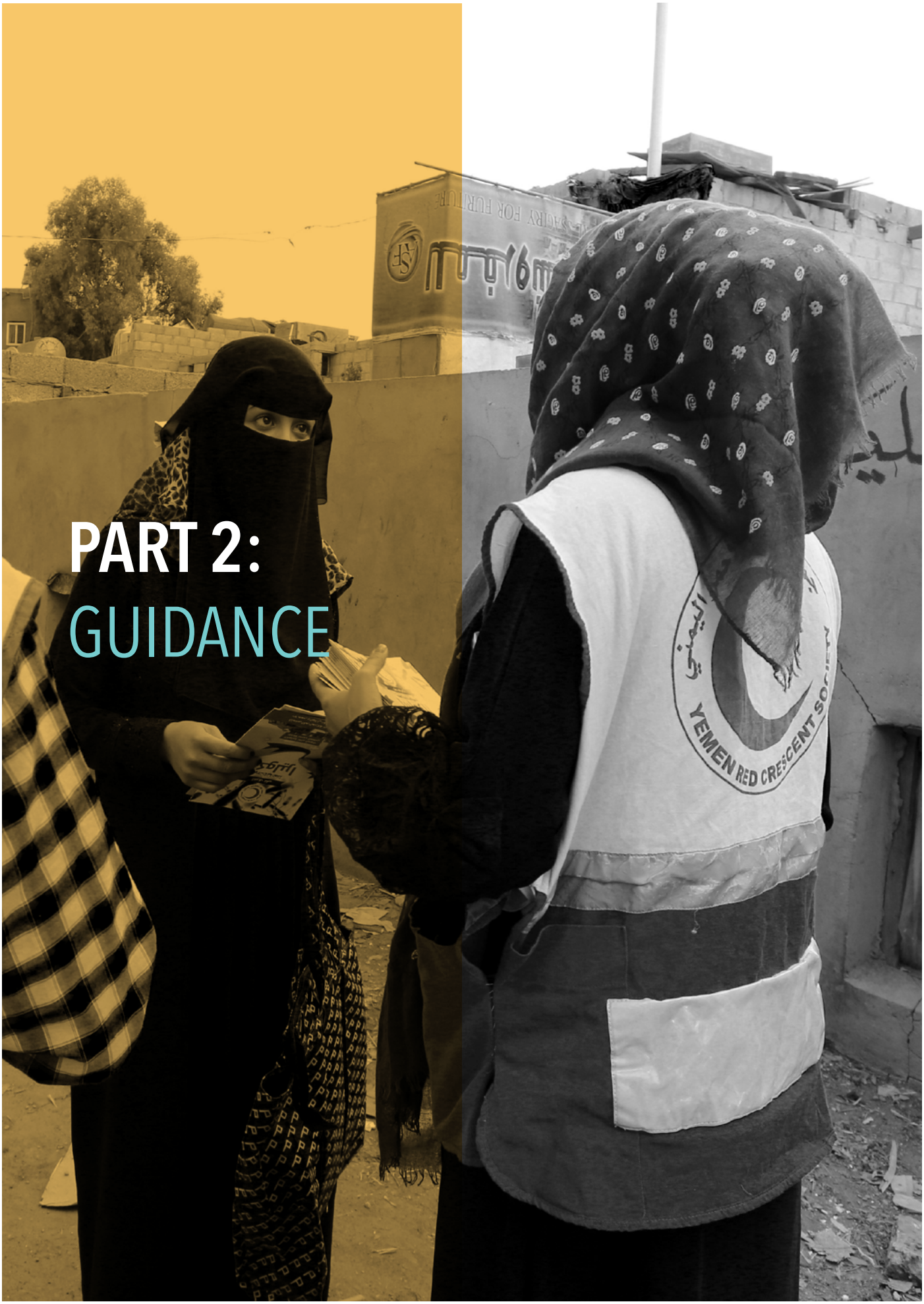
The GTFCC has identified **five pillars** that form the basis of effective cholera control strategies and require strong leadership and coordination:



In countries affected by cholera, context-specific strategies and interventions should be identified for each of these five pillars and organized in an NCP. According to the GTFCC, the conception and execution of an NCP is divided into **four phases**:



2. *GTFCC, 2017, Overview of Ending Cholera: A Global Roadmap to 2030,* https://www.gtfcc.org/about-cholera/roadmap-2030/
3. *GTFCC, 2020, Interim Guiding Document to Support Countries for the Development of their National Cholera Plan:* gtfcc-interim-guiding-document-to-support-countries-for-the-development-of-their-national-cholera-plan.pdf



PART 2:
GUIDANCE

The guidance below suggests activities to integrate community engagement into the four phases of the conception and execution of an NCP, both within the community engagement pillar itself and as a support function to the other pillars. The overarching goal is that people-centred and community-led approaches are championed widely across the five pillars – resulting in increased trust and participation, more effective and efficient responses, and ultimately a reduction in the negative impacts of cholera.

Specific community engagement activities that support the outcomes of other pillars should be integrated within the plans of that pillar. For example, activities to support uptake of OCV should be included within the implementation plan of the OCV pillar. This helps to ensure that community engagement underpins the NCP as a whole and that this work is not siloed. Cross-cutting community engagement activities which support all pillars, such as establishing national community feedback mechanisms, should be captured under the plans of the community engagement pillar. Representatives from all pillars should come together once they have identified their community engagement needs, to ensure that activities are coordinated and parallel systems are not created.

2.1 Phase 1: Inception[4]

The inception phase of an NCP is the preparatory phase, where overall strategy and plans will be decided, and key stakeholders identified and engaged. Actions which can be taken to integrate community engagement principles and activities during the inception phase are listed below:

1. Establish national leadership and coordination for community engagement

If there is an existing national and government-led coordination mechanism for community engagement in health outbreaks (e.g., an RCCE or social and behaviour change technical working group), then it may be possible for cholera control planning and response to be integrated in that. Otherwise, a community engagement working group should be established to lead this work, under the overall cholera response coordination architecture. The terms of reference (ToR) for this group should include (but not be limited to) strategies to integrate community feedback and social science research, community participation, social and behaviour change, two-way information sharing, and engagement with the media. It should also outline how principles on diversity and inclusion will be mainstreamed, and how the group will coordinate with other response coordination mechanisms. At all levels (national and provincial/subnational), the community engagement working group should include all relevant stakeholders working on RCCE in cholera or related issues. For example, representatives from the community, such as elected spokespeople, religious leaders, women's associations, local influencers, and the media. Links to other pillars' coordination mechanisms must be established at this stage.

2. Establish priority areas for multisectoral interventions (PAMIs) mapping

This corresponds to the mapping of geographic areas where cholera persists, reappears, or spreads regularly due to environmental, cultural, and/or socio-economic factors. These areas act as sources for transmission of the disease.

The GTFCC recommends different methods depending on whether PAMIs are identified to develop an NCP for cholera control or an NCP for cholera elimination:

- An NCP for cholera control,[5] developed by countries with high to moderate cholera transmission, should primarily rely on epidemiological indicators, although vulnerability factors may be considered optionally
- An NCP for cholera elimination,[6] by countries with limited to no cholera transmission, should rely both on epidemiological indicators and vulnerability factors.

Community feedback may be considered for the assessment of some vulnerability factors as part of the identification of PAMIs.

3. Conduct a situational analysis

At the inception stage, a situational analysis involves conducting a national capacity assessment and a mapping of stakeholders and existing initiatives. The community engagement pillar should collaborate with the other pillar leads to undertake a review of their own capacities and constraints (such as through the suggested SWOT analysis[7]) to inform honest reflection and planning. This should be done as a cross-pillar exercise where the output is a multisectoral situational analysis. Identified capacities could include reactivating or using existing inter-agency community feedback mechanisms, updating or using historical social science research on cholera-related issues, mobilizing existing community committees, or repurposing partnerships with local academic institutions, think tanks, or trusted media outlets (e.g., radio stations) for two-way information sharing on cholera. Constraints may include lack of funding or technical resources (e.g., social science technical expertise). Ensure localization of the response and involvement of academic/research institutions as much as possible throughout.

4. *Reference Inception section of* GTFCC Interim Guidance to Support Development of NCPs *pg. 10-16*
5. *Identification of PAMIs for cholera control* https://www.gtfcc.org/resources/identification-of-priority-areas-for-multisectoral-interventions-pamis-for-cholera-control/
6. *Identification of PAMIs for cholera elimination* https://www.gtfcc.org/resources/identification-of-priority-areas-for-multisectoral-interventions-pamis-for-cholera-elimination/
7. *See Appendix 3 in the* GTFCC Interim Guidance to Support Development of NCPs

Malawi Red Cross Society volunteers distribute chlorinated water to members of a community in Blantyre. The chlorinated water will be used to disinfect drinking water and to help improve the general hygiene and sanitation within the community which has become a hotspot for cholera transmission. Malawi's cholera outbreak, which started in March 2022, has spread to all 29 districts of Malawi and is the worst such outbreak in decades. © Victor Lacken/IFRC

A stakeholder mapping could take the form of a 4Ws (Who, What, Where and When), outlining the relevant organizations and their existing initiatives and programmes. Relevant organizations could include CBOs, working in social mobilization, health promotion, health advocacy, social science, risk communication and community engagement, community participation, and social and behaviour change.

Collectively, the capacity assessment and stakeholder mapping will help the community engagement pillar to identify, assess, and prioritize the roles and responsibilities of active stakeholders and develop clear plans and strategies to address identified capacity gaps.

Community engagement tools for the inception phase of NCPs

- Context analysis
  - ↘ RCCE Collective Service Cholera Questions Bank (for community and responders)
  - ↘ Community Engagement for Cholera Control Context Analysis – Urban
  - ↘ Community Engagement for Cholera Control Context Analysis – Rural
  - ↘ Community Engagement for Cholera Control Context Analysis - Schools
- Community stakeholder mapping
  - ↘ Community Mapping Tool
- Participatory planning and community-led action tools
  - ↘ Enhanced Vulnerability and Capacity Assessment Tools
- Coordination
  - ↘ SBCC for Emergencies: Coordination and Mapping
  - ↘ Coordinated Planning Guidance and Tools
- Guidance and tool for countries to identify priority areas for intervention
  - ↘ Guidance and Tool for Countries to Identify Priority Areas for Intervention
  - ↘ Tool for Identifying Cholera Hotspots

2.2 Phase 2: Development and Phase 3: implementation of NCPs[8]

Using the results of the situational analysis and stakeholder mapping, countries will develop operational plans for each pillar with budgeted activities targeted at PAMIs. This section provides guidance on the type of community engagement interventions to include for each pillar. These are suggested interventions, recognizing that all activities should always be adapted to the context and capacities of each country.

Pillar 1: Surveillance and reporting

Strategic objectives *(as defined in GTFCC Interim Guiding Document to Support Countries for the Development of their NCP)*

- To rapidly detect all signals potentially related to cholera through all relevant sources, to verify these signals in a timely manner (i.e., within 48 hours between the occurrence of the signal and its verification) and to allow for timely implementation of full control measures (i.e., within five days of laboratory confirmation)
- To maintain, regularly update, analyze and share datasets at each administrative area (down to the same level used for PAMIs). This data should be integrated into existing surveillance systems and include a 'zero reporting' feature

The detection of suspected cholera cases should routinely integrate health-facility-based surveillance, community-based surveillance (CBS), and event-based surveillance. CBS complements health-facility-based surveillance through detecting and reporting individuals in the community who meet the definitions of suspected cholera case or cholera death, but who may not seek medical attention and consequently may not be captured by health-facility-based surveillance.

The analysis and interpretation of cholera surveillance data should identify vulnerable or at-risk groups which may be disproportionately affected by a cholera outbreak, and this should be used to guide community engagement interventions.

Community engagement outcome: The community contributes to the identification, early reporting and referral of suspected cases or deaths from cholera in support of the early detection and monitoring of cholera outbreaks.

The role of the community engagement pillar in supporting CBS should be to:

- Conduct community stakeholder mapping (or share existing mapping) to support in identifying influential and trusted community members who could be involved in CBS
- Ensure that communication on decisions, improvements, and activities is fed back to the community, through trusted and accessible channels, at each step of CBS, so that communities are listened to
- Establish two-way communication and share information on signs and symptoms of cholera and how to report suspected cases or deaths (based on clear community case definitions)
- Collect local knowledge on symptom recognition, and understand gender dynamics and influential community actors to be included in CBS
- Support the facilitation of training for community health workers, traditional healers, teachers, business leaders, youth leaders, etc. to ensure they can identify suspected cholera cases/deaths and understand the role of CBS teams
- Establish trusted feedback mechanisms so that any community concerns or questions around CBS can be quickly addressed, as well as to monitor rumours or misinformation around transmission of the disease which may impact surveillance and other pillar activities

Pillar 2: Case management

Strategic objective: To increase access to early effective treatment at community and health facility levels to reduce overall cholera deaths by 90%

To reduce cholera mortality, individuals with cholera must know of the importance of rapid and effective hydration, ideally with oral rehydration solution (ORS), and have access to quality treatment as soon as symptoms appear. The health care system should be prepared to treat individual cases within the existing system, as well as have the capacity to scale-up treatment response in the event of an outbreak.

8. *See the GTFCC Interim Guiding Document to Support Development of NCPs pp. 17-36*

Community engagement outcome: The community has trust in the public health response to cholera and seeks treatment. Several community engagement approaches are proposed to support strengthening of the health care system to prevent and control cholera outbreaks:

- Understand and map community preferences (disaggregated by age, sex, location, disability) on sources of cholera information
- Work with community leadership – traditional healers, birth attendants, community health workers etc. – to integrate the use of oral rehydration therapy (ORT) into normative health care practices in the community, such as key family care practices[9]
- Ensure that emergency response plans, including locations of cholera treatment centres (CTCs) and oral rehydration points (ORPs), are designed, planned, established, and monitored with communities, and that their services are flexible enough to enable adaptations to be implemented based on feedback
- During emergencies, ensure proper consultation with communities (not just leaders) prior to the establishment of treatment structures, including ORPs, to ensure there is buy-in and consensus around where the structures are located in the community and what services they will provide
- Establish community feedback mechanisms at CTCs and ORPs to gather feedback on patient care and treatment
- Collect social science data (through focus group discussions, key informant interviews, community meetings, etc.) to better understand social and behavioural drivers which may lead to delayed health-seeking behaviour, fear of treatments, negative perceptions towards care in clinics or vaccine hesitancy. Use this data to adjust social and behaviour change interventions to promote uptake of healthier practices, particularly around seeking treatment early. This could include, for example, working with the other pillars to ensure transport for early referrals, food provision at facility level and that family members can visit patients
- Understand from social science data which groups of people might be at higher risk – they may be groups you do not expect, such as fishermen or casual/seasonal labourers. Triangulate this information with available epidemiological data and other relevant data, for example through an integrated outbreak analytics (IOA) approach.[10] It is important to develop targeted interventions to support these groups based on their specific vulnerabilities
- Regularly share and discuss community feedback data with community representatives, community health workers, health staff in CTCs or ORPs, as well as pillar leads to agree on actions that should be taken and/or adjusted

- Ensure the community is kept well informed about actions that have been taken to strengthen access to treatment based on their feedback
- Share two-way information on the location of treatment centres as well as services which have been put in place to respond to the outbreak
- Conduct community demonstrations on how to prepare and use ORS. Where packaged ORS is not available, and with the guidance of the ministry of health, seek local knowledge to find alternatives which are viable, known, and effective e.g., homemade sugar-salt solution, rice water
- Collaborate with local media to promote knowledge and behaviours related to identifying cholera symptoms and seeking treatment, and respond to rumours/ misinformation which may negatively impact health-seeking behaviours or perceptions
- Train and work with trusted community health workers, representatives, and leaders to act as 'go-to people' on cholera in the community. Encourage these 'go-to people' to refer suspected cases to ORPs and CTCs
- Ensure a space is dedicated for the reception of family members and visitors to the CTCs and cholera treatment units (CTUs)
- Conduct circuit walks or 'go-and-see' visits of the facilities with clinical staff, relevant authorities, and influential community members to explain how patients are cared for and answer any questions

9. *Commonly practised behaviours at household and community level that impact child survival, growth and development or the causes of morbidity (illness/disease) and mortality (death) in children. See* https://www.unicef.org/uganda/all-key-family-care-practices
10. *For more information about IOA, watch* this video

- Conduct trust-building activities with local health care providers and respected members of the community – this might include 'go-and-see' visits to CTCs or question-and-answer meetings with clinic staff, for example
- Develop job aids and question-and-answer sheets for community health workers, volunteers, and community leaders so they can answer questions and concerns from the community
- Ensure community representatives and/or volunteers have a clear role to play at CTCs and ORPs so that they can reinforce communication and build positive working relationships between health staff, patients, and their families

Pillar 3: Use of oral cholera vaccine (OCV)

Strategic objectives: To implement preventive OCV campaigns in selected cholera PAMIs and reach high coverage of target populations

To implement reactive OCV campaigns (when appropriate) in case of emergency and reach a high coverage of target population

OCVs should be used in selected cholera PAMIs for planned campaigns and during cholera outbreaks; it is a key tool in ending transmission. The vaccines should always be used in conjunction with other cholera prevention and control strategies (e.g., case management, emergency WASH). Based on available evidence on short-term protection conferred by OCV, a single-dose strategy can be considered in the context of a shortage of vaccines. Community engagement is crucial to improve confidence in OCV, as misunderstandings about OCV persist, such as confusion with COVID-19 vaccines. Community engagement will be fundamental to increase trust, promote honest and transparent information, and act on people's fears, doubts, and concerns. Before OCV campaigns start, socio-cultural assessments to identify social norms, economic, and other barriers to immunization should be a minimum action. Community engagement principles and activities must strongly underpin OCV campaigns.

Community engagement outcome: Individual behaviours support the uptake of OCV and those who are eligible actively seek vaccination. Below are some suggested actions on how to do this:

- Involve community groups and leaders early in the planning of OCV campaigns. Ensure two-way communication about why vaccination is important, who is eligible for OCV, in which locations it will be administered, which days and times are convenient for target groups, why two doses provide longer protection and, how to properly take the full vial. This requires special attention to avoid confusion with oral polio vaccine (usually two drops) and ensure communities are effectively taking OCV. In this case, trusted community members or community health workers can be effective role models to demonstrate how to take the vaccine in front of their peers
- Identify sections of the community that may be marginalized, at higher risk or difficult to reach, and ensure that their specific needs and capacities are included in OCV plans. For example, mothers are more routinely in contact with health services and thus often receive better and more targeted health information than adult males and youth. Collaborate with 'go-to people' for ORP (see Pillar 2 guidance) to act as role models for encouraging vaccination. For example, ask them to get vaccinated publicly or talk about their vaccination experience during community meetings or question-and-answer sessions, and work with them to plan activities and test key messages
- Conduct rapid social science research (e.g., knowledge, attitudes, and practices surveys (KAP), focus group discussions, behaviour and social drivers studies) on attitudes towards OCV to understand potential barriers (social, cultural, practical or economic), which may hinder some groups from accessing the vaccine and enablers that may support uptake
- Ensure this data informs OCV campaign planning and implementation
- Rapid research is also important to understand people's perceptions of administering OCV (e.g., to understand risks of tensions between communities who receive the OCV and communities in neighbouring districts who are not eligible to receive the OCV but perceive themselves at risk), as this may lead to discontent or frustrations especially where tensions already exist
- Co-develop, test, and disseminate, through trusted and accessible two-way communication channels, key messages on OCV characteristics, campaign dates, times, and locations, eligibility, and delivery strategies, including the reason for single-dose strategy when applicable, ensuring opportunities for open dialogue
- Develop community engagement micro-plans and materials that cover OCV characteristics, address vaccine hesitancy, and the timing and locations of campaigns
- Ensure that there is a trusted and locally accessible community feedback mechanism in place (with both reactive and proactive channels) to listen to and act on questions, suggestions, observations, perceptions, and beliefs about the OCV
- Share and discuss the feedback analysis in key coordination platforms before, during, and after campaigns to take appropriate and timely action to address issues and maintain trust

- Continue to engage communities on the need to maintain other key preventive measures before, during, and after outbreaks (handwashing, improved sanitation practices, safe food and water preparation etc.). Emphasize these measures both during and after an OCV programme. Appreciate the need for localized approaches in rural versus urban contexts and adapt accordingly. Vaccination programmes in urban settings, for example, may require more house-to-house communication approaches, and vaccinations may need to take place during weekends with early start and late finishing times and at fixed sites
- Work with local media to understand and respond to misinformation and rumours regarding the OCV campaign or vaccine hesitancy more broadly, for example by organizing media question-and-answer sessions with vaccination specialists
- Align community engagement activities with the stages of vaccination roll out so that people who are eligible to receive vaccinations understand where, when, and how they can access them (and to ensure those who are not eligible understand why). For example, explain that the vaccine is safe for pregnant and lactating women as there are many reluctances observed.

Remember: Communities should not be labelled 'hesitant' or 'resistant' simply for asking valid questions or sharing genuine concern about the efficacy, safety, or legitimacy of the vaccine (or any other intervention relating to cholera elimination). The burden of responsibility to build trust around the vaccine rollout lies with organizations involved in the OCV campaign, and not on communities to simply accept the vaccine. Communicate this message widely to staff and organizations supporting the OCV pillar, as well as other pillars working on behaviour change.

Pillar 4: Water, sanitation and hygiene (WASH)

Strategic objective: To increase (to 80%) the portion of the population with access to basic plus[11] water and basic sanitation services and hygiene promotion in all cholera PAMIs.

WASH is the key intervention for long-term cholera control and elimination because safe water and adequate sanitation are the cornerstones of cholera prevention. In addition, most behaviours that affect the spread and/or elimination of cholera are WASH-related.

Community engagement outcome: The self-efficacy of individuals, particularly the most vulnerable or at risk, is strengthened to support uptake of locally led actions to identify risks, reduce open defecation, advocate for improved WASH in their community, and improve rates of handwashing, safe water storage and usage, food safety, and environmental sanitation. This section suggests community engagement interventions that countries can consider when preparing, implementing and evaluating activities within the WASH pillar:

- Use participatory planning approaches to conduct community-led risk assessments and develop action plans (with all pillars) on upgrading, rehabilitating, or constructing new water sources, sanitation and wastewater infrastructure (ensuring they are accessible to women, girls and people living with disabilities), and community clean-up campaigns to improve drainage, handwashing, and sanitation facilities at community and household level, etc.
- Establish or support existing community networks, groups, and committees (e.g., WASH committees, food and water vendors) to design, implement, monitor, and evaluate the success of agreed community-led action plans
- Regularly ask the wider community about their opinion of how the committee is performing and take steps to improve accountability as needed
- Conduct social science research on open defecation prevalence, handwashing practices, food safety, and water usage. Use this evidence, and community consultations, to design social and behaviour change plans to drive safer water and sanitation practices (e.g., water treatment methods and storage, excreta disposal/toilet construction, and handwashing at critical times)
- Ensure that there is a trusted and locally accessible community feedback mechanism in place (with both reactive and proactive channels) to listen to and act on questions, suggestions, observations, perceptions, and beliefs about WASH interventions
- Ensure strong collaboration with existing hygiene promotion actors or working groups to understand effective ways of working
- Support evidence-based advocacy objectives by generating community feedback and social science research, as improving WASH infrastructure often requires large-scale investments and longer-term planning by governments, donors, and development partners

11. Access to basic plus water is defined as an improved facility within 30 minutes (round trip collection time) and low-cost water treatment to ensure safety

In 2020, volunteers from the Red Cross of the Democratic Republic of the Congo - trained in epidemic preparedness through the Community Epidemic and Pandemic Preparedness Programme (CP3) - helped prevent a deadly cholera outbreak from spreading further and claiming more lives. © Pitshou Budiongo/IFRC

Strategic objective: To further engage communities in cholera prevention and control to stop community level transmission.

Communities, particularly vulnerable and marginalized groups, should be empowered to take action and actively participate in prevention, preparedness, readiness, and response for cholera outbreaks. The community engagement pillar collaborates across all pillars to enable people to act as equal partners in any cholera preparedness and response actions. Community engagement ensures communities actively participate in decision making when designing and delivering cholera-related actions, based on their own needs and on their own terms. When communities are engaged, the adoption of protective behaviours, particularly relating to water handling, handwashing, food hygiene, sanitation, funerals, patient treatment, and health seeking, can be more effective, efficient and inclusive. At the same time, it can reduce risky behaviours. Engagement can be done through activities that span health promotion, social mobilization, social and behavioural science, or risk communication etc.

Before implementing any community-based activities under the NCP, the following three steps should be considered as the building blocks for successful community engagement strategies:

A. Contextual analysis

Community engagement starts with gaining or deepening existing understanding of the socio-economic context, cultural and traditional beliefs, power dynamics, and behavioural and social drivers in a community. This contextual understanding will inform how community engagement actors build and strengthen relationships with affected communities and those at risk.

B. Building rapport

Engaging with a community at the start of an intervention involves approaching communities through their leadership.[12] The leaders should authorize and facilitate bringing the whole community together to discuss issues of water consumption and sanitation, and how response actors could support the community to implement solutions to overcome risks and barriers identified. This phase is particularly important to gain social licence to act and build trust between gatekeepers and response actors, particularly as the subject is often taboo.

C. Community stakeholder mapping

After this initial engagement, there is a need to do a stakeholder mapping of influential and trusted people who already play a role in issues related to cholera (e.g., those with health care responsibilities, water management committees, religious leaders who supervise burials). This mapping can identify vulnerable, marginalized, or at-risk groups who need to be engaged. Finally, it can provide evidence of existing community-based initiatives, such as NGO-run programmes, which may contribute to overall cholera elimination plans.

An effective cross-cutting community engagement strategy will therefore work in partnership with these influential community members to deliver an action plan. It will tackle identified risks and barriers in a way which respects the specific contexts and realities of that community. This helps to ensure that decisions are taken with the understanding and agreement of the community, according to their perception of their needs, and not as a result of ideas and solutions imposed on them by outsiders.

The overarching objectives of the community engagement pillar are to:

- Identify and engage trusted community representatives, networks and influencers, including from at-risk and vulnerable groups. It should ensure their meaningful participation in decision making during the design, implementation, monitoring, and evaluation of activities for cholera preparedness, prevention, and response. It should operate across all pillars and for additional topics, including safe food preparation, burials, and health care at home
- Understand community beliefs, local knowledge, cultural values, and social norms associated with preventive and health-seeking behaviours related to cholera and the official response, and enable community-led solutions to address identified risks and barriers
- Listen to, and act on, the knowledge, suggestions, questions, practices, and observations of community members in order to build trust and ensure that local insights are driving decision making
- Work collaboratively with community leaders, networks, and local influencers to reduce and mitigate stigma of those who have survived cholera, or whose family members have been affected by it
- Ensure that community members have access to trustworthy, reliable, and actionable information, in whatever language they speak, on how to protect themselves and their loved ones

For the community engagement pillar to achieve these objectives, this work must be integrated into the work plans and strategies of the other pillars. Community engagement leads should regularly look for ways to contribute to achieving the goals of the surveillance and reporting, case management, OCV, and WASH pillars so that this work is not siloed.

12. *Leadership is a broad term that can encompass faith leaders, women and youth leaders, teachers, local healers, or community health workers – those with respect and trust in their community.*

Community engagement tools for the development and implementation phase of NCPs

- Surveillance and reporting
  - ↘ Public Health Surveillance for Cholera, GTFCC Interim Guidance, February 2023
  - ↘ Social Science Lessons for Community-Based Surveillance
  - ↘ Community-Based Surveillance Guiding Principles

- Case Management
  - ↘ Q&A for Volunteers (example)

- OCV
  - ↘ Demand for Health Services: A Human-Centred Field Guide
  - ↘ Behaviour and Social Drivers framework

- WASH
  - ↘ Compendium of Hygiene Promotion in Emergencies
  - ↘ Community Approaches to Total Sanitation
  - ↘ Community-Led Total Sanitation

- Cross-cutting
  - ↘ Cholera Question Bank (community level and responders)
  - ↘ Community Feedback Tools
  - ↘ Community Feedback Qualitative Coding Framework for Cholera
  - ↘ Social Science Lessons Learned from Cholera Epidemics
  - ↘ Building a Social and Behaviour Change Strategy
  - ↘ Behaviour Change Guidance
  - ↘ Implementation and Monitoring Resources for Cholera
  - ↘ Posters for the Prevention and Control of Cholera
  - ↘ Community Messages Bank
  - ↘ Key messages for health education
  - ↘ The story of cholera

Community engagement sessions for Cholera in Malawi - Katola. © IFRC

2.3 Phase 4: Monitoring and reporting in NCPs[13]

A continual monitoring and evaluation process should be put in place to measure progress of the implementation of the NCP. There should be a clear monitoring and evaluation plan with a set of indicators tailored to the activities in the operational plan. Below is a list of suggested community engagement indicators which can be integrated into the monitoring and evaluation plans for each pillar of the NCP. For more information on the definition, purpose, disaggregation level, computation, frequency, data sources, and limitations of these indicators, please see the list of tools in the box at the end of this section.

Indicators marked with an * could be adapted and integrated across all the pillars' monitoring and evaluation frameworks.

Pillar 1: Surveillance and reporting

- Completeness of CBS reporting
  - ↘ Indicator: % of active CBS volunteers that reported cholera surveillance data to local health authorities (including zero reporting) in a given week

- Timeliness of CBS reporting
  - ↘ Indicator: % of active CBS volunteers that reported cholera surveillance data to health authorities in a given week by the applicable deadline

Pillar 2: Case management

- Community engagement
  - ↘ Indicator: % of targeted community groups that promote public health recommendations to stop transmission of cholera

- Participation in response management*
  - ↘ Indicator: % of targeted areas where community members actively participate in the public health decision-making processes

Pillar 3: Use of oral cholera vaccine

- Community participation*
  - ↘ Indicator: % of targeted areas where community members actively participate in the OCV campaign plan
  - ↘ Indicator: % of individuals who feel satisfied with their level of participation in planning and roll out of the OCV campaign

- Observance of social norms for OCV
  - ↘ Indicator: % of the population who expect most people in their community to get an OCV if it is available and accessible to them

13. *See* GTFCC Interim Guiding Document to Support Development of NCPs *pp. 37–43*

"I heard about the outbreak and wanted to help since people are dying of cholera. In my community everybody knows me. So now I will tell them about cholera, what the symptoms are and tell them to boil the water, and wash their hands reguarly.
I think I have spoken to over 800 people and about 30 of them suspectedly had cholera. I was happy to help them."

In a response to the cholera outbreak in Zimbabwe, volunteers visit communities to spread information on the disease and how to protect yourself. One of them is Elizabeth. © Fleur Verwer/IFRCThe door to door visits are a very importent part of the cholera outbreak response.© Fleur Verwer/IFRC

Pillar 4: Water, sanitation, and hygiene (WASH)

- Community-led action*
  - Indicator: % of targeted areas where communities have been supported to establish and implement community-led action plans for improving WASH infrastructure
- Accountability to the community*
  - Indicator: % of individuals who feel their feedback on WASH infrastructure and services is listened to and acted on by response partners
- Knowledge of risk information on cholera
  - Indicator: % of individuals who know how to protect themselves from cholera

Pillar 5: Community engagement

- Community feedback
  - Indicator: % of individuals who know how to provide feedback
  - Indicator: % of individuals who feel their feedback is listened to and acted on by response partners
  - Indicator: % of targeted areas where changes have been made to cholera response plans based on community feedback
  - Indicator: % of individuals who would feel safe using community feedback channels to report any inappropriate behaviour by response partner staff or volunteers
  - Community engagement
  - Indicator: % of targeted areas where community dialogues on public health are regularly taking place
  - Indicator: % of individuals who feel the cholera activities implemented in their community helped to address or mitigate stigma of cholera patients and their families
- Trust in the response
  - Indicator: % of individuals who feel response partners treated them with respect
- Community participation
  - % of individuals who felt able to participate in decisions about how the cholera response was designed and delivered
  - % of individuals who feel the main risks or challenges they faced from the cholera outbreak were addressed by the cholera activities implemented in their community
- Coordination mechanism
  - Indicator: A community engagement coordination mechanism is active and formally implemented
  - Indicator: % of targeted areas where community members actively participate in the public health decision-making processes

Community engagement tools for the monitoring and evaluation phase of NCPs

- Community engagement indicator guidance
  - Risk Communication and Community Engagement Indicator Guidance for COVID-19 (can be adapted for cholera response)
  - Measuring Results in Social and Behaviour Change Ccommunication Programming
- GTFCC cross-pillar monitoring and evaluation guidance
  - GTFCC Cholera Roadmap Research Agenda

Anedy is a volunteer for the Zambia red cross. Now she goes door to door to spread information on the cholera outbreak in Zambia. One of the hard affected areas is Kanyama, Lusaka. © Fleur Verwer/IFRC

ANNEXES

Annex 1: Community engagement planning template

There is no mandatory format for an NCP, as this is up to the country team to decide. However, all NCPs should include the following key components:

- Overview/introduction (e.g., epidemiological history of cholera in the country, background information, risk factors, demographic information, and current situation)
- Cholera elimination strategy (e.g., overall goal and targets, political commitment, and country coordination structure)
- Situational analysis (cholera PAMIs and capacity assessment/SWOT analysis per pillar)
- Implementation plans per pillar (including strategic objectives, targets, and key activities)
- Monitoring and evaluation (key indicators per pillar)

As community engagement should be typically one of the five pillars of an NCP, there will be specific sections where cross-pillar community engagement work can be captured. Community engagement activities which are aligned to a specific pillar are best captured in that pillar's plan, instead of under the community engagement pillar. This helps to ensure that community engagement work remains integrated and aligned to the goals and objectives of the other pillars.

Below is a planning template, with guiding questions, that can help the community engagement pillar to ensure that cross-cutting activities that are not reflected under other pillars work plans are integrated into each phase of NCP creation and execution:

COMMUNITY ENGAGEMENT (CE) PLANNING TEMPLATE FOR NCPS							
NCP activity	**CE outputs**	**Who**	**Resources**	**Timeline**	**Enablers**	**Barriers**	**Solutions/ mitigations**
	What are the key outputs expected from the CE pillar to support this NCP activity?	*Which colleagues/ partners can lead this work? Who else needs to be involved?*	*What level of funding, staff time commitments, and materials are required to implement the activities?*	*When will these activities be implemented by, and does this align with the overall NCP deadline for this activity?*	*What enablers could help implement the activity?*	*What barriers might prevent the activity from being implemented?*	*What solutions could overcome the barriers?*
PHASE 1: INCEPTION OF NCP							
Capacity assessment	A SWOT analysis for CE pillar is completed CE capacity is integrated into other pillars' assessments	*E.g., all partners working under the CE pillar* *E.g., CE focal point for Surveillance, Health system strengthening, OCV and WASH*	*E.g., venue for CE capacity assessment workshop*	*E.g., 1-2 days for workshop; 1 week for feedback on draft assessment; 1 week for integration of CE into other pillars' assessments*	*E.g., CE working group for health outbreaks already functional at national level*	*E.g., security situation preventing physical workshop with partners*	*E.g., remote workshop sessions to be held*
Stakeholder analysis	CE stakeholder mapping (e.g., 4Ws) completed with identified CE focal points for collaboration with other pillars						
Identification of coordination mechanisms	CE working group ToR is updated/ finalized						

PHASE 2: DEVELOPMENT AND PHASE 3 : IMPLEMENTATION OF NCP							
Surveillance and reporting	CE activities specific to surveillance and reporting are integrated						
Case Management	CE activities specific to health care system strengthening are integrated						
Use of oral cholera vaccine	CE activities specific to use of OCV are integrated						
WASH	CE activities specific to WASH are integrated						
Community engagement	Cross-cutting CE activities not specific to a pillar are planned and budgeted for						
PHASE 4: MONITORING AND REPORTING OF NCP							
Surveillance and reporting	CE indicators specific to surveillance and reporting are integrated						
Health care system strengthening	CE indicators specific to health care system strengthening are integrated						
Use of oral cholera vaccine	CE indicators specific to use of OCV are integrated						
WASH	CE indicators specific to WASH are integrated						
Community engagement	Cross-cutting CE indicators not specific to a pillar are planned and budgeted for						


Republic of Zambia
Ministry of Health
OCV - VACCINATION CARD
Oral Cholera Vaccine