February 2023

Presentation: During February 2023, 130 Cholera Perception Surveys were collected in Nippes department by Haitian Red Cross volunteers. Topics addressed include demographics, water, sanitation and hygiene, economic impact, mental health, and community participation and accountability.

This report provides an indicative input for guiding strategies aimed at building trust in vaccination processes, in this case, against cholera.

Methodology: The Haiti Cholera Perception Survey 2023 was designed based on existing quantitative surveys questionnaires conducted by humanitarian actors in cholera-affected settings worldwide. Sources include publicly available question banks from: Collective Service, IFRC, USAID, WHO and UNICEF.

Local contextual factors were analysed in the sample design. As a result, a non-probability convenience sampling design was applied on communities previously targeted by the Haitian Red Cross Society.

Indicative figures

130 Collected surveys
1 Visited Department

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Restrictions: Figures presented in this document are not statistically representative, cannot be extrapolated, and do not allow for prospective exercises. Their use is indicative on general topics and contextual matters.

Disclaimer: This report does not imply the opinion, concept, data, or position of Haitian Red Cross (HRC) or IFRC. Please, consider this report as an internal document, and an indicative instrument of the opinion of a small portion of the population which may change rapidly. Please, do not share it externally.
Main quantitative findings

Demographics

Following the trend observed in the other departments surveyed (Sud, and Grand Anse), women exhibited higher participation (63.85%) compared to that recorded for men (36.15%).

Sample design, and socioeconomic or cultural dynamics may have impacted this concentration.

In terms of age, women (left graph) had homogeneous distribution between ranges with a higher point in the 40-49 one (26.71%). Men (right graph) showed marked concentrations and its peak in the 30-39 range (34.04%).

Connectivity

Women with no mobile phones represent 18.46% of participants, and of these, 75% are over 40 years old; while Non-mobile phone-owning men account for 9.2%. Furthermore, 57.7% of respondents lack any internet connection (Women 36.9% - Men 20.8%)

Of the respondents who do not take action to improve the safety of drinking water, or who did not answer this question: i) 10% are women with no mobile phones, and 0.8% are men; and ii) 17.7% lack internet access (Women: 14.62% - Men: 3.08%).

These findings are essential in defining key messages, their media channel, and the differential approaches to be considered. It encourages the use of communication channels apart from mobile phones and internet.

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WASH (safety, sources, cooking, and handwashing water)

81.58% of respondents take actions to improve the safety of their drinking water. The remaining 17.54% who do not take such actions is made up of 12.28% women (mostly concentrated between 30 and 49 years) and 5.26% men.

Overall, Aquatabs and chlorine solution are the main measures taken. Nevertheless, in women aged 30-49 years, Aquatabs and boiling the water remain the primary measures.

The proportion of men (84.44%) who care for the safety of their drinking water, is greater than women (79.71%). This finding requires further research, and the alignment of communication strategies, channels, and key messages.

Main drinking water sources:

i) River, stream, lake, and irrigation canals
ii) Spring water
iii) Rainwater
iv) Public piped water

Sources vary by gender, while men emphasise spring water and public piped water, women list river, stream, lake and irrigation canals, and rainwater as their main source.

Age range also set differences among women. 30 to 49 women point at river, stream, lake, and irrigation canals as their main source, while 18 to 29 women list public piped water as theirs.

Respondents list as main sources for cooking and handwashing rainwater, followed by river/stream/lake/irrigation canal. This list remains in the overall figures, and for women aged 30-49, but varies for women aged 18-29 (Spring water, unprotected; Rainwater) and men (Man: Rainwater; Spring water).

Women aged 18-29 once again exhibit distinct behaviour compared to women aged 30-49, as do men. Recommendations include leveraging in CEA approach the statistical heterogeneity detected; and jointly analysing statistics with field staff.

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50% of participants have heard about the cholera vaccine, while 48.44% have not, and 1.56% do not know how to respond. Of those who have heard about the cholera vaccine:

i) 6.35% have received it, and 92.06% have never received it.

ii) 54.84% would receive it when available and recommended, 35.48% would refuse it and 8.06% do not know.

iii) 85.71% have a low level of trust, and 14.28% trust in it.

Those who have not heard of it were not asked about their vaccination record or their trust in it. However, it was found that when it is available and recommended 43.55% would receive it, 25.81% would refuse it and 29.03% do not know yet. Main refusal determinants to a potential vaccination can be grouped into:

i) Fear of the pain caused by syringes and needles (although the vaccine is not administered by injection but orally).

ii) Distrust of the vaccine due to lack of knowledge of how it works, what it consists of and/or its side effects.

When participants were asked if they would give the cholera vaccine to their children when it is available and recommended, 44.62% would, 26.92% would refuse it, 20.77% do not know, and 6.62% preferred not to answer. The main reasons for refusal are:

i) They do not trust the usefulness and safety of the vaccine; and

ii) They consider that it does not improve their children’s health and, on the contrary, could make them sick.

It is encouraged that cholera vaccination messages address the determinants of refusal or lack of knowledge in participants. The following examples of questions may guide and facilitate this task:

- What is the cholera vaccine, and is it given by a shot or by oral drops?
- What good does it do for me or my children to be vaccinated against cholera?
- Does the cholera vaccine prevent me or my children from getting cholera, or is it focused on reducing the severity and intensity of symptoms?
- Does the cholera vaccine have any side effects for me or my children?
Vaccination against cholera (rumours)

35.77% of participants indicate hearing misinformation, rumours, fears, and stories about the cholera vaccine in their communities. This is a comparatively high percentage given that only 50% of respondents have heard of the cholera vaccine.

Most reported misinformation or rumours are related to spiritual or religious rituals and practices which form part of the local belief systems.

This could not only foster stigmatisation against religious communities, but also make it difficult to address vaccine-related rumours given the elevated sensitivity associated with spiritual and religious matters, particularly in a context of high humanitarian and multifactorial complexity.

Socioeconomic effects of cholera cases detected

61.72% indicated that recent cholera case detection has affected their economic situation, as they have:

i) seen their income reduced.
ii) perceived an increase in the cost of living.

When asked whether the recent detection of cholera cases has affected their ability to meet their basic needs, 42.64% do not know and 15.50% do not respond (Total: 58.14%). While 24.81% said it had worsened their ability to meet their basic needs.
Cholera Perception Survey
BHA Building Trust – Haiti
Interim report - (June 2023)

It is highly likely that these concentrations genuinely indicate that participants are unable to determine whether or not the recent detection of cholera cases has been a determinant factor affecting their ability to meet their basic needs, because:

Cholera adds to other high-impact factors that also influence both the ability of communities to meet their basic needs and the local socio-economic and humanitarian context.

The language and comprehension of the questionnaire was validated through pilot testing prior to its application in the field.

It is recommended that, when designing CEA strategies and media channels, various relevant socio-economic and cultural factors, as well as local humanitarian access and physical security conditions, be considered.

Mental health and cholera cases detected

While only 29.69% of participants have access to mental health and emotional wellbeing services (Women: 25.93% - Men 36.17%), 67.97% indicated that cholera has affected their mental health and emotional wellbeing (Women: 65.43% - Men 72.34%).

Data indicate a remaining high demand for mental health and emotional wellbeing services associated with cholera, and other socio-economic and humanitarian aspects.

It is suggested to engage the internal capacities of the National Society (Health, Mental Health and Psychosocial Support; Protection, Gender and Inclusion; Livelihoods) in the analysis of this hypothesis, with the resulting evidence informing decision making on mental health and emotional wellbeing.

Contracting cholera is the main concern of participants, followed by the risk of losing a loved one to the disease. Inability to meet basic needs is the third one, being higher in women (24.21%) than men (10.39%). For participants over 60 years of age of both genders, the major concern is losing a loved one to cholera.

Mapping these concerns may be relevant in designing CEA strategies aimed at building trust in the cholera vaccine.
Community Engagement and Accountability (CEA)

Participants reported receiving information on cholera mainly through: i) Radio; ii) the Ministry of Health; and iii) Community health workers; and prefer to receive this information in Haitian Creole (97.69%) or in French and Haitian Creole (2.31%).

91.34% found the information received useful, and 88.38% was satisfied at a level with it (Very satisfied: 36.80% - Satisfied: 52%).

In asking participants about the most trusted sources of information, the following were highlighted: i) the Ministry of Health; ii) radio; and iii) healthcare workers at the community and hospital level.

Furthermore, the level of trust in specific actors was 80.77% for health workers (Strongly trust: 43.85% - Trust: 36.92%), followed by religious leaders with 70% (Strongly trust: 28.46% - Trust: 41.54%), humanitarian workers with 67.69% (Strongly trust: 36.92% - Trust: 30.77%), and scientific staff with 63.85% (Strongly trust: 30.77% - Trust: 33.08%).

When designing Community Engagement and Accountability and key messaging strategies, it is recommended to include radio and community media that incorporate health or scientific staff communicating in Haitian Creole.

Community Engagement and Accountability (CEA)

8.46% of participants are familiar with Haiti Red Cross Society feedback mechanisms (Women: 3.08% - Men: 5.38%).

To increase this rate, it is recommended to coordinate with the NS leadership, technical areas such as Security, Protection, Gender and Inclusion (PGI), Mental Health and Psychosocial Support (MHPSS), among others. Also, it is important the promotion of the National Society’s feedback mechanisms during the transmission of key messages to the communities.

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55.38% of respondents have received humanitarian assistance during various emergencies and from multiple actors, and a 39.23% acknowledged that such assistance has not met their most important needs, while 11.54% stated that it met their most urgent needs during times of emergency.

41.53% have felt consulted during the design of the emergency assistance they receive, in contrast to 30% of the respondents.

66.92% consider that they do not have an influence on the decisions made in their community regarding cholera. However, 31.54% say they do have an impact on these decisions, which is a relatively high level given the multiplicity of factors affecting local communities and the complexity of humanitarian setting.

This represents an opportunity for the Haitian Red Cross to continue to maintain its leadership by encouraging other humanitarian actors working in the country to engage communities when designing emergency programmes and assistance, and to demonstrate by example how to operationally apply the voices of communities.

CEA recommendations with operational focus

Engaging the National Society’s internal capacities (Health, MHPSS, PGI, Livelihoods among others) with the objective of delivering the same unified message.

Be culturally sensitive, respect the belief systems of local communities, and include differential approaches (according to age, gender, vulnerabilities among others).
Deliver messages through non-conventional means, other than mobile phones. Community radio, community and family networks, and the posting of information pieces at points of community concentration (markets, water collection points, frequently used footpaths, public transport facilities, schools, health facilities, etc.) are recommended.

As suggested by the community, deliver messages in Haitian Creole through health or scientific staff, in a style familiar to communities.

Conduct prior an analysis of local humanitarian, socio-economic, cultural, and physical security conditions. This may favour the work without transgressing cultural, social, or belief systems and local community dynamics.

Align key messages with:

**Determinants of vaccine hesitancy** [fear of syringes, and lack of knowledge about the vaccine: (i) delivery; (ii) function; (iii) and side effects in adults and children]

**Participant’s main concerns** (catching cholera, losing a loved one to the disease, and the inability to meet basic needs)

Men (84.44%) taking care of the safety of their drinking water was higher than Women (79.71%). This finding requires further qualitative research at the local level to more efficiently align communication strategies, channels and key messages.

Women aged 30-49 exhibited behaviours that differed from the trend shown by other participants, and it is recommended to analyse these statistics qualitative and with technical and field staff to target key messages more effectively.
Conduct local research on the relationship between cholera and/or other health variables, livelihoods, mental health, and emotional well-being.

Promote community feedback mechanisms on a continuous basis and build capacity within the National Society to monitor and operationalise these inputs.

Monitor the impact of these recommendations. This includes defining measurable variables, establishing a baseline, setting a target to be achieved, designing an implementation strategy, periodically measuring progress and, if necessary, adjusting during implementation. If necessary, count on technical support from IFRC's regional CEA team for the development of these tools.

If you have any questions, please contact:

Roméo Nganha - romeo.nganha@ifrc.org
Delegate - Community Engagement and Accountability (CEA)
Haiti Country Office

Carla Guananga - carla.guananga@ifrc.org
Senior Officer, Community Engagement and Accountability (CEA)
Americas Region. Health, Disaster, Climate & Crisis (HDCC)

Virginia Laino - virginia.laino@ifrc.org
Regional Community Engagement and Accountability (CEA) Strategic Lead
Americas Region. Health, Disaster, Climate & Crisis (HDCC)

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