Democratic Republic of Congo (DRC)

Community Epidemic and Pandemic Preparedness Programme (CP3)

Qualitative KAP Survey Results

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Introduction

The Community Epidemic and Pandemic Preparedness Programme (CP3) strengthens the capacity of communities, Red Cross National Societies, and other partners to prevent, detect, and minimise the impact of epidemics. It is working with communities to provide basic information about the spread of diseases and how to prevent them, simple and effective systems to detect outbreaks, and communication mechanisms to ensure timely information sharing.

As part of the Monitoring and Evaluation (M&E) Framework, a mid-line Knowledge, Attitudes and Practices (KAP) survey was conducted to generate evidence, measure changes and identify gaps to communities' knowledge, attitudes and practices about epidemic diseases. The mid-line data collection process included household surveys, key informant interviews (KIIs) and focus group discussions (FGDs). The results of the quantitative household survey can be found on the IFRC GO – Democratic Republic of Congo dashboard. This report summarizes the qualitative analysis of the KIIs and FGDs. These are compared with the results of the quantitative household survey.

Method

The KAP survey was conducted in August 2023 in the Democratic Republic of Congo (DRC) applying a mixed methods (qualitative and quantitative) approach to gather data. The qualitative methods applied a questionnaire of open-ended questions with individuals through KIIs and small groups of stakeholders through FGDs. The same thirteen questions were applied to both KIIs and FGDs (see Annex 1). However, many of the questions had follow-up questions that were applied differently between the KIIs and FGDs. Data was analysed by sub-question, and as a result there are many responses that are categorized as "N/A" because there was no data for that specific question.

The questionnaire was carried out with 11 key informants and 5 focus group discussions (16 total interactions). The KIIs and FGDs were held across 13 health areas within 5 health zones, in 3 territories within 2 provinces (see Table 1).

Table 1: Geographical distribution of key informant interviews and focus group discussions

Province	Territory	Health zone	Health Area	Number of KIIs	Number of FGDs
Kinshasa	Maluku	Maluku 1	Kimpoko	1	
			Maluku	1	
			Monaco	1	
	Ngaliema	Binza Meteo	Djelo Binza	1	
			Lubudi	1	
			Binza Meteo		2
Kongo Central	Songololo	Nsona Pangu	Lufu Nzola	1	1
			Songololo	1	1
			Kisonga	1	
			Lombe	1	
		Kimpese	Kiasungua	1	
			Kilueka		1
	Kimpese	Yanga Dia Songa	Ndembo	1	
			Total	**11**	**5**

KIIs were held with people of varying roles in the district (see Table 2).

Table 2: Role and gender of key informants

Role	Number of KIIs	Gender
Area Assistant Chief	1	Male
District Head	2	Male
Health, education executives	1	Male
Religious leader	1	Male
Community leader	3	N/A
Teacher	1	N/A
Nurse	1	N/A
Unspecified role	1	Male

Focus group sessions were held with three types of groups (see Table 3).

Table 3: Type and gender of participants in focus group discussions

Group	Number of FGDs	Gender
Mothers	2	Female
Motorcycle group	1	Male
Youth	2	Mixed

Six of the KII respondents were male, with data not available for the 5 others. Two FGDs were with all females, one FGD was with males only, and two were mixed gender.

Data was analysed from the KIIs and FGDs using qualitative methods. Common themes were identified, and the responses were tagged accordingly. Descriptive statistics were used to show the frequency of occurrence of the themes. The FGDs were counted as one respondent/entry, even though there were multiple people in a group. Responses were calculated as a percent of KIIs (N=11) and a percent of FGDs (N=5). Data was disaggregated mainly by the type of data source (KII or FGD) or by district, where relevant.

Engagement with Red Cross

The first question was about the respondents' frequency and type of engagement with the Red Cross. More of the key informants had frequent contact with Red Cross, mainly in engagement meetings (see Table 4). One of the focus groups had frequent engagement with the Red Cross.

"*We work a lot with Red Cross volunteers on a regular basis*." - FGD with males in Lufu Nzola.

Table 4: Frequency of engagement with the Red Cross

Frequency	Number of KIIs	Number of FGDs	Per cent of KIIs	Percent of FGDs
Often	6	1	55	20
Occasional	1	2	9	40
Rarely	1	0	9	0
No contact	2	2	18	40
N/A	1	0	9	0

Two of the focus groups described an irregular or occasional engagement with the Red Cross, participating in health information sessions or meetings.

> "*From time to time we see Red Cross volunteers coming to talk to us about diseases and protective measures and we see their presentations from time to time*." – FGD with women from Songololo.

Those with no contact mostly indicated that they are aware of Red Cross activities and the meetings that take place, but they do not participate. The FGDs respondents from Kiasungua noted that the lack of contact was because "*here there are no Red Cross meetings due to the lack of adherence of volunteers in Red Cross."* Similarly, a key informant who said there was rare contact said that "*engagement meetings rarely took place due to a lack of support from the population in the Red Cross*."

Comparing to the household surveys, the majority of respondents in Kinshasa (80 per cent) and Kongo Central (70 per cent) had contact with the Red Cross in the past 3 months, though the frequency was not recorded.

Immunization

Participants were asked about their opinion on immunization, with follow-up questions on whether vaccines prevent serious diseases and whether vaccines are dangerous to one's health. In the the quantitative household survey, the majority think vaccinations are good for children's health (98 per cent), prevent serious diseases (90 per cent), and are safe (98 per cent). There is good awareness that measles (85 per cent) and polio (80 per cent) can be prevented by immunizations, but there is a low awareness of other diseases preventable by immunizaitions. There was, however, a small percent of respondents that believe vaccines cause infertility (5 per cent), that they are dangerous to health (8 per cent), or are a trick of the Government (4 per cent). Despite the generally positive view of immunization, there was low uptake. Only 27 per cent of respondents from Kinshasa and 30 per cent from Kongo Central had an immunisation card for his/her child. There were also 17 per cent with missed vaccines in Kinshasa and 7 per cent of missed vaccines in Kongo Central.

The KIIs and FGDs confirmed the positive view of immunizations. The majority of the respondents were positive about immunizations (see Table 5). They stated that vaccination saves lives, prevents diseases, or that it was 'necessary' or 'a good thing' for the community. One focus group acknowledged that it was because of the Red Cross that they know vaccines are necessary. Only one key informant answered 'no' to vaccines saving lives.

> "*Yes, vaccines prevent children from contracting certain diseases and thereby save lives*." – KII respondent from Maluku.

> "*Yes, it's necessary for the community, and it's thanks to the Red Cross that we know about the different vaccinations*." – FGD with women from Ngaliema.

Table 5: Do vaccines prevent disease and save lives?

Response	Number of KIIs	Number of FGDs	Per cent of KIIs	Percent of FGDs
Yes	10	4	91	80
No	1	0	9	0
N/A	0	1	0	20

None of the respondents said that the vaccines were dangerous to health, although only the key informants answered the question directly. None of the opinions on immunizations given in the FGDs indicated any beliefs of danger or harm (see Table 6).

Table 6: Are vaccines dangerous to one's health?

Response	Number of KIIs	Number of FGDs	Per cent of KIIs	Percent of FGDs
No	11	0	100	0
N/A	0	5	0	100

KII and FGD respondents were also asked about the obstacles to implementing immunization programmes. The most common obstacles reported were religion, culture, and traditions (see Table 7). Similarly, other barriers for individuals to get vaccinated are rumours or a lack of awaress or knowledge about vaccines. One respondent mentioned specifically that it was due to insufficient sensitization by the Government. There were also obstacles hindering programmes to be carried out. These include insecurity and conflict, lack of finance and resources for mobilization, the poor state of the roads, as well as floods that further affect access to communities. One response from the FGDs recognized that they face no obstacles for the community because they do not contribute to implementing an immunization programme.

Table 7: Barriers to implementing immunization programmes

Response	Number of KIIs	Number of FGDs
Lack of awareness	5	1
Religion/culture	2	2
Insecurity	2	0
Lack of finances, resources	2	0
Rumours	1	1
Climate risks	1	0
Poor road network	1	0
Nothing	0	1
N/A	2	1

Ebola

Participants were asked about their knowledge of Ebola. In the household survey, there was a moderate level of awareness of Ebola, its symptoms, modes of transmission, and preventative measures. Respondents most commonly identified the symptoms of high fever (48 per cent), diarrhea (40 per cent) and vomiting (26 per cent), while only 13 per cent identified bleeding. The modes of transmission identified were shaking hands with an infected person (55 per cent) and eating bush meat (41 per cent), with fewer identifying sweat (17 per cent) or blood (7 per cent) of an infected person and burial practices (14 per cent). However, for preventative measures there was moderate awareness to not handle dead bodies (56 per cent) and vaccination (38 per cent), and to a lesser extent to wear protective equipment (26 per cent) and to not hunt bushmeat (16 per cent).

The key informants were asked about the signs of epidemic diseases and specifically whether they can identify three signs of Ebola. All of the key informants could identify three signs of Ebola. The three most common symptoms identified were diarrhoea, including bloody diarrhoea, bleeding from orifices, and fever (see Figure 7). Respondents also identified prolonged vomiting, soreness, weakness, and internal haemorrhaging.

Table 8: Symptoms of Ebola identified by key informants

Symptom	Number of KIIs
Diarrhoea	8
Bleeding	8
Fever	9
Vomit	2

Soreness	1
Red eyes	1
Weakness	1
Internal haemorrhaging	1

Respondents were also asked about the treatment and response to Ebola. The household survey respondents were asked about actions to be taken for a suspected Ebola case. The majority said they would call the health centre (77 per cent), call the Red Cross volunteer (45 per cent), or call the community health worker (26 per cent). Few said they would take them to the Ebola Treatment Centre (6 per cent).

Key informants and focus groups were asked if a person discharged from an Ebola Treatment Centre can come back to the community safely. There was a very high awareness among both KII and FGDs that the person can safely return to the community (see Table 9). There was understanding that the person has received treatment and has been cured or 'is no longer ill'. Even in areas where the respondents had not experienced Ebola or where there are no treatment centres, there was understanding that the person could return.

> "*Here in Lufu, we don't know any Ebola centers, but if the patient is discharged, it's because he's cured and has been given permission to leave*." – FGD of men in Songololo.

> "*We don't have any cases of Ebola yet, but if a person comes out of a treatment center, it means he is cured and can go home to his family*." – FGD of women in Songololo.

Table 9: Perception of a person's ability to return safely to the community from an Ebola Treatment Centre

Response	Number of KIIs	Number of FGDs	Per cent of KIIs	Percent of FGDs
Safe return	9	5	82	100
Stigma	1	0	9	0
N/A	1	0	9	0

Just one of the key informants recognized that the person would face stigma upon return.

> "*No, because the community will still believe that he is sick*." – KII from Maluku.

Safe and Dignified Burial

Participants were asked about safe and dignified burials (SDB), who should be involved and who should lead. In the household survey, respondents nearly equally identified the key decision makers of SDB as the authorities (40 per cent) and family (39 per cent), followed by health workers (16 er cent).

In the KIIs and FGDs there was a greater understanding that SDB should be led by someone who is qualified. The most common response key informants and focus groups was that it should be led by Red Cross volunteers who are trained in SDB (see Table 10). The second most common response was the government should be responsible. One key informant mentioned specifically the Epidemic Surveillance Directorate.

> *"If someone dies of an epidemic disease, the government must ensure the safety of others, and the burial arrangements must be made by the government*." – KII respondent from Ngaliema.

Table 10: Perception of who should lead safe and dignified burials

Lead	Number of KIIs	Number of FGDs	Per cent of KIIs	Percent of FGDs
Red Cross	5	2	45	40
Government	3	2	27	40
Health authorities/workers	1	1	9	20
Local authorities	1	0	9	0
Doesn't know	1	0	9	0

Other actors identified to lead were health authorities and doctors, as well as local authorities, such as the sanitation department.

In terms of who should be involved in SDB, respondents identified one or a combination of the same stakeholders (Red Cross, Government, local authorities). One key informant also mentioned that a member of the family should be involved and another mentioned a community committee.

Participants were also asked what the consequences would be if traditional burial practices are not followed. In the household survey, there were clearly negative effects of not following traditional burial practices. The majority said that it would cause sadness to the family (80 per cent), anxiety and worry (72 per cent), negative reactions from the community (57 per cent), economic difficulties (68 per cent), or land ownership issues (42 per cent). A smaller amount identified spiritual consequences relating to the deceased persons' soul (27 per cent) or related to God (16 per cent). However, nearly half also responded that there would be no consequences (43 per cent).

In the KIIs and FGDs, although there were negative consequences identified, there was a greater understanding of the potential for the transmission of the disease if burial is not carried out correctly (see Table 11).

> *"If we don't respect the rules, there's a risk of major contamination and the epidemic could spread rapidly."* – FGD of youth in Ngaliema.

> "*If the body is affected by an infectious disease and we don't respect traditional practices, the community will be saved from the disease, otherwise we'll all be contaminated*." – FGD of mothers in Songololo.

Table 11: Consequences of not following traditional burial practices

Consequence	Number of KIIs	Number of FGDs	Per cent of KIIs	Percent of FGDs
Transmission	7	4	64	80
Spiritual	1	0	9	0
Negative reaction	1	1	9	20
Conflict	1	0	9	0
Economic crisis	1	0	9	0
N/A	0	1	0	20

Those that identified negative consequences said there would be negative reactions (sadness and grief), that the deceased's spirit will not rest, possible border conflict, and economic crisis.

> *"If traditional burial practices are not respected, the community may react negatively, causing sadness and family grief, and leading to the spread of the epidemic*." – FGD of youth in Kiasungua.

Response to an Outbreak

The respondents were asked about reporting health risks. In the household surveys, respondents said they reported to Red Cross volunteers (34 per cent), health workers (23 per cent), community health assistants (11 per cent), or veterinary officers (10 per cent). However, half the respondents said they have never reported (50 per cent). Most said that some action was taken as a result of the health risk reporting, including an NGO took action (36 per cent), the community health worker took action (29 per cent), the local health facility or veterinary officer came (16 per cent). Few said that no response was taken (1 per cent) or didn't know (12 per cent).

The key informants and focus groups were asked what they would do if they saw the signs of a serious possible outbreak disease and specifically if they knew where to report a human epidemic disease alert and an animal epidemic alert. All of the respondents were aware of how to report suspected outbreaks. There was a high degree of confidence about the ability to report among the FGDs who responded either very confident or moderately confident (see Table 12). The answers were more mixed for key informants with an equal amount showing high or moderate confidence compared to those that were slightly confident or not at all confident to raise an alert. FGD respondents attributed their high confidence to the sensitization work of the Red Cross.

> "*With the information received from the Red Cross, yes, I'm confident*." – FGD of women in Songololo.

Table 12: Level of confidence to report an epidemic disease alert

Level of confidence	Number of KIIs	Number of FGDs	Per cent of KIIs	Percent of FGDs
Very confident	2	3	18	60
Moderately confident	3	1	27	20
Slightly confident	2	0	18	0
Not confident	3	0	27	0
N/A	1	1	9	20

The respondents also identified where to report human epidemic disease alerts and animal epidemic disease alerts. It was mostly the FGDs that responded to this question. Of those that responded, the majority said they would report to the nearest health center or doctor/nurse (see Table 13). One focus group and two of the key informants identified the Red Cross. For animal disease alerts, all those that responded said veterinarian or veterinary officer.

Table 13: Where to report epidemic disease alerts

Report	Number of KIIs	Number of FGDs	Per cent of KIIs	Percent of FGDs
Health workers/Health centre	1	4	9	80
Red Cross	2	1	18	20
N/A	8	0	73	0

Community Preparedness

Participants were asked to what degree they feel the community is prepared to overcome epidemic outbreaks. In the household surveys, the respondents were divided between those who thought the community was very prepared (37 per cent), somewhat prepared (18 per cent), not prepared at all (19 per cent), or didn't know (20 per cent).

The key informants and focus groups were also divided. More of the key informants and focus groups felt that communities were either very prepared or moderately prepared (see Table 14). However, nearly two fifths of respondents felt that the community was not prepared at all.

Table 14: Level of community preparedness by data source and gender

Level of preparedness	Number of KIIs	Number of FGDs	Per cent of KIIs	Percent of FGDs
Very prepared	4	1	36	20
Moderately prepared	3	2	27	40
Not prepared	4	2	36	40

The respondents provided reasons for why they think the community is or is not prepared. In the household survey, the reasons were mainly because they don't know how to prepare (28 per cent), there are no money or resources to do anything (23 per cent), or it is not in their control (18 per cent).

Among KIIs and FGDs, those who did not feel the community was prepared said that it was due to a lack of knowledge or information (see Table 15). Other reasons for not being prepared was that although they have knowledge, the habits are hard to change. Others noted insufficient resources, trained staff, and limited reach of communities.

Table 15: Reasons for lack of preparedness

Reasons	Number of KIIs	Number of FGDs	Per cent of KIIs	Percent of FGDs
Lack knowledge or information	3	1	27	20
Habits	1	1	9	20
Have knowledge	0	2	0	40
Reporting system	1	0	9	0
Lack resources/materials	1	0	9	0
Lack of trained personnel	1	0	9	0
Few communities reached	1	0	9	0
N/A	5	1	45	20

For those who felt that the community was prepared this was because they had sufficient knowledge or because the reporting system is functioning, and they have already reported cases of measles.

> *"We are not prepared enough because the community of Binza Meteo is very large and there is need to work even more on awareness and other actions to better know the epidemics and how to prevent them*." – FGD of youth in Ngaliema.

> *"Red Cross has given us the necessary information, so we are capable of reacting to epidemics. But we'll have to keep going because of the habits that are still very much in our heads*." – FGD of women in Songololo.

Less than half of the key informants and focus groups identified improvements required to increase preparedness. All of the respondents said that more, continued, and timely sensitization was required. One added that the sensitization must reach "*all the health areas, all the villages and the most remote corners*." Another key respondent added that more awareness was needed specifically on SDB.

Major Health Risks

Participants were asked about major risks affecting health. In the household survey, respondents the major risks affecting health as floods (53 per cent) and drought (42 per cent), followed by diarrhea (62 per cent), malaria (63 per cent), and malnutrition (20 per cent).

In the KIIs and FGDs respondents listed the main serious epidemic diseases in humans and animals in their area (see Table 16). The most commonly identified diseases were cholera, measles, and COVID-19. Ebola was identified in Maluku and Songololo. Respondents from Songololo also identified chikungunya, chicken pox, meningitis, diarrhoea, and varicella.

Table 16: Major epidemic diseases identified by key informants and focus groups by territory

Disease	Territory			
	Maluku	Ngaliema	Songololo	Kimpese
Cholera	2	3	7	1
Measles	2	3	8	1
COVID-19	3	3	3	1
Yellow Fever	1	1	3	0
Rabies	1	1	1	1
Malaria	1	1	1	0
Ebola	2	0	1	0
Chikungunya	0	2	0	0
Chicken pox	0	0	1	0
Meningitis	0	0	1	0
Diarrhoea	0	0	1	0
Varicella	0	0	0	1

The household surveys show that there is a high awareness of the forms of transmission of COVID-19 (87 per cent) and cholera (72 per cent), and a moderate awareness of the mode of transmission of measles (51 per cent). There is a low awareness of the transmission of meningitis (9 per cent) and it was not identified in KIIs or FGDs as a major risk. The KIIs and FGDs also did not identify zoonotic diseases, but the household survey found a moderate awareness of the symptoms of rabies in animals (up to 55 per cent).

All participants asked about difficulties to make improvements to reduce health risks. The household survey found clearly that the main difficulty to making improvements was the financial situation (78 per cent), as well as a lack of resources (42 per cent) and lack of knowledge (35 per cent).

The answers of key informants and focus groups were more wide ranging (see Table 17). The lack of knowledge of prevention methods was the most common, followed by lack of financial resources to make improvements. Poor sanitation, hygiene and the lack of latrines was another challenge. The focus groups also identified difficult access and long distance to health facilities.

Table 17: Difficulties to addressing health risks identified by key informants and focus groups

Difficulty	Number of KIIs	Number of FGDs
Lack of knowledge, awareness	4	0
Financial resources	2	1
Sanitation/Lack of latrines	2	1
Access	0	2
Landslides	0	1
Population increase	0	1
Behaviour change	0	1
Vaccination	1	0
Timely response	1	0
Insecurity	1	0
Religion	1	0
Lack safe water	1	0
Lack of preparedness	1	0

There were also difficulties in getting vaccinated, getting a timely response when a case is reported, insecurity, landslides and rapid population increase in the communities. Difficulties affecting an individual's ability to reduce health risk include traditional and religious beliefs, a lack of knowledge, a lack of behaviour change, and poor sanitation practices.

"The number of toilets still low. Proper use of toilets is not yet well understood, and residents still defecate or throw their waste into rivers." – FGD with men from Songololo.

The household survey corroborates the poor sanitation practices, where more than half of respondents practice open defecation sometimes (48 per cent) or always (9 per cent).

Influential People

Respondents identified the most influential people in the community regarding human health and animal health. For human health, the most influential people were Red Cross volunteers and health workers, including the head nurse, chief zone doctor, and community health workers (see Table 18).

Table 18: Most influential people in the community for human health

Influential person	Number of KIIs	Number of FGDs
Red Cross volunteers	7	5
Health workers	2	5
Local leaders	3	0
Political and administrative authorities (APA)	1	0
Religious leaders	2	0
Youth	1	0

Key informants also identified other influential people including local leaders like the Head of District, religious leaders, and youth.

Regarding animal health, nearly all of the people who responded said veterinarians were the most influential (see Table 19). One key informant from Maluku said health authorities because "*We don't have veterinarians in this health zone.*"

Table 19: Most influential people in the community for animal health

Influential person	Number of KIIs	Number of FGDs
Veterinarians	2	5
Health authorities	1	0
N/A	8	0

Communicating Key Messages

Participants were asked what are the main sources from which they receive health information. In the household surveys, the most common sources of information were television (39 per cent), radio (29 per cent), and megaphone announcements (19 per cent). Fewer respondents mentioned (internet health information (8 per cent), community events (7per cent), mobile SMS (7 per cent), newspaper (4 per cent), and posters (1 per cent).

The key informants were asked about the main sources from which they receive health information. Focus group participants were asked about effective ways of communicating key messages to the community. For both groups, the most common communication channel identified was by local radio and through Red Cross volunteers (see Table 20). Similar to the household surveys, key informants also cited television, followed by health authorities or workers, on billboards, by phone, or through local leaders. FGD respondents also identified door-to-door household visits and megaphones.

Table 20: Communication channels for health information

Communication channel	Number of KIIs	Number of FGDs
Radio	8	2
Red Cross	8	4
Television	5	0
Health authorities/workers	3	0
Community health workers (RECO)	3	0
Household visit	1	1
Megaphones	1	2
Billboards	1	0
Phone	1	0
Leaders	1	0
Community members	1	0

Half of the respondents identified key messages to deliver to community members to inform them of how to stop outbreak diseases. Most of them reinforced the importance of disseminating messages about prevention and awareness of infectious diseases. There was also encouragement to adopt the practices being shared.

> "*The most effective way of communicating messages is to raise awareness and provide information beforehand to prevent the spread of the disease.*" – KII respondent from Ngaliema.

> "*Let's accept and practice the advice given to us by the Red Cross and even by health workers*." – KII respondent from Maluku.

> "*Keeping the environment clean, toilets, raising awareness at all times.*" Key informant from Ngaliema.

> "*The environment must be clean, build latrines, drink clean water, wash at all times*." – Key informant from Nsona Pangu.

Conclusions and Recommendations

The results of the qualitative surveys found that the target groups had a moderate to high level of awareness of epidemic disease prevention and that many of them attributed the knowledge to the Red Cross. Although the sample size of KIIs and FGDs was small, many of the findings were corroborated by the household survey.

The perception of immunization was positive, with most believing vaccines prevent diseases. While none of the KII and FGD respondents demonstrated belief in misconceptions, they recognized that rumours and a lack of awareness were barriers to immunization. The household survey also found a segment of the population that believes it causes infertility or other harm, or that it is a trick of the government.

There is good awareness of the symptoms of Ebola among key informants, but the awareness is slightly lower among the wider community. There was a high level of understanding that patients can be treated, recover and return safely to the community following an Ebola Treatment Centre. However, the household survey found that few would take the action of bringing the infected person to the Ebola Treatment Centre.

There was also a good level of awareness of the necessity for qualified people to perform safe and dignified burials. However, there was recognition that not following traditional burial practices may cause negative reactions, sadness and economic difficulties among the community.

Respondents demonstrated good awareness and confidence to report epidemic diseases. However, many felt that the community was not very well prepared due to a lack of knowledge of epidemic diseases, lack of knowledge of how to prepare, and a failure to change behaviours to prevent illness.

Based on the findings of the qualitative and quantitative survey results, key recommendations for the CP3 in DRC are:

1. Continue to raise awareness of the symptoms, modes of transmission, and preventative measures of common diseases, particularly measles, yellow fever, Ebola, meningitis, malaria, and cholera.
2. Raise awareness about the use and effectiveness of Ebola Treatment Centres. Address the stigma/misconception that a discharged patient is still contagious and promote their safe return to communities.
3. Work with local health authorities to increase the uptake of immunizations, which is currently low. Continue to raise awareness about the diseases that can be prevented through vaccination and address rumours about vaccinations causing infertility, being harmful, or are a trick of the government.
4. Increase awareness of zoonotic diseases, such as rabies, and promote animal vaccinations.
5. Continue to promote the use of latrines and good hygiene practices, while working with stakeholders to install improved sanitation infrastructure.
6. Implement behaviour change communication techniques to encourage community members to put knowledge into practice.
7. Transmit key messages on preventive measures through radio and television. Complement this with the face-to-face delivery of health information through Red Cross volunteers and health workers. Work with local leaders to strengthen their role in sharing key messages.
8. Clarify the communication lines and protocols to report human or animal epidemic disease alerts.
9. Work with the community to identify strategies to better prepare for and overcome epidemics and other health emergencies.

Annex 1: Questionnaire for key informants and focus group discussions

1. **Participation in Red Cross Activities**
- How often engagement meetings with partners and the Red Cross take place?
- How much contact do you have with the Red Cross?

2. **What is your opinion on immunization?**
- Are vaccines dangerous to our health?
- Do vaccines prevent serious diseases and save lives?
- What do you think is the greatest obstacle in implementing immunization programmes?

3. **Know the sign of Epidemic diseases**
- Can you please give me at least 3 signs of EBOLA?

4. **Perception of Ebola Treatment Centres**
- Can the people discharged from Ebola isolation come back to the community safely? Why?

5. **Safe and Dignified Burial**
- If there is a need to do a safe burial because of an outbreak disease, who should be involved?
- Who is the best to lead SDB?
- What are the consequences if traditional burial practices are not followed?

6. **What would you do if you thought you saw the signs of a serious, possible outbreak disease?**
- Know where to report an alert i) human epidemic disease alert; ii) animal epidemic alert
- How confident are you about raising these alerts?

7. **Perceived current capacity of the community to raise alerts of potential human or animal disease outbreaks**
- How ready and able are you at the baseline?
- Or how vulnerable you are?

8. **To what degree do you feel that your community is well prepared and easily able to overcome epidemic diseases or emergencies?**
- If not prepared, why not?
- What changes / improvements are required?

9. **What do you feel are the most major risks that have most impact on the health of this community?**
- What are the main serious outbreaks or epidemic disease in your area?

10. **What makes it difficult for them to make improvements to address these risks?**

11. **Who is most influential on the people in this community, regarding their practices of**
- Human health
- Animal health

12. **What are the main sources from which you receive health information and updates?**

13. **What would be the most important messages to give community people here to inform them of how to stop outbreak diseases?**
- What would be the most effective ways to communicate those messages to them?