Methodist Development and Relief Agency

RAPID GENDER ANALYSIS OF THE 2023 CHOLERA OUTBREAK IN BUHERA DISTRICT, ZIMBABWE REPORT

APRIL 2024

Authors

Nixon Nembaware and Chipiwa Mundandanda: The views in this Rapid Gender Analysis (RGA) are those of the authors alone and do not necessarily represent those of MeDRA or its programs, Christian Aid or the Zimbabwe Government /any other partners.

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The cover photo was taken by Nixon Nembaware during data collection process in wards 5 and 13 in Buhera in April 2024. Consent was given to use the photos.

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Abbreviations and Acronyms

EHT-Environmental Health Technician

FGD-Focus Group Discussion

GALS-Gender Action Learning Systems

GBV-Gender-Based Violence

ISALS-Internal Savings and Lending

KII-Key Informant Interviews

LFSP-Livelihoods Food Security Program

NFI-Non-Food Items

NGO-Non-Governmental Organisation

PwD-Persons with Disability

RGA-Rapid Gender Analysis

SAGs-Sanitation Action Groups

UDACIZA- Union for the Development of Apostolic Churches and Zionists in Africa

VHWs-Village Health Workers

WEAI-Women's Empowerment in Agriculture Index

WCOZ-Women's Coalition of Zimbabwe

WIPSU-Women in Politics Support Unit

ZRBF-Zimbabwe Resilience Building Fund

Definition of Terms

Cholera: Cholera is an acute diarrhoeal disease that can kill within hours if not treated. Cholera is a poverty-related disease that affects those who lack access to safe drinking water and basic sanitation. Conflict, chaotic urbanization, and climate change also contribute to the risk of cholera.[1]

Gender: Gender describes the socially constructed characteristics of women, men, girls, and boys. This covers the norms, behaviours, and roles that are ascribed to women and girls or men and boys. as well as how they interact with one another. Gender is a social construct that differs from society to society and can change over time. Gender has to be contrasted with sex which is biologically determined.

Intersectionality: Intersectionality recognizes that people's social identities can overlap, creating compounding experiences of discrimination.Gender-based discrimination is connected to various forms of discrimination, including race, socioeconomic status, disability, age, geographic location, gender identity, and sexual orientation..[2]

Manyika: The Manyika are one of the Shona-speaking groups found in Zimbabwe. They are an ethnic and linguistic subset of the larger Shona peoples of southern Africa. inhabit extreme eastern Zimbabwe and portions of interior Mozambique.

Patriarchy: Patriarchy is defined as an ideology that maintains men's dominant position over women, justifies male superiority, and rejects equal arrangements in both public and private life. It includes the view that men should possess authority in the home and society, resulting in the acceptability of violence against women as a means of sustaining male control.[3]

Rapid Gender Analysis (RGA): A Rapid Gender Analysis (RGA) reveals information about the unique needs, capacities, and coping mechanisms of women, men, girls, and boys in a crisis.[4] The results of a Rapid Gender Analysis are accessible quickly and utilized to build humanitarian response plans.

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[1] https://www.who.int/news-room/fact-sheets/detail/cholera
[2] https://www.who.int/health-topics/gender#tab=tab_1
[3] https://www.sciencedirect.com/topics/social-sciences/patriarchy
[4] https://insights.careinternational.org.uk/images/documents/rapid-gender-analysis/Rapid-Gender-Analysis-External-Comms.pdf

Gender Analysis: Gender analysis refers to the various methodologies used to examine men's and women's interactions, access to resources, activities, and the constraints they confront in relation to one another. Gender analysis recognizes that gender, and its relationship with race, ethnicity, culture, class, age, disability, and/or other status, is important in understanding the different patterns of participation, behavior, and activities that women and men have in economic, social, and legal structures.[5]

[5] https://www.international.gc.ca/world-monde/funding-financement/gender_analysis-analyse_comparative.aspx?lang=eng

1.0 Executive Summary

1.1 BACKGROUND

This is a qualitative study report examining how pre-existing and emerging gender dynamics affected cholera experiences during the 2023 cholera outbreak in Zimbabwe. The Gender analysis was essential for understanding how cholera affected men, women, boys, and girls differently.

Selecting wards and sites was purposeful and data analysis was guided by multiple gender analysis frameworks such as Gender Equality and Social Inclusion (GESI); Gender, Inclusion, Power and Politics (GIPP) Analysis, Intersectionality and the Havard Analytical Framework.

1.2 FINDINGS

1. **Socio-religious norms**: Buhera has a complex diversity of religious beliefs and social practices. Some of these practices are retrogressive and they increase women's vulnerability to Cholera, care load, and limited access to medical assistance. The significant population adhering to their beliefs, along with the close proximity to the original shrines and foundational roots of the two prominent apostolic sects, raises concerns regarding the intertwining of apostolic beliefs and traditional cultural beliefs in Buhera.

Cholera outbreak in the context of changing gender norms: The cholera pandemic caused transitory changes in gender norms and practices such as strict demands for women to attend funerals and spend the night vigil and men and boys sharing the duties of fetching water for domestic use. However, these are not permanent as people return to their former ways.

2. Inadequate Sanitation services

2.1 Inadequate female-friendly sanitation services at the hospital: Women wait for sick relatives in Murambinda Growth Point, which lacks adequate public bathing facilities and female-friendly sanitation services. This problem exacerbates the already significant burden on women compromising their health and dignity. Women are expected to care for the sick, which includes accompanying them to the hospital and waiting close to the hospital in case something essential is required. This role is played by women, not men.

2.2 Inadequate sanitation services at the gardens: Ggardening and selling vegetables is a major source of income for women in Buhera. However, this important economic activity puts them at extreme risk of contracting cholera due to lack of sanitation facilities at gardening sites, lack of

clean drinking water and reliance on contaminated river water for washing kitchen utensils while camping at the garden.

3. **Poverty and lack of knowledge on cholera transmission routes:** Generally, individuals used the same utensils to retrieve dirty water, water plants, and transport drinking water. There are no separate buckets, jugs, or cups for the kitchen, which disproportionately affects women since they are the ones expected to cook, fetch water and serve meals.

4. **The burden of fulfilling gender roles during the outbreak:**

4.1 Attending funerals was a community management duty required of women, which increased their risk of contracting cholera. Traditionally and according to their social norms, women are expected to attend funeral gatherings and support the bereaving families and lack of participation at such important gatherings was associated with discrimination and/or labelling e.g. witchcraft accusations. Cholera nuanced the gender household roles of women, men, girls, and boys: Cholera increased the burden of unpaid care-work for girls and women as they were responsible for taking care of sick relatives. This in turn meant increased amounts of water required for daily (routine) use and to cater for the sick (bathing, laundry for soiled clothing) which translate to women and girls travelling long distances to fetch water. In most cases there was limited or no access to potable water to support women in discharging care-work which also exposed them to cholera.

4.2 Cholera and the household roles of women, men, girls, and boys: The cholera outbreak reinforced traditional gender roles within household. Women were tasked with teaching youngsters about health and hygiene practices in response to the cholera outbreak and designing of tippy-taps for handwashing. Men did not do care duties before, during, or after cholera, but they did attend meetings and funerals and led committees. The unpaid household and care work burden of women, girls, and a few young men (who collected water with scotch carts) increased due to cholera.

4.3 Cholera and Women's Livelihoods: Many women had to spend more time queuing for clean water at distant boreholes (7 km average distance), reducing the time available for income-generating activities. The Women-led small businesses, such as local vegetable vending, were impacted as people avoided public spaces due to the outbreak. The increased care burden for sick

family members, especially children, fell disproportionately on women, limiting their ability to engage in economic pursuits.

4.4 Cholera and Men's Livelihoods: The cholera outbreak disrupted men's economic activities, such as, casual labor, brick molding, selling firewood as they could not access their main labour market (Murambinda). Male cattle traders faced decreased business as the monthly market was closed.

4.5 **Gender and coping mechanisms:** Due to the 2022/2023 droughts, most households lost their livestock and had no assets to sell. Few homes possessed cattle under male control and few women had chickens which demonstrates patriarchal norms as women are not allowed to own productive assets in a patriarchal society. Young couples struggled due to a weaker asset base. Young males relied on casual work that required travel outside the home, which was banned. Most households struggled to cope and relied on MeDRA, World Vision, and CARE's Takunda programs for food and health services during the cholera outbreak. The aged and PWD received government aid.

4.6 Internal Savings and Lending Schemes (ISALS): The impact of cholera on women's livelihoods extended to their Internal Savings and Lending schemes. ISALs, a prominent women dominant livelihood activity slowed down due to the way cholera affected their income sources. They could not service loans or do their monthly contributions, let alone convene their monthly ISAL meetings.

4.7 Men disregarded medical counsel: Men openly defied the guidance to restrict inter-village travel either for church, funeral, or casual visits. Their defiance put themselves and others at risk of contracting and spreading cholera, undermining efforts to contain the outbreak.

4.8 Under-age Child-mothers and religion: Young mothers (underage girls below 18 years child brides) who marry in secret due to religious customs struggle to care for their children as well as prepare food. The little girls are not assertive and naively embrace religious teaching over medical advice for cholera treatment. They are not allowed or discouraged from attending sessions where they are taught childcare and food preparation since they are minors, and if they do, the husband is terrified of being imprisoned for illegal marriage.

5. Cholera is a layered and superimposed shock:

5.1 **Drought:** A cholera outbreak worsened that existing drought crisis, causing a double crisis in an already struggling community. Water scarcity was already a challenge for women and girls. The drought had caused the majority of deep wells in communal homesteads to dry up, and most ward residents were far from boreholes. As a result, village residents were forced to utilize contaminated river water for washing clothes, bathing, and caring for livestock. During the outbreak, there was therefore restricted availability of water for home and livelihood purposes due to the great distance to water sources, which primarily affects women because collecting water is traditionally a woman's job. Girl children helped their mothers collect water further entrenching the gendered impact of this compound crisis.

5.2 Stress and anxiety during the cholera outbreak: It was difficult for marginalized groups including the elderly, pregnant, PWD, young people, and the poor to deal with Cholera because they could not afford transportation charges to the health center, which is around 7 kilometres away. This resulted in increased stress levels and heightened anxiety making it even more challenging for the marginalised groups to cope.

5.3 Impact of Cholera on Food and Nutrition Security: Cholera disproportionately affected women and children, undermining household food and nutrition security. Some homes reported family support from other development partners but lamented that it was blanket and not tailored for pregnant and breastfeeding mothers. They were already vulnerable when cholera struck. Many households, especially female-headed ones, fell into food poverty and malnutrition category due to increased caregiving, food production disruptions, and dietary diversity restrictions.

5.4 Cholera Outbreak and Access to Education: Overall Children were highly vulnerable as they interacted with other children from various households. As a coping mechanism, the children carried their own bottles of water to school. Girls' access to education was affected by the many roles they played in the household. In some cases, girls performed poorly due to lack of concentration because of exhaustion and/or absenteeism as some missed school days to assist their mothers with household chores. This was largely due to religious practices in the Apostolic Sect and a pre-existing culture of leniency and tolerating children to miss school. Some school-going girls received sanitary pads from NGOs to promote sanitary health though was very selective.

5.5. Impact of MeDRA's Cholera response intervention: MeDRA's intervention beyond helping the communities cope has brought changes in terms of the practice of personal hygiene, hand washing, health education, and establishment of village saving and lending clubs to construct toilets. It also facilitated improved access to Cholera drugs. MeDRA also provided support for the establishment of Sanitation Action Groups (SAGs) at the village level, which are responsible for water and sanitation activities in the village.

1.3 RECOMMENDATIONS

- **Gender-sensitive response in emergencies:** There is need for gender-responsive interventions during cholera outbreaks and other emergencies. This includes supporting women's agricultural activities, a crisis-modifier mechanism for protecting business activities during the crisis. This may also involve strengthened awareness around the GBV referral pathway, providing child-care assistance, and ensuring access to nutritious food for vulnerable populations. Addressing the disproportionate burden of emergencies on women. Using participatory appraisal methods such as drawing exposure and sensitivity matrices for different population profiles to comprehend their levels of vulnerability.
- **Resilience focus for MeDRA's interventions:** Interventions with diversified livelihood options will be necessary to strengthen the resilience pathway in the event of another outbreak. Those with no diversified livelihood options especially gardens and livestock suffered way too early into the outbreak and could not last long in keeping the impacts at bay. MeDRA in its day-to-day programming could focus on the diversification of livelihoods as a resilience pathway. Including encouraging households to mix agro-based and non-agro-based livelihood options. Youth specific livelihood options and resilience pathways include expanding the youth's frame of mind beyond agro-based enterprises (vocational skills, sales and trade, importing). A mapping exercise of possible resilience pathways for different population groups to the common shock profiles in the district could be a starting point.
- **A long-term empowerment focus for MeDRA's programming post-cholera**-MeDRA could use the Women's Empowerment in Agriculture Index (WEAI). This should be guided by a proper baseline setting the current levels of empowerment.
- **Water-centered programs:** 100% of the participants feel that any meaningful intervention in Buhera should be centred around access to water. Reads like a finding.

- **Maximizing on the potential of ISALs:** MeDRA can program around ISALs as a resilience pathway in the face of vulnerability to shocks such as cholera and drought. ISALs have withstood the test of time, they have a legacy of success, and uptake in addition to great government participation and support.
- **Small livestock as gendered shock absorbers:** Good practices from other projects are showing that small livestock (both small ruminants and poultry) such as goats, sheep and indigenous chickens may not bring huge amounts of money but have potential to increase the resilience of women since traditionally its acceptable for women to own them. The climatic conditions in Buhera are suitable for goats, indigenous sheep, and indigenous chickens.
- **Community Dialogues:** Gender and inter-generational dialogue challenging the harmful norms and reinforcing the good ones are recommended. These can be on-going activities mainstreamed into MeDRA's interventions.
- **Male engagement strategy:** MeDRA needs to invest in a clear male engagement strategy to deal with the cultural and religious practices. The forms of masculinity dominant in Buhera need a proper strategy. MeDRA could consider transformative masculinities drive targeting in schoolboys and young men to redefine masculinities and gender roles as standalone projects or mainstreamed into already existing interventions. Churches, Pastors, parliamentarians and prominent individuals in the communities can be utilized.
- **GBV-Awareness-raising on the referral pathway and strategic partnership with existing structures and systems:** With reference to GBV, there is an opportunity to maximize Village Health Workers and Agriculture extension workers as they have greater community presence and contact with communities.
- **Working with trusted religious and traditional leaders- aiming for transformation:** Investment in longer-term innovative interventions related to changing religious practices and norms, positive interpretation of scriptures, training of church leaders, providing secure and private access to family planning, STI treatment and treatment for mothers and babies with guaranteed confidentiality. Collaboration with strategic partners of the Apostolic sects, for example, UDACIZA.

2.0 INTRODUCTION

The 2023 cholera in Zimbabwe lasted about a year. From February to December 2023, 54 of 64 districts reported 22,790 cholera cases, 62 confirmed fatalities, and 430 suspected deaths. All 64 districts were impacted, however the Ministry of Health and Child Care selected Marange and Buhera in Manicaland Province as the epicenters. September 2023 saw 12 deaths and 157 cases in Buhera, according to the Ministry of Health[6]. This Rapid Gender Analysis (RGA) study illuminates gender dynamics during the year-long Cholera outbreak in Buhera. The analysis examines how pre-existing power imbalances affect cholera experiences. This research uses primary data from two wards (5 and 13) and secondary data from MeDRA, Development Partners, and government ministry announcements. Study was qualitative and modelled after Interpretive Phenomenology.

3.0 BACKGROUND

Buhera (220 kilometres from Harare) contains 33 wards and is entirely communal. It is located in natural regions 3, 4, and 5, which receive an average of 400mm to 151.89mm of rainfall. Despite the fact that the area experiences severe droughts and food shortages, the majority of the population relies on seasonal agriculture. Summers are typically characterized by strong winds, sandstorms, and lightning. Rainwater runoff increases as a result of environmental degradation, generating flash floods and siltation issues in rivers and dams. Since 2019, the district has been adversely affected by cyclones, flooding, heat waves, and droughts. As a result, this study viewed cholera as a superimposed shock since Buhera is a vulnerable district with socioeconomic concerns and unstable agro-food systems. MeDRA, in collaboration with Christian Aid, other NGOs and government agencies, responded to the 2023 cholera outbreak with a 45-day response that focused on NFI distribution, GBV dialogues, cholera medications, and water point rehabilitation in selected wards.

[6] https://www.herald.co.zw/measures-to-contain-buhera-cholera-outbreak-bear-fruit/

3.1 Rationale of the RGA: Differential vulnerability influences exposure and sensitivity to cholera. Understanding these vulnerabilities is critical for designing targeted interventions and recovery strategies during and after the outbreak. Gender analysis was thus critical to understanding how cholera affected men, women, boys, and girls differently.

3.2 Objectives of The Rapid Gender Analysis (RGA)

- To examine how women, men, girls and boys were/are differently affected by cholera.
- To assess the impact of the disasters on gender dynamics.
- To establish emerging opportunities to provide emergency and developmental responses that meets the differing needs and vulnerabilities of women, men, boys, and girls.

4.0 METHODOLOGY

4.1 Qualitative Phenomenological study: The study used qualitative data gathering methods and triangulated them with secondary evidence from desk studies and government, news outlets, and MeDRA's implementation observations. This study used interpretive phenomenology [7] because so much is known about Buhera's sociocultural environment, such as White Garment churches and the local cultural practices.

4.2 Data Collection and analysis: Data was acquired from primary and secondary sources. Online reports and publications on the 2023 cholera outbreak were examined as secondary data. Focus Groups Discussions and Key Informant Interviews were used to collect data. Seven of 10 focus groups and five key informant interviews were completed. The study data was analysed using thematic analysis. Data gathering was conducted using a pre-designed interview guide.

4.3 Guiding theories: The Gender Analysis Framework was the study's main framework. This paradigm investigates social, economic, and cultural influences on gender roles, relations, and inequality. Intersectionality was used to analyse different identities and recognize that they influence people's experiences. In the background there is mention of use of the GESI/GIPP and HAF which silent in this section.

[7] Interpretive phenomenology, is also known as hermeneutic or existential phenomenology and is influenced by Martin Heidegger, a student of Husserl

4.4 Site selection: Selecting wards and sites was purposeful. Wards 5 and 13 were chosen as the appropriate study locations because these are areas where the Emergency Cholera Response was implemented.

4.4 Sampling: Seven focus groups and five key informant interviews were completed.

FGD Composition	**Number of FGDs/KIIs**	**Total Number of participants (84)**
Young Women (18yrs-24yrs)	2	19
Women (25yrs-35yrs)	2	23
Young Men (18yrs-24yrs)	1	12
Men (25yrs-35yrs)	2	15
Elderly People & people with disabilities this group is not mentioned in the objectives.		4 PwD and 6 people above 65 participated. They refused to be separated from the main group and the councilor supported their decision.
KII	**5**	Ministry of Health, Min of Women Affairs, Church leader, Councilor, youth leader

4.5 Ethical considerations: The study was conducted after cholera was contained in view of the 'Do-no-harm' considerations. Consent was sought for participation and photos. All questions were framed in terms of rights (rights of participants to good health and justice.) The data gathering team included gender-sensitive male and female collectors. Data was obtained in gender and age-determined groups and persons with disabilities. All data and findings were anonymized.

4.6 Limitations of the study: The study was conducted in Buhera two weeks before the national independence festivities. The community divided its efforts between receiving high-level delegates' advance teams and the RGA.

5.0 STUDY FINDINGS AND ANALYSIS

Zimbabwe's cholera outbreak followed socio-cultural fault lines of pre-existing inequalities. UNICEF estimates 51% of cases are female, with 36% of cases and 21% of deaths involving

children under 15. By October 2023, the district had 27 deaths with a 3.7% case fatality rate, the suspected cases in Buhera had climbed to 726, although hospitalization in Cholera treatment centers was only 46 since some people refused health care owing to religious beliefs. The Buhera district case fatality rate reached 4.4% by October 2023, well above the permitted 1%.

5.1 Pressure from Male patriarchal dominance: Despite a cholera outbreak and the announcement of an official ban on gatherings, male church officials continued to pressure populations to attend religious services at shrines (male patriarchy). Women stated they couldn't say "no" to church invites from husbands, even when gatherings were prohibited by the government. The patriarchal dominance extended to funeral attendance. Women had to care for sick relatives who sought treatment at shrines. They feared that if they declined, they could be accused of cheating or attempting to meet a lover. The church authorities disregarded professional warnings and were only rudely awakened when death was documented.

> *"When three (3) men from an apostolic church died at a gathering north of ward five, people then took Cholera seriously"—**A ward 13 youth.***

5.2 Religious beliefs, Gender and Cholera[8]: According to the Apostolic sect members "Chipostori/their apostolic beliefs and lifestyle -Is a lifestyle as it transcends business, home life and public life." The Ward 13 Councillor observes that Johanne Marange Apostolic sect members pose a difficulty and are officially on the radar of the Ministry of Health and Child Care and the Zimbabwe Gender Commission. They refused to go to the clinic even when death was impending, and if a wife or daughter took children or herself there, her husband or father would chastise her and excommunicate her. The Ministry of Health official stated that the affected individuals were hidden, and women and children were not permitted to answer questions in their homes when researchers came.

> *"I realised that they need treatment, but they are afraid of other church members...I think both NGOs and the government, we have made mistakes in our approach to dealing with the apostolic sect. Our aim is ensuring they access healthcare and not to force them to publicly access health facilities which to them is regarded as publicly shaming and*

[8] Whilst the respondents blamed the apostolic sects. MeDRA in its interventions should strive to find more creative ways of including them because they are more vulnerable. They should not be stigmatized.

renouncing your faith. Yes! It's ideal but if we want real changes in future, we should allow private access to medications because I realised during the cholera outbreak that if the treatment is private, they really accept it" ***-Ministry of Health Official.***

They claimed to have spirit-inspired cholera remedies, yet they were endangering congregants, particularly women, youth, and children, due to their limited decision-making authority. To treat cholera, churches bathed individuals in dishes and buckets of water, or seven river dips. Those with sick relatives, particularly women, would camp at the temple to seek divine assistance, putting the caregivers at risk of contracting cholera. Buhera's apostolic congregation shrines lacked female-friendly facilities, such as restrooms and diaper disposal. They cluster in open areas around dams, wells, and rivers. They drink and bathe in unprotected water. Women, particularly mothers, needed water to bathe, whereas men could spend three days without bathing. Women were also considered unclean during menstruation. Shrine guests shared bath water as a brotherly practice. This is done by both men and women which is risky during a cholera outbreak. During the cholera pandemic, established norms and values were modified, increasing the care load for women and restricting access to medical treatments, resulting in disempowerment. The apostolic sect is characterized by intrinsic self-censorship and restrictions.

5.3 Inadequate female-friendly sanitation services:

The communities had their own ideas about how Cholera was spread throughout the outbreak. First, rural communities, downstream of the Mwerahari River, blamed Murambinda inhabitants for dumping disposable baby diapers in the river. Second, women in the Mwerahari River, infected with diapers from the Murambinda growth point, may have propagated cholera. They also accused ladies who care for ailing relatives at Murambinda Hospital of open defecation in the Mwerahari River bank and bathing in cholera-infested water. They agreed that men's hospital visits did not require overnight stays as they are not culturally expected to wait on sick relatives. They also acknowledged that men could go longer periods without bathing than women or requiring special sanitary facilities. Without the means to return to their outlying villages those waiting on sick relatives carried food and cooked while sleeping in open areas. They defecate in the bush and have a nighttime wash in the Mwerahari River. Third, women resided in makeshift shelters downstream of the Mwerahari River with little sanitation where they tended to gardens, guarding them against thieves, harvesting or weeding. Those who stay far from the gardens camp there for 3 days or more then go back home. While

men own gardens through family land and lineage, women cultivate the gardens dominating the vegetable -producing trade. They defecate openly and live in makeshift houses with no bathrooms for the time they will be in the gardens. They only build temporary structures during the non-farming season, from winter to spring. They end up bathing, drinking, and cleaning dishes/kitchenware in the river. Some claim that they boil the water but upon investigation, they wash the utensils in the river and use the same containers to irrigate their crops and wash their vegetables for the market

> *"They claim they will boil it but realistically speaking after walking long distance and working hard they will be too tired to boil the water."-**female respondent***

5.4 Lacking knowledge about basic hygiene: There is a blame game going on, and it is believed that rural mothers who do not know how to dispose of baby diapers properly are to blame for cholera transmission through faeces. They mocked them for adopting Western baby-care ideas, which they are incapable of. There have been stories of people keeping diapers for days before discarding them because it is not permitted to use diapers at church gatherings, claiming that this is Westernization. They believe that a true African lady should not be too sophisticated about dealing with her baby's vomit or excrement to the extent of using a diaper instead of a washable nappy where she lovingly comes into contact with faeces. Furthermore, they feel that children who are nursed using disposable diapers rather than washable/reusable towel nappies are weaker and less well-behaved than those who wear cloth diapers.

5.5 Material Poverty: People generally use the same utensils for fetching dirty water, watering plants, and transporting drinking water. For example, they use a cup washed with river water and not properly dried to drink boiled water (cooled down), which contradicts the purpose of boiling the water. There are no designated buckets, jugs, or cups in the kitchen since they cannot afford them. MeDRA provided some buckets and non-food items, but these were insufficient to meet the demand.

5.6 Unpaid Care Work Pressure: Women will face pressure to meet their role expectations because gender roles are not shared. With boreholes up to 7 kilometres away, some women resort to fetching water from the 'Mufuku' in the river which is a shallow hand-dug well where water is

abstracted from the muddy riverbed. This is a risky and unhealthy coping technique. The food preparation procedure will be rushed, and water obtained from such dangerous sources will not be adequately boiled and cooled down as the burden of gender roles increases.

5.7 Unhygienic business practices: Some vegetable vendors were using dirty water to wash vegetables from the gardens for resale and for domestic consumption thus increasing the risk of fecal-oral transmission of cholera.

5.8 Men disregarded medical counsel: Men openly disregarded recommendations to limit inter-village travel, whether for church, burial, or informal visits. They went on to visit beer halls and after watching soccer or drinking beer, they would return home late and eat cold food, increasing their chances of catching cholera and putting wives and children at risk. They were encouraged by community health workers to consume the food while it was still hot, but by the time they arrived home(late), the food would be cold and due to a lack of firewood, the women (who are culturally expected to get up and warm the food) did not do so.

"*I would rather die than forsake my religion and go to the hospital*," said a male respondent from ward 13

5.9 Under-age/Child-mothers: Young lowly educated[9] mothers (child brides) who are married in secrecy are not adequately mature enough to care for children and prepare food well. The young mothers trusted religious doctrine against medical advice for cholera treatment. In reality, they are simply children taking care of other children and needing proper guidance on hygiene practices such as hand-washing at the recommended critical times. There are also cases of children who do not wear nappies at all due to poverty and this increases the risk of oral transmission of cholera. Young mothers are prone to poverty since they do not have land and have not acquired productive assets to cushion them. Some of the girls in the apostolic church are young mothers who were married illegally below the age of majority and they are not brought to meetings where they can access information on proper child care and food preparation by health specialists who taught childcare. The husbands are afraid that they may be arrested for the crime of child marriage.

[9] Who cannot read or write

5.10 The burden of community management roles:

Women can't refuse to go to funerals for fear of witchcraft accusations. Attending to funerals is a community management role expected of women in addition it builds their social capital because when they are also faced with bereavement the community will come and commiserate with them. There are specific expectations of roles expected of them at funeral such, cooking and spending the night vigil or the funeral wake singing with other women in the room with the corpse. Women had no choice to say no, for fear of victimization and retribution. Even though they knew it was not allowed during an outbreak they continued playing their expected roles till the government effected arrests.

5.11 Cholera and Women's Livelihoods:

Gender norms in Buhera dictate that women are largely responsible for domestic duties such as fetching water, cooking food, and caring for the sick. Many women had to spend more time queuing for clean water at remote boreholes (4km on average), which reduced their time available for income-generating activities. Women-led small businesses, such as local vegetable vending, were impacted as people avoided public spaces due to the outbreak, and both the women and the produce from the Mwerahari river gardens were stigmatized as *'ma veg ane Cholera/cholera infested vegetables'* People discovered that one of the transmission channels was washing vegetables with contaminated river water. Gardening is a significant source of income and is predominantly carried out by women. They grow vegetables like tomatoes and onions and sell them in Murambinda Town. Women bore a disproportionately high responsibility of caring for sick family members, particularly children, limiting their ability to pursue economic opportunities. Traditional brewed beer (consumed locally or shipped to Mbare in Harare) is another key source of revenue for women in Buhera; however, this was hampered by the inability of people to meet at their homes.

5.12 Internal Savings and Lending Schemes (ISALS):

ISALs were introduced by Development Partners and the Ministry of Women's Affairs, Community, Small and Medium Enterprise Development, and they have become a popular women-specific livelihood activity. ISAL's activities halted during the cholera outbreak because members, mostly women, were unable to service loans or maintain the required monthly contributions, let alone conduct monthly ISAL meetings. ISAL gatherings typically do not include men. Some of the men who belong to ISAL organizations are not actually members, but are there for strategic and sometimes selfish reasons. Their spouses are the ones who register them to boost their contribution and borrowing ability.

5.13 Cholera and Men's Livelihoods: Men in Buhera are more involved in public-facing economic activities such casual labour, brick moulding, and selling firewood. The cholera outbreak affected these income streams since they were unable to access their primary labour market (Murambinda). Farmers, both men and women, reported lower yields and incomes as the outbreak coincided with the agricultural season, because of a lack of market access. Buhera has a monthly cattle market that meets every Tuesday of the first week of the month. Traders reported lower business as movement restrictions and fear of contagion affected market participation. Casual laborers, primarily young males working as support staff in the construction of houses in Murambinda, lost jobs and worked fewer hours as a result of the outbreak's influence on economic activity.

5.14 Impact of Cholera on Food and Nutrition Security: Cholera disproportionately affected women and children, undermining family food and nutrition security. A few households reported family assistance and World Vision food aid, but it was general and not customized to pregnant or breastfeeding mothers. Cholera began in February 2023, lasted a year, and spread throughout the country. It coincided with the 2023-2024 summer drought. Higher cholera rates, particularly among children, increased the caregiving load on women, who are typically responsible for sick family members. This reduced them time for income-generating and food-producing activities. Women struggled to provide diversity and nutritious meals for small children due to a limited household food supply. Food poverty and malnutrition affected many households, particularly those led by women, as a result of increased caregiving, food production disruptions, and dietary diversity constraints.

5.15 Cholera outbreak and access to Education: Cholera exacerbated the challenges of girls' access to education, which was already hampered by the numerous duties they played in the household. In some cases, kids fared poorly or dropped out of school to help their mothers with home responsibilities. Cholera disrupted education, and this occurred against the backdrop of an established culture of leniency and tolerance for children missing school. It is not uncommon for girls to become pregnant and marry while still in school. This is mostly due to religious activities in the Apostolic Sect and a pre-existing culture of leniency. Respondents agreed that skipping a day or two per week was common especially to attend the religious night Virgil's (Masowe) and

on Friday which is a sacred day of worship. While cholera played a role, it also exacerbated a pre-existing culture of laxity among parents in terms of ensuring that their children did not skip school. Without reference to the Cholera outbreak, there appear to be four key causes driving a lack of access to education. For starters, there is widespread apathy and scepticism about the benefits of education. The economic downturn appears to have deterred many from prioritizing schooling. There are not as many role models of people who live better lives because of education. The common role models are teachers, the police and other civil servants whose lives are not enough of an inspiration. Second, religions prominent in the area mostly promote 'mabasa emaoko/home-schooled vocational skills'. Third, the distance to school is a discouragement (an average of 7km). Fourth, a lack of funds to pay for school fees becomes an additional consideration. Overall, children were quite vulnerable when they engaged with other children from other houses. As a coping mechanism, the students brought their own water bottles to school, and lunchboxes were not permitted. Other families simply stopped sending their children to school.

5.16 Access to healthcare during the cholera outbreak: It was difficult for marginalized groups such as the elderly, pregnant, individuals with disabilities, young people, and those with limited resources to access the healthcare facility, which was around 7 kilometres distant. Those with disposable assets, such as small livestock, could sell them and gain access to health care services. Religion was identified as a major barrier to women's health seeking, specifically Sexual and Reproductive Health (SRH) for women and Childcare. Church principles of the Apostolic Sect had a negative impact, as women gave birth at home and children were not immunized. Some ladies from the Apostolic Sect said that they sought health care in secret. Another problem that women experienced when it came to their SRH needs and childcare was the distance to the clinic, which may range from 7 to 12 kilometres. Most women reported being unable to afford transportation to the clinic, so they chose not to go and, in some circumstances, gave birth at home. There was also a notion that Cholera could be contracted more easily at health centres. The mothers also reported poor menstrual hygiene for themselves and their daughters, as they were unable to purchase pads. Some schoolgirls received pads from non-governmental organizations, and the distribution was quite selective. The pre-existing issues of limited access to potable water aggravated the situation because water was scarce. MOHCC outreach services provided acceptable services to pregnant women and breastfeeding mothers, albeit only on a monthly basis.

5.17 Water Sanitation and Hygiene: Women in Buhera are disproportionately affected by recurrent water scarcity. During the Cholera pandemic, most women had difficulty accessing water. The drought had caused the majority of deep wells in communal homesteads to dry up, and most ward residents were far from boreholes. As a result, village residents were forced to utilize polluted river water for washing clothes, bathing, and caring for livestock. The women stated that they would travel 2-4 hours to reach water sources. Cholera outbreaks and other water-borne illnesses pose a significant risk to the community when using river water for cooking and drinking. Men and boys assist with ox-drawn carts, but it is traditionally considered the responsibility of females. Girl children helped their mothers collect water, which disrupted their schoolwork. Women are vulnerable to sexual harassment's and other risks when traveling alone to water collection points. Participants in the assessment reported receiving sanitation and hygiene training during the cholera outbreak. Village health officials, EHTs, and councillors supplied information. MeDRA provided families with water buckets and soap to help avoid cholera in their homes.

5.18 Cholera and the household roles of women, men, girls, and boys: Following the cholera outbreak, women were tasked with teaching young people especially children about health and hygiene. Women's jobs included making tippy-taps and keeping things clean. Men did not perform caregiving chores prior to, during, or following cholera, but they did attend meetings, funerals, and lead committees. Before and after school, girls assisted their mothers with fetching water, cooking, and cleaning. Girls do more tasks than boys: they learn to cook early, sweep the yard, and clean the kitchen on a daily basis. Girls as young as ten learn to cook, clean, wash laundry, and collect household water on a regular basis. Boys typically herd cattle and transport firewood and water with carts and wheelbarrows. These role designations were consistent throughout the pandemic, indicating a solid culture that MeDRA should consider developing upon in their programs. A 24-hour time-task study of female participants revealed that the majority began at 5 a.m. and went to bed at 8 p.m. This was a simulation of normal daily practices in the culture before to cholera. Men's everyday schedules are uncertain outside of farming seasons. Normal working hours are from 7 a.m. (non-farming season/chirimo) until 9 p.m. Men receive 8–10 hours of entertainment per week. They usually go to friends' houses, hang out in the beer hall, watch soccer in stores, and ride to towns 15 kilometres away for homemade beer. Younger guys were mainly free and were expected

to care after cattle as well as repair household equipment and tools. Younger guys received approximately 5 hours of amusement every day. If they had the money, they could go to Murambinda every two weeks to watch school games and sponsored soccer activities throughout the winter. Except for church and the occasional soccer tournament at adjacent schools, no time has been set aside expressly for women's entertainment. Women's movement is limited. Cholera increased the unpaid household and care job burden for women, girls, and a few young men (who carried water in scotch carts) and also worsened their already existing time poverty.

5.19 Gender and coping mechanisms: Due to the droughts of 2022/2023, most households lost livestock and had no assets to sell. They had also sold the remaining livestock after three consecutive seasons of dealing with theileriosis/January disease, a deadly livestock disease. Few households had livestock, which were controlled by men. Women owned fewer hens. Young couples struggled due to their limited asset base. Young guys relied on piece work that required travel outside the home, which was prohibited. Most households struggled to manage and relied on MeDRA, World Vision, and Takunda for food and health care during the cholera outbreak. The Ministry of Health set up makeshift clinics at designated points to treat and isolate patients, preventing cholera from spreading to their families and communities. Some leased ox-drawn carts to cover the scarcity of transport to government cholera treatment facilities, as the official vehicle for patient transfer was delayed and overworked. The elderly and people with disabilities could get assistance from the government in terms of food, but it was irregular. During the pandemic, both men and women sought health care seldom because they lacked transportation funds and believed disinformation about treatment facilities as the epicentres. Disability-related concerns about contracting the condition caused PLWD significant distress.

5.20 Cholera outbreak in the context of changing gender norms: The cholera pandemic caused transitory changes in gender norms and practices, but these are not permanent as people return to their former ways. The conversation referenced “hunhu/expected social codes of acceptable behaviour” and historical precedence following social, economic, and legal institutions that shaped gender dynamics and power connections. Cultural, societal, and historical elements shape Buhera’s gender norms. The community had to accept new norms, such as no handshakes at funerals and restrictions on movements during the cholera epidemic (including controlling the

movements for men), and women did not have to spend nights away from home on funeral wakes, as is expected of them. MeDRA may use cholera's in-roads to start a longer conversation on gender roles. The potential to alleviate women's workload of triple roles-the blurring of the work division dichotomy produced by Cholera gives women greater agency and men more incentive to share unpaid domestic responsibilities. New knowledge gained from interaction with NGOs, accessing formal education to higher levels and modern values are challenging traditional gender norms as well. Education, particularly for women, can promote independence[10], job opportunities, and shift gender stereotypes. For men and boys' accessing new knowledge can begin to emphasize more egalitarian forms of masculinity.

5.21 Impact of MeDRA's Cholera response intervention: Prior to the outbreak, the population used domestic water from the Mwerahari River and did not exercise personal hygiene practices, such as hand washing after using the latrine and at the recommended critical times. MeDRA worked with other partners to equip the community with information, buckets, jerry cans, and a water guard for domestic water treatment. VHWs and MOHCC staff delivered health education to the community about the disease. MeDRA promoted toilets as a disease-control measure in communities, in addition to the use of the non-food items they distributed (soap and buckets). MeDRA also promoted the establishment of village saving and lending clubs for the purpose of building toilets as a mechanism to maintain impact after the Cholera response intervention. MeDRA also supported the formation of Sanitation Action Groups (SAGs) at the village level, which are in charge of sanitation initiatives in the village. Despite barriers to treatment, information about the cholera transmission pathway has been communicated. Households that have not had toilets for a long time are now contemplating and building toilets. Secretly seeking treatment by some members of sects, demonstrates widespread awareness and inroads into dismantling the toxic the culture.

6.0 RECOMMENDATIONS

[10] Independence as defined by Feminists Philosophers like Mary Wollstinecraft in '***A Vindication of the Rights of Woman: with Strictures on Political and Moral Subjects*** (1792), who says "she must not be dependent on her husband's bounty for her subsistence during his life, or support after his death—for how can a being be generous who has nothing of its own? or, virtuous, who is not free?"

6.1 Gender-sensitive response in emergencies: Whilst MeDRA and other implementing partners with coordination from MoHCC responded with a 45-day response which had uniform support to all, the gendered nature of these impacts highlights the need for gender-responsive interventions during cholera outbreaks for MeDRA in future characterized by special attention to underage mothers, women in apostolic sect with restricted access to health information services. Consideration should be given to the disrupted livelihoods of women.

Enhanced gender-sensitive health communication: Develop and implement gender-sensitive health communication strategies that specifically address the needs and concerns of women, men, and marginalized groups in the community. Women often bear the brunt of health crises, both as primary caregivers and as those responsible for household health. Tailored messaging, delivered through accessible channels (e.g., community meetings, local radio, and social media), should focus on prevention, treatment options, and hygiene practices. Engaging local leaders and health workers in these efforts can ensure the information reaches all community members effectively.

6.2 Livelihood diversification: It was clear that those with no diversified livelihood options, especially gardens and livestock, suffered way too early into the outbreak and could not last long in keeping the impacts at bay. Inclusion quotas and re-negotiation of land ownership in the new initiatives such as piped water schemes is an advocacy drive MeDRA can take in Buhera because land along the river banks was distributed a long time ago and there is need for re-negotiating ownership and usage to secure the livelihoods especially for young families, the youth and widowed women who do not necessarily inherit family land. This will allow the youth to be included and secure young families' livelihoods. Scenario-mapping with the communities on what to do if Cholera strikes again is recommended.

6.3 Resilience focus for MeDRA's interventions: Interventions with diverse livelihood options will be required to enhance resilience pathways in the case of a further shock. The likelihood of cholera recurring in the 2024 to 2025 farming season is high as people will be fetching water from shallow wells closer to their homes. This rapid study provided insights into youth concerns; nevertheless, an in-depth study focused on Buhera's unique youth characteristics is required, with an emphasis on youth-specific livelihood opportunities and resilience pathways. Barrier analysis of youth engagement (intergenerational interaction). How to develop positive masculinities for

young men. There is also need to invest more attention into methods of broadening the youth's perspective outside agro-based industries (vocational skills, sales and trade, importing). The biggest difficulty for women was the lack of viable livelihood ventures in the community. However, participants recommended that the Government and Non-Governmental Organizations (NGOs) train all women in livelihood projects such as soap making, floor polish production, and sewing, as well as provide raw materials so that they can meaningfully carry out the projects.

6.4 A long-term empowerment focus for MeDRA -MeDRA can conduct a participative baseline to determine existing levels of empowerment, beginning by defining the major domains of interest. The Women's Empowerment in Agriculture Index (WEAI) domains could then be utilized as design guidelines. Furthermore, for qualitative improvements, outcome mapping might be done at the start of any intervention, as well as co-creating realistic changes with men, women, and youth.

6.5 Water-centered programs: 100% of the participants feel that any meaningful intervention in Buhera should be centred around access to water. This will shorten the distance travelled looking for water for both humans and livestock, curb cholera and other diarrhoeal diseases which clearly are likely to rebound in haphazard cycles. Water sanitation and hygiene interventions have been done by GOAL Zimbabwe, Mercy Corps in collaboration with the government but behaviour change is slow. Some households still don't have toilets, open defecation still persists and disregard for medical advice and counsel abounds. Livelihoods interventions for women and youth centred around water layered with sanitation outcomes are recommended for MeDRA. This will ensure buy-in, strengthen agro-based livelihoods, lessen the burden of labour on women and ensure food and nutrition security which affects women and children more.

6.6 Maximizing the potential of ISALs: MeDRA can program around ISALs as a resilience pathway in the face of vulnerability to shocks such as cholera and drought. ISALs have withstood the test of time, they have a legacy of success, and uptake in addition to great government participation and support. ISALs create a co-group of assertive, women with capital and skills to trade and lead. They are provided with an alternative way to learn leadership and decision-making processes with regular reporting and accountability mechanisms. They could be revitalized and supported to allow women to draw from them in times of shocks such as cholera outbreaks (giving a resilience dimension-which MeDRA started on already by linking ISALS to toilet construction). The addition could be encouraging youth to take up ISALs. Revitalization of existing groups, creating new groups, layering and sequencing household and community resilience outcomes and

fostering empowerment outcomes especially women's voice, agency, decision making, and community leadership is recommended.

6.7 Small livestock as shock absorbers: Good practices from other projects for example the Livelihoods Food Security Program (LFSP), The Zimbabwe Resilience Fund (ZRBF) and Amalima Loko are showing that small livestock (both ruminants and poultry) such as goats and indigenous chickens may not bring huge amounts of money but have potential to increase the resilience of women since traditionally its acceptable for women to own them. The climatic conditions in Buhera are suitable for goats, indigenous sheep, and indigenous chickens. Women's goat groups in Gokwe, Binga and Mbire (similar climatic conditions) have recorded success stories in terms of breed improvement income per member and resilience. The following advantages are being continually affirmed: Women and youth have relatively more control over own income from small ruminants and poultry including the decision to sell, the small livestock have better chances of surviving droughts and midseason spells compared to larger stock like cattle. There are fewer cultural inhibitions around women and youth having total control of small livestock. Beyond their utility as coping mechanisms for the shocks, the costs of restocking are relatively less and thus the decision to sell is less complicated hence they will likely be used for coping. In addition, you can sell them quicker and faster thus increasing the potential to effectively use them to deal with an imminent shock like cholera. The small livestock can also be easily integrated into ISALs

6.8 Community Dialogues: Gender and generational dialogue challenging the harmful norms and reinforcing the good ones are recommended. These should be designed with clear outcomes and expected timelines based on realistic behavior change timelines. A special training of the community-based facilitators is recommended to curb the issue of reinforcing negative behaviors. Identifying and training suitable dialogue leaders (change activators) and developing a manual will be key success factors. Layering and integrating the dialogues into already, existing projects will be desirable. The dialogues should push the frontiers of cultural norms focused on not only the condition but also the position (both practical and strategic gender needs)

6.9 Male engagement strategy: MeDRA needs to invest in a clear male engagement strategy to deal with cultural and religious practices. Buhera being a male-dominated community in terms of culture and practices needs a well-thought-out strategy to engage the gatekeepers. MeDRA could consider a transformative masculinities drive targeting in school's boys and young men to redefine masculinities and gender roles. Younger men are more burdened with reinforcing culture. These

could be standalone projects or mainstreamed into already existing interventions. It is clear men and boys in Buhera like everywhere else suffer tremendous societal pressure to preserve existing norms and power imbalance. Beyond the preservation of culture and norms, they are co-creators of the gendered world and thus they consciously or unconsciously transfer and pass on discriminatory gender norms. The dialogues conducted by MeDRA in the Cholera response phase need to be structured for the long term. This male engagement strategy could include the following:

- A methodology preferably a participatory rural appraisal methodology such as Gender action learning systems (GALS). [11]
- Clear outcomes with short, medium, and long-term indicators co-created with the community in a participatory outcome mapping exercise.
- Allies within the church and community leaders (Chiefs, councilors and pastors)
- Partnerships with other interested parties such as Padare, Ministry of Women affairs ministry and UDACIZA,
- Community Action plan, Communication plan and an Advocacy plan including commitment charters signed and promoted by key opinion leaders from churches, politics, business and development partners.

6.10 Women's and youths' meaningful participation, leadership solidarity and assertiveness:

The political power route provides an opportunity to increase women's political and community level influence. This can be accomplished through advocacy campaigns and persuading men to support female political candidates. This, however, is subject to the scope of MeDRA's program portfolio and mission. Partners with capacity and skillsets in this area exist for example the Women's Coalition of Zimbabwe (WCoZ), Women in Politics Support Unit (WIPSU) has invested in this area in the years 2023-2024 in terms of methods on creating male allies. The

[11] Gender Action Learning Systems (GALS) is a participatory learning approach that empowers individuals and communities to analyze and address gender inequalities and social issues, including Gender-Based Violence (GBV). By fostering dialogue, reflection, and collaborative action, GALS utilizes visual tools and participatory methods to engage participants effectively. It specifically engages men in combating GBV by promoting understanding of its root causes and encouraging reflection on their behaviors and societal norms. GALS creates a platform for open dialogue between men and women, breaks down barriers, and emphasizes shared responsibility in addressing gender inequalities. By fostering a sense of community ownership, GALS motivates men to actively participate in creating safer, more equitable environments, leading to tangible changes in attitudes and healthier relationships. https://gender.cgiar.org/tools-methods-manuals/gender-action-learning-system-gals

needs of women will be amplified, such as the need for land, water, vocational skills, access to health will be better represented by other women.

6.11 Meaningful Participation and Building their leadership Capacity:

Ensuring that women and youth are well represented in community structures, rather than tokenism, by establishing quotas and terms and conditions that make meaningful involvement by women and youth a prerequisite for participation in MeDRA initiatives. Developing the capacity of women and youth to participate meaningfully in public places and community decision-making. Female participants advocated for capacity training so that they could engage in public places and community decision-making processes. They also advised initiatives aimed at traditional leadership to persuade them to include women and youth in decision-making systems. Women require broad leadership skills such as assertiveness, negotiation, and problem solving, which can be achieved through participatory approaches such as Problem Trees, social empowerment mapping and Gender Balance Trees. This allows women and youth with limited literacy and numeracy skills to lead and make sound decisions. Beyond basic leadership abilities, MeDRA's program might invest in specialized knowledge skills, such as water and sanitation[12] and basic agronomy, to increase women's confidence and encourage them to take on leadership roles.

6.12 GBV-Awareness-raising on the referral pathway and strategic partnership with trusted religious leaders:

With reference to GBV, there is an opportunity to maximize on Village health workers and Agriculture extension workers as they have greater community presence and contact with communities. Working with them on a project that empowers them as first line contact for GBV is likely to yield good results. Empowering chiefs in modern ways that suit the modern context and pathways for dealing with GBV. Training leaders to work as allies for example councilors, church leaders, traditional leaders are already responding to GBV cases in their line of

[12] Women's skills related to WASH could include technical expertise leading to a strong understanding of water and sanitation systems, infrastructure, and technologies which is essential for providing credible leadership. A starting point could be pump minders training. In terms of soft skills, a leading role in Communication and Advocacy is desirable this will lead to effective communication with diverse stakeholders, including community members, government officials, and technical teams. Being able to advocate for the needs of women and vulnerable groups is also important. The other soft-skill could be on resilience and adaptability since the water and sanitation sector faces many challenges, from climate change to infrastructure breakdowns and economic meltdown leading to non-repairs. Leaders should be able to problem-solve, make decisions under uncertainty, and adapt to changing circumstances. Knowledge of basic policy and governance around WASH so that they understand the policy and regulatory environment for water and sanitation, and being able to influence decision-making processes, can help drive systemic change. They should know their rights and obligations including the duty-bearers.

work. The community's thought framework is the church, so they are likely to seek assistance from church leaders or counselors. MeDRA could consider investing in the GBV support services knowledge if these people. They could be trained on gender, transformative masculinities, resilience pathways and basic counseling for GBV. The denial of children access to education, statutory rape of minors and denial of access to health care and health information are key GBV issues that should be dealt with urgently yet strategically.

6.12 Recommendations on Religion and gender norms in Buhera:

Investment in longer term interventions related to changing religious practices and norms. This can be standalone activities or mainstreamed in areas to do with climate change. An intervention around water is a possible rallying point as the need for water was unanimously echoed by all participants. The following are specific possible interventions:

- Gender dialogues around religion with specific themes and expected outcomes co-designed in a participatory outcome mapping.
- Mainstreaming gender in climate change adaptation and resilience initiatives as these will attract more participants considering the dire need for water.
- Creative intervention around positive interpretation of scriptures, training of church leaders.
- Innovatively, providing secure and in private access to family planning, STI treatment and treatment for mothers and babies. Confidentiality should be guaranteed.
- Male engagement through, creating gender champions, male allies or structured gender dialogues. This can be done targeting smaller groups of men to effect norm changing
- Collaboration with strategic partners with capacity to mobilize and be listened to by the Apostolic sects for example UDACIZA. Beyond churches organisations like Padare/Men's Forum or Fathers Against Abuse are working in similar projects.

7.0 CONCLUSION

The Rapid Gender Analysis of the 2023 cholera outbreak in Buhera District, Zimbabwe, uncovered significant gendered effects. Women were more affected by cholera than men because of their increased exposure and susceptibility, as well as cultural expectation to undertake the triple tasks of productive, reproductive, and communal management. Men and boys were also affected. Women and girls' domestic roles exposed them directly to cholera. Girls and women are on the front lines of the family's water, food, and hygiene issues, putting them at a higher risk of cholera exposure and having no influence over cholera prevention and treatment in the household. The caregiving role culturally assigned to women includes a range of duties susceptible to getting and transmitting cholera, including preparing and cooking food (and tasting it); feeding, nursing, and cleaning newborns and young children; and changing diapers and emptying toilets.

The lives of the women and girls in Buhera when analysed from an intersectional perspective have multiple dimensions as below:

- **Poverty:** the women are poor and struggling with agro-based livelihood options and face the brunt of climate change.
- **Religion:** They are belonging to strong discipleship religions where they are groomed for early marriages, subservience and poverty.
- **Education:** Limited access to education since the girls come from families which does not value the education system, do not attend classes regularly due to religion and domestic tasks and eventually get married off before reaching age of majority.
- **Culture:** Limited decision-making power and subjected to child marriages.
- **Age and disability:** Younger men, men with disability and women with disability struggle to face life, with no asset-base, no land for gardening and limited participation in community decision making.

The findings show how this public health emergency worsened pre-existing gender inequities and placed an excessive burden on various demographic groups, particularly women. The increased caregiving obligations, interruption in food production and livelihood activities, and restrictions on dietary diversity have resulted in a considerable number of households, notably those led by women, the elderly, and young couples, slipping deeper into food poverty and malnutrition. Apart from Cholera increasing women's vulnerabilities to contracting the virus, it also diminished their

power to make decisions such as stopping going to church and public gatherings related to the church a, taking children and themselves to hospital for treatment, and not attending funerals.

The recommendations section emphasizes the importance of taking a gender-responsive strategy to cholera outbreak management and recovery. Longer-term interventions must be targeted to the unique challenges that women face in order to strengthen community resilience and provide food and nutrition security for all households. To reduce the long-term effects of this outbreak, women must be empowered as active change agents. MeDRA and its partners may develop more effective and inclusive strategies for preparing for and responding to future public health emergencies by focusing on the experiences of women, girls, and other marginalized groups. To address these inequities and gendered fracture lines, a forward-looking resilience building effort must be combined with a comprehensive, gender-transformative strategy that recognizes women as key contributors to household and community resilience with men as allies.

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