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Prevention and Response to Sexual Exploitation and Abuse (PRSEA) in Emergencies: Beneficiary Experiences from a Cholera Outbreak Response in Kadoma City, Zimbabwe, 2024"

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ABSTRACT

Introduction

Sexual Exploitation and Abuse (SEA) is a fundamental failure to protect the vulnerable by those in power. The heightened vulnerability of individuals during public health emergencies contributes to a significant increase in reported SEA cases worldwide. PRSEA is essential to safeguarding survivors and offering support that prevents further exploitation or abuse. Kadoma City was one of the most affected areas in Zimbabwe that reported cholera cases in 2024. This study assessed the beneficiaries' knowledge and experiences of SEA during the outbreak response.

Methods

We conducted a mixed methods study in Kadoma City. The study population were beneficiaries who received hygiene kits during the response from January to July 2024. A sample size 371 was calculated using Dobson's formula. Data were collected using an interviewer-administered questionnaire, and a focus group discussion guide. Beneficiaries were selected from the cholera linelist. Analysis was done using Epi Info 7™ and thematic analysis for qualitative data.

Results

We interviewed 371 beneficiaries of which, 300 (81%) were females. Two hundred and ninety (78%) of them attained a secondary education (Form 1-4). Twenty-six (9%) females and 9 (13%) males had high SEA knowledge (*p=0.3005*). Seven (2%) respondents reported knowing a sexual relationship between a responder and a beneficiary. Three (1%) reported being sexually exploited and five (1%) reported being sexually abused during the response. Barriers to reporting SEA mentioned included fear 318 (86 %), slander 119 (32%) and perpetrator victimization 90 (24%). Respondents preferred to report SEA anonymously 247 (67%) and 158 (43 %) using toll-free lines.

Conclusion

Beneficiaries' knowledge of SEA was limited. Fear was the main reporting barrier. Anonymous reporting was

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the preferred reporting method. We recommend integrating PRSEA mainstreaming into outbreak response activities. Addressing barriers to reporting through awareness-raising campaigns. Establishing robust accountability mechanisms for holding perpetrators accountable. Expansion of confidential reporting options.

Key Words: Sexual Exploitation, Sexual Abuse

Word Count: 300

INTRODUCTION

Prevention and Response to Sexual Exploitation and Abuse (PRSEA) is a framework designed to address and mitigate the risk of sexual misconduct during public health and humanitarian emergencies(WHO, 2023). The United Nations (UN) defines sexual exploitation as any actual or attempted abuse of a position of vulnerability, differential power, or trust for sexual purposes, including monetary, social, or political gain(UNHCR,2021.). Sexual abuse refers to actual or threatened physical intrusions of a sexual nature under coercive or unequal conditions. Both forms of misconduct disproportionately affect vulnerable populations, particularly during emergencies, where societal norms and power dynamics are often disrupted(WHO, 2023).

Globally, humanitarian and health emergencies have consistently highlighted the heightened risk of Sexual Exploitation and Abuse (SEA). SEA first emerged as a peacekeeping issue during the UN Transitional Authority in Cambodia (UNTAC) in 1993, where the number of prostitutes reportedly rose from 6,000 to more than 25,000 during the mission(Westendorf & Searle, 2017). In 1995, further reports of SEA surfaced in Bosnia and Herzegovina, where women and girls were trafficked and exploited in brothels frequented by UN personnel(Westendorf & Searle, 2017). These incidents emphasized systemic failures in recognizing and addressing SEA within peacekeeping operations, with policy responses emerging only after negative media coverage and public attention in 1999(Silvera, 2012).

Public health emergencies, such as infectious disease outbreaks and natural disasters, similarly create environments of desperation and dependency that increase the prevalence of SEA(Shukla *et al*., 2023; WHO, 2022). In Africa, incidents of SEA have been reported during emergencies such as the 2014 – 2016 Ebola outbreak in the Democratic Republic of Congo (DRC) and conflicts in Sierra Leone, Liberia, and the Central African Republic(WHO, 2021). These cases stemmed from the intersection of poverty, aid dependency, and unequal power dynamics between responders and affected populations. Investigations done as part of response to reports highlighted significant gaps in the implementation of preventive measures, weak accountability frameworks, and the exploitation of vulnerable groups, particularly women and children(WHO, 2021). In Zimbabwe, SEA cases were recorded during the 2018 Cyclone Idai emergency, where aid-dependent communities were exposed to exploitation amidst relief efforts(Nyahunda *et al*., 2022).

In 2013, a UN investigation described SEA as *"the most significant risk to UN peacekeeping missions, above and beyond other key risks including protection of civilians*"(Westendorf & Searle, 2017). In response, the UN established a zero-tolerance policy emphasizing proactive prevention, including SEA training for humanitarian workers and the implementation of reporting and accountability mechanisms(WHO, 2023). Despite these frameworks, enforcement remains challenging due to stigma, fear of retaliation, and inadequate victim support, leading to significant underreporting of cases(Chibango & Chibango, 2022; Westendorf & Searle, 2017).

In 2024, Kadoma City recorded a cholera outbreak that required a coordinated response involving various stakeholders including governmental and non-governmental organizations. While these efforts were vital in containing the outbreak, the influx of external aid and resources also heightened the risk of SEA, particularly for economically disadvantaged and vulnerable populations. Recognizing these risks, the Kadoma City Health Department emphasized the importance of integrating PRSEA measures into outbreak response activities. This study therefore assessed the experiences, knowledge, reporting mechanisms, and barriers to reporting SEA among beneficiaries of hygiene kits distributed during the cholera outbreak in Kadoma.

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MATERIALS AND METHODS

Study Design

We employed a mixed methods approach, utilizing both quantitative (descriptive cross-sectional) and qualitative data collection techniques, to investigate the knowledge, experiences and barriers to reporting SEA among beneficiaries of cholera hygiene kits in Kadoma.

Study Setting

We conducted the study in Kadoma City, located in Sanyati District, Mashonaland West Province, Zimbabwe. Based on the 2024 population projections from the District Health Information System 2 (DHIS-2), Kadoma City has an estimated population of 123,081. During the 2024 cholera outbreak, the city operated one Cholera Treatment Center (CTC) in Ngezi and established five Oral Rehydration Points (ORPs) in the most affected areas. Kadoma City is divided into 17 administrative wards, encompassing approximately 40,000 households. Among these, wards 7, 11, and 1 were the most affected by the outbreak. The map of Kadoma City, administrative wards and location of cholera treatment facilities are shown in ***Plate 1.***

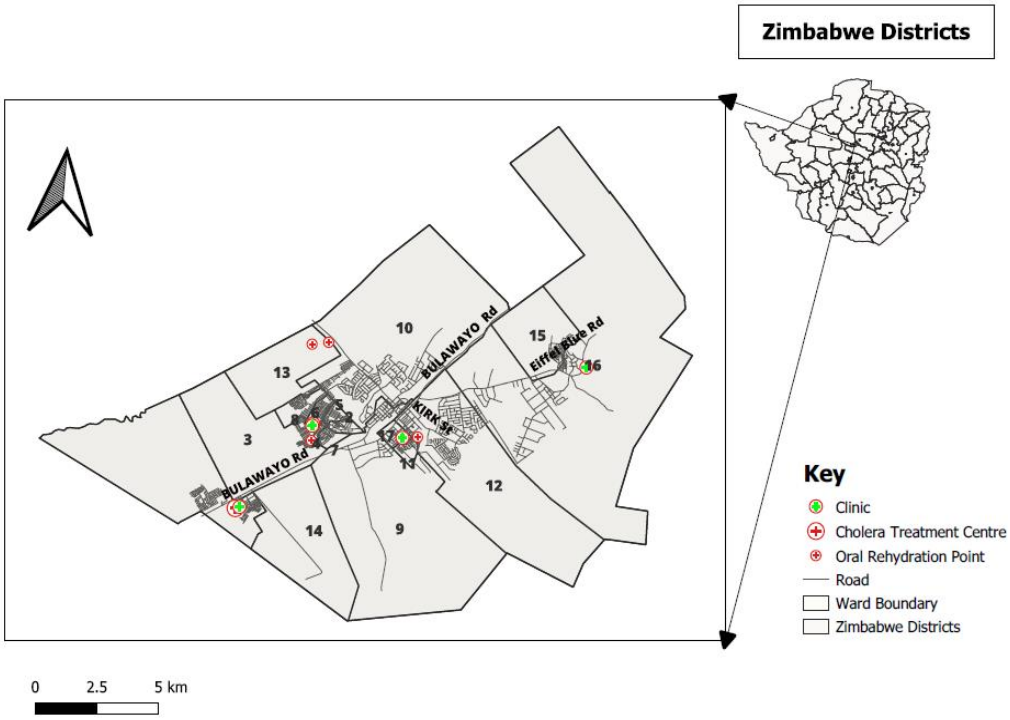

Plate 1: Map of Zimbabwe showing Kadoma City

Study Population

The study population were residents of Kadoma city who received hygiene kits through the cholera Case Area Targeted Interventions from the 8th of January 2024 to 8 July 2024.

Study Unit

The study unit was any adult member of a household that received hygiene kits from cholera Case Area Targeted Interventions (CATIs) from the 8th of January 2024 to 8 July 2024.

Sample Size

We calculated a minimum sample size of 352 respondents using the Dobson's formula according to a study by a PSEA taskforce in Kenya (Xefina Consulting, 2007).

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Sampling

Using simple random sampling, we selected 352 beneficiaries aged 18 years and above from the cholera line list.

Data Collection

Data were collected using an interviewer-administered questionnaire created in Kobo Toolbox and exported Open Data Kit (ODK™). The questionnaire collected information on socio-demographics, knowledge, experiences, reporting mechanisms and barriers to reporting SEA. Four focus group discussions were conducted, and data was collected using an interview guide.

Measurement of Knowledge

Knowledge of Sexual Exploitation and Abuse (SEA) was assessed using four questions. These questions assessed respondents' understanding of the definitions, enablers, and consequences of SEA. Each question included five correct answers, with one point awarded for each correct response, resulting in a maximum possible score of 20. Respondents who scored ≥10 were classified as having high knowledge of SEA, while those with scores <10 were categorized as having low knowledge of SEA.

Data Analysis

Data were analyzed using Epi Info 7.2.5™ and Microsoft Excel to generate frequencies, proportions and medians for analysis. Data from focus group discussions was thematically analyzed to extract key insights into beneficiaries' experiences.

Permission and Ethical Considerations

Permission to conduct the study was obtained from Kadoma City Council Institutional Review Board (IRB). Written informed consent was secured from all respondents. To maintain the confidentiality of the respondents, coded questionnaires without personal identifiers were used throughout the data collection process.

RESULTS

Demographic Characteristics

A total of 371 respondents were recruited into the study. Three hundred (81%) were females and seventy-one (19%) were males *(p=<0.001)*. The median age for females was 32 years (Q_1=25; Q_3=41) and for males was 28 years (Q_1 = 24; Q_3 = 38). Two hundred and ninety (78%) respondents had attained a secondary level (Form 1 to 4) education and 149 (40%) were Christian Apostolic. The demographic characteristics of the respondents by sex are presented in ***Table 1***.

Table 1: Demographic Characteristics of Respondents by Sex in Kadoma City, 2024

Demographic characteristics	Female n (%)	Males n (%)	Total n (%)	p-value
Age group				
18-25	82 (27)	27 (38)	109 (29)	
25-35	98 (33)	25 (35)	123 (33)	**0.2343**
35-45	73 (24)	8 (11)	81 (22)	

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45-55	27 (9)	5 (7)	32 (9)	
55-65	13 (4)	5 (7)	18 (5)	
Above 65	7 (2)	1 (1)	8 (2)	
Level of education				
None	4 (1)	2 (3)	6 (2)	
Primary (Grade 1-3)	1(0.33)	0	1 (0.27)	
Primary (Grade 4-7)	18 (6)	3 (4)	21 (6)	**0.1448**
Secondary up to Form 1- 4	240 (80)	50 (70)	290 (78)	
Secondary up to Form 5- 6	18 (6)	7 (10)	25 (7)	
Tertiary	19 (6)	9 (13)	28 (8)	
Marital Status				
Single	45 (15)	35 (49)	80 (22)	
Married	229 (76)	33 (49)	262 (71)	**< 0.001**
Divorced	7 (2)	2 (3)	9 (2)	
Widowed	16 (5)	0	16 (4)	
Separated	3 (1)	1 (1)	4 (1)	
Religion				
Christian Apostolic	137 (46)	12 (17)	149 (40)	
Christian Pentecostal	93 (31)	22 (31)	115 (31)	
Christian Catholic	55 (18)	18 (25)	73 (20)	**<0.001**
African Traditional Religion	1 (0.33)	3 (4)	4 (1)	
Islam	3 (1)	0	3 (1)	
None	10 (3)	16 (23)	26 (7)	

Assessment of Knowledge on SEA

Definitions of Sexual Exploitation and Abuse

When asked to define sexual exploitation and abuse, 199 (54%) females and 42 (11%) males could correctly define sexual exploitation. Sexual abuse was correctly defined by 277 (75%) females and 60 (16 %) males. The respondents who correctly defined sexual exploitation (SE) and sexual abuse (SA) by sex are presented in ***Figure 1***.

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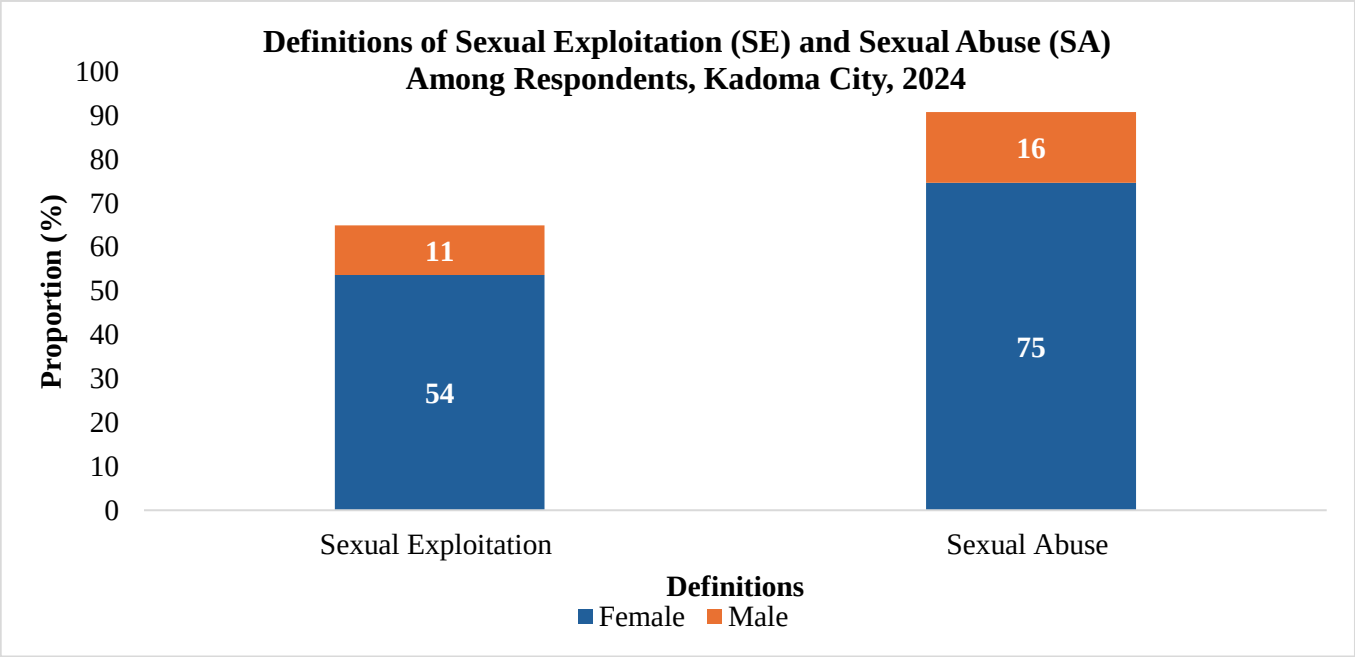

Figure 1: Definitions of Sexual Exploitation and Sexual Abuse Among Respondents, Kadoma City,2024.

Enablers of Sexual Exploitation and Abuse

Among the respondents, 190 (51%) identified power imbalances as enablers of SEA, 94 (25%) identified inadequate reporting systems and 69 (19%) mentioned lack of SEA redress mechanisms. The enablers of SEA identified by respondents in Kadoma City are presented in ***Figure 2***.

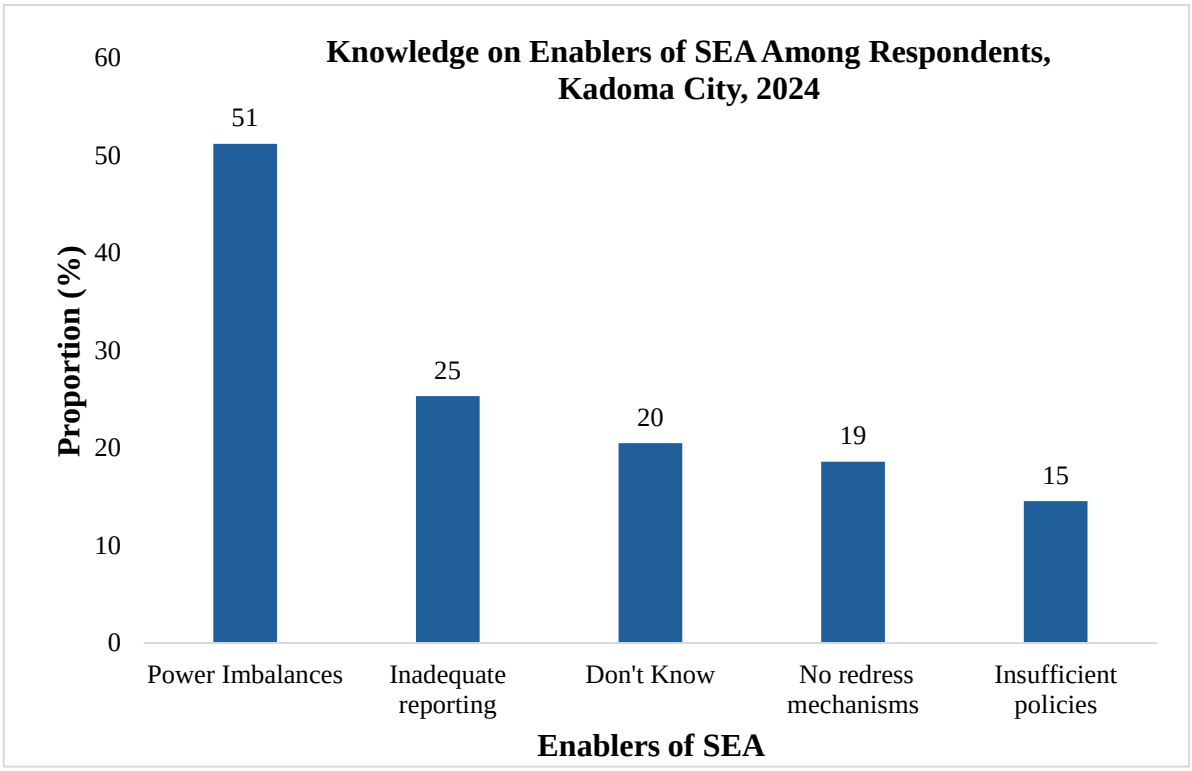

Figure 2: Knowledge on Enablers of SEA Among Respondents, Kadoma City,2024.

Consequences of Sexual Exploitation and Abuse (SEA)

Of the 371 respondents interviewed, physical health risks were mentioned as consequences of SEA by 302 (81%) respondents. One hundred and ninety-eight (53%) mentioned psychological trauma while 62 (17%)

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identified stigma. The consequences of sexual exploitation and abuse mentioned by respondents in Kadoma City are presented in ***Figure 3.***

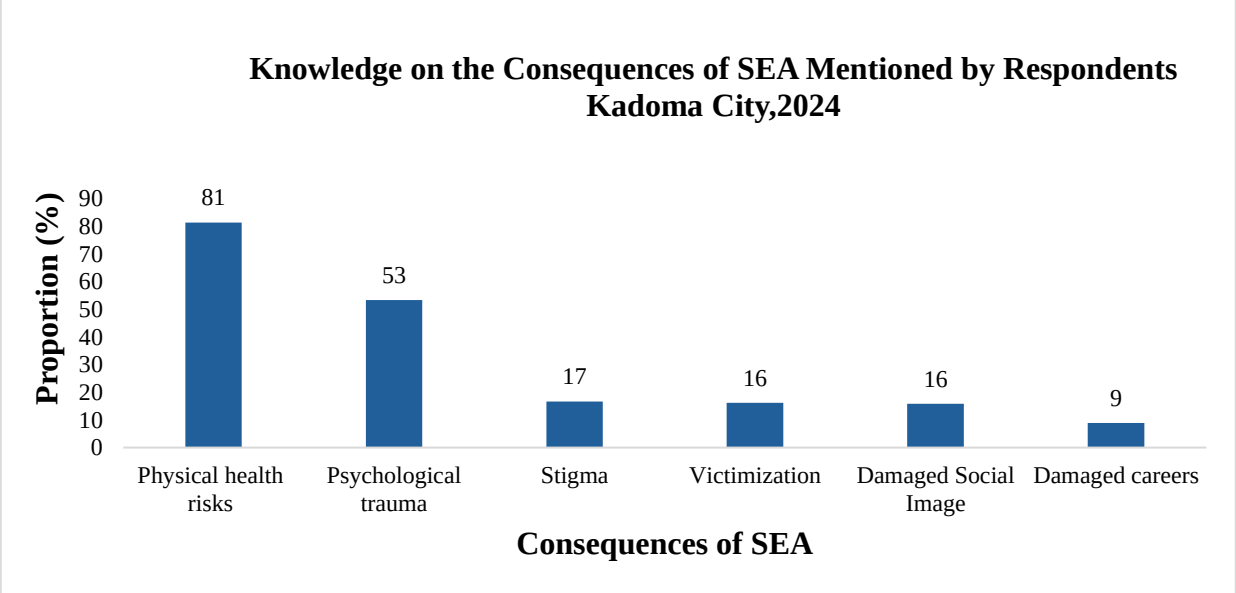

Figure 3: Knowledge on the Consequences of SEA Mentioned by Respondents, Kadoma City ,2024.

Experiences of Sexual Exploitation and Abuse During the Outbreak

When asked about their experiences of SEA during the outbreak, 23 (6%) knew someone who had been sexually exploited. Seven (2%) reported knowing sexual relations between a responder and a beneficiary, 5 (1%) reported that they were sexually abused and 3 (1%) reported they had been sexually exploited. The experiences of SEA among respondents during the cholera response in Kadoma City,2024 is presented in ***Figure 4***.

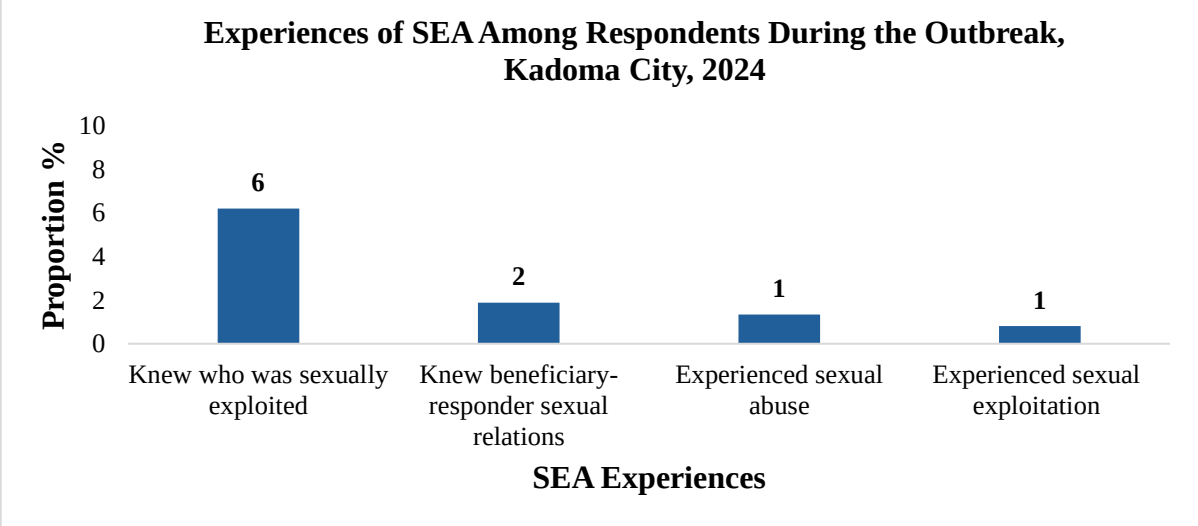

Figure 4:Kadoma City Respondents' Sexual Exploitation and Abuse Experiences,2024

During a focus group discussion, the beneficiaries mentioned that they had not seen or heard of male or female beneficiaries having sexual relations with responders for personal gain. However, they highlighted that there were instances where suspicion arose due to the unfair distribution of hygiene kits like buckets and soap among community members. One of the participants mentioned that:

"Commodities should be given equally and shared accordingly by responders especially of the opposite sex as it makes us question why one was given more goods than the other. For example, a responder gave a younger

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lady five buckets whilst an elderly woman in need only received 2 buckets. It raised the suspicion that something is going on and such cases should be reported and investigated."

Availability of Reporting Mechanisms for Sexual Exploitation and Abuse

Two hundred and thirty-nine (64%) of the respondents mentioned that they were aware of the available reporting mechanisms in Kadoma City. Of these, 188 (79%) females and 51 (21%) males mentioned the police (Victim-Friendly Unit). Ten (4%) females mentioned community leaders,7 (3%) females mentioned the health facilities (clinics) and 4 (2%) females mentioned the Child Care toll-free line. The available reporting mechanisms mentioned by the respondents are presented in Figure 5.

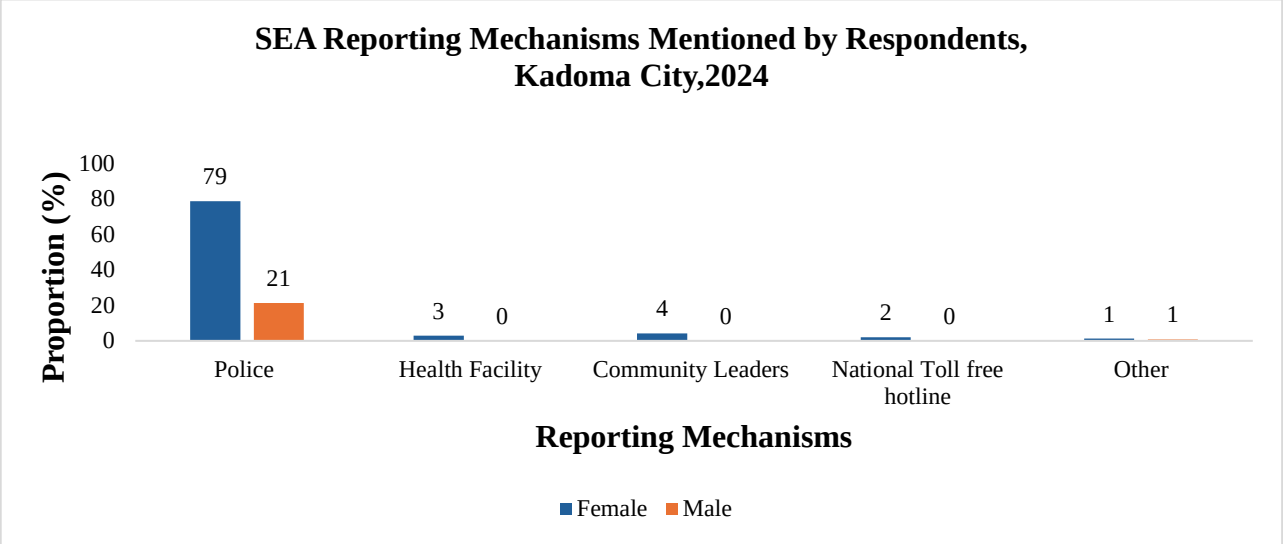

Figure 5:SEA Reporting Mechanisms Mentioned by Respondents, Kadoma City,2024

During a focus group discussion, the beneficiaries mentioned that health facilities, national toll-free hotline and community leaders as mechanisms for reporting SEA. However, they indicated that it is not easy to report SEA as tangible evidence is required to support the claim.

One participant mentioned: *"Reporting SEA incidents is not easy as evidence is required for the investigations to proceed. One does not have a stamp mark that I have been sexually exploited or sexually abused."*

Barriers to Reporting Sexual Exploitation and Abuse Incidents

On the barriers to reporting SEA incidents, 318 (86%) respondents reported fear ,119 (32%) mentioned negative social image (slander) and 90 (24%) mentioned perpetrator victimization. The barriers to reporting SEA mentioned by respondents are presented in ***Figure 6.***

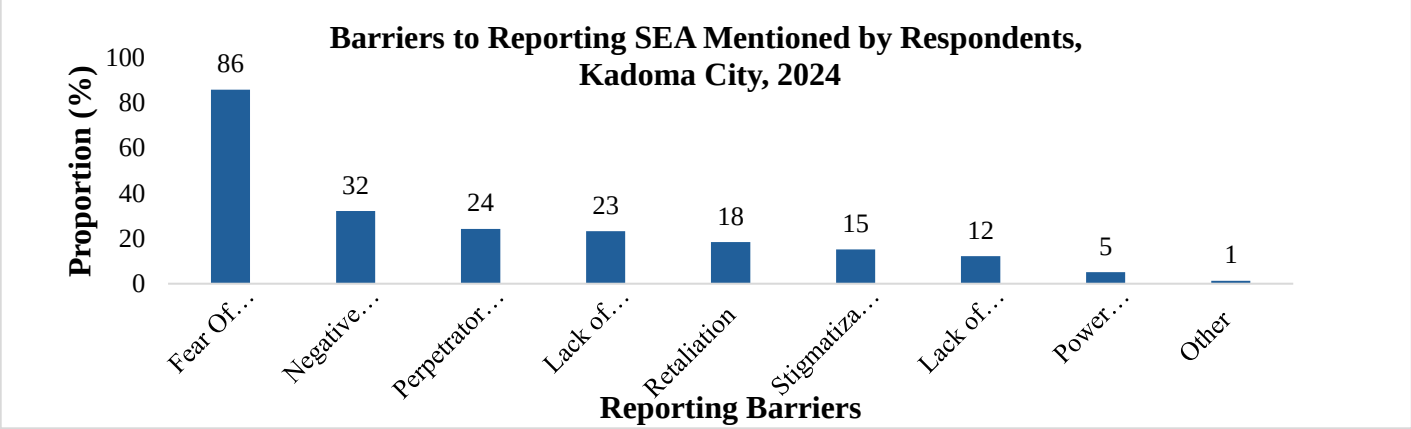

Figure 6: Barriers to Reporting SEA Among Respondents, Kadoma City,2024.

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During focus group discussions, the beneficiaries mentioned that victims could be given bribes by their perpetrators so that they do not report to the relevant authorities.

One participant mentioned that *"The perpetrator will pay the victim money so as to save their social image in a bid to protect their families."*

Furthermore, participants also mentioned that intimidation coming from the perpetrator could instill fear of reporting as they would say ,*"Go and report,nothing will happen to me!"*

Victim blaming can also hinder people to report SEA incidents as mentioned by the participants that *"People will blame the victim because of the way they dress,monetary status or they would blame the victim that they were looking for it"*

Preferred Methods of Reporting SEA Incidents

Among the 371 respondents interviewed, 247 (67%) preferred the use of anonymous reporting systems ,158 (43%) opted for a toll-free hotline, 150 (40.%) preferred reporting to relevant authorities and 21(6%) preferred a dedicated PRSEA focal at health institutions. The preferred methods of reporting SEA incidents among respondents are presented in ***Figure 7***.

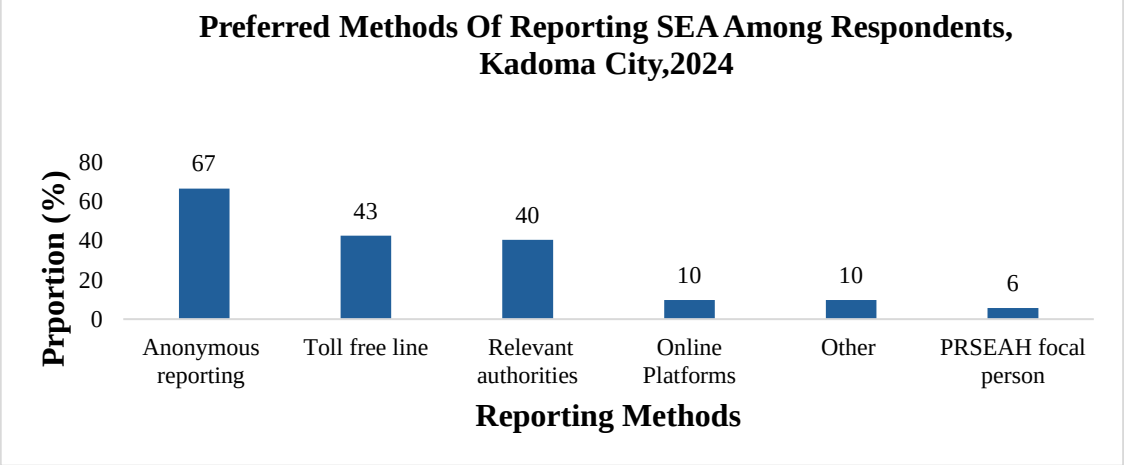

Figure 7: Preferred Methods of Reporting SEA Among Respondents, Kadoma City,2024.

Level of SEA Knowledge Compared Across Demographic Characteristics

Among the 371 respondents interviewed, 26 (9%) females and 9 (13%) males (***p= 0.3005***) had high knowledge of SEA. The age group 25-35 years had 9 (9 %) females and 3 (12%) males with high knowledge (*p=0.9754*). Those with tertiary education who had high level of knowledge were 19 (8%) females and 3 (3%) males (*p=0.0045*). The level of SEA knowledge compared to demographic characteristics is presented in ***Table 2.***

Table 2: Level of SEA Knowledge Compared Across Demographic Characteristics, Kadoma City, 2024

Characteristics	**Level of Knowledge n (%)**				***p-value***
	Females (**n=300**)		Males (**n=71**)		
	High Knowledge	**Low Knowledge**	**High Knowledge**	**Low Knowledge**	
Sex	26 (9)	274 (81)	9 (13)	62 (87)	***0.3005***
Age group					

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18-25	8 (10)	74 (90)	2 (7)	25(93)	
25-35	9 (9)	89 (91)	3 (12)	22 (88)	***0.9754***
35-45	5 (7)	68 (93)	1 (13)	7 (88)	
45-55	3 (11)	24 (89)	2 (40)	3 (60)	
55-65	1 (8)	12 (92)	1 (20)	4 (80)	
Above 65	0 (-)	7 (100)	0 (-)	1 (100)	
Level of education					
None	0 (-)	4 (100)	0 (-)	2 (100)	***0.0045***
Grade 1 -3	0 (-)	1 (100)	-	-	
Primary (Grade 4-7)	1 (6)	17 (94)	0	3 (100)	
Secondary (Form 1- 4)	19 (8)	221(92)	4 (8)	46 (92)	
Secondary (Form 5- 6)	3 (17)	15 (83)	2 (29)	5 (71)	
Tertiary	3 (16)	16 (84)	3 (33)	6 (67)	
Religion					
Christian Apostolic	6 (4)	131(96)	1 (8)	11 (92)	***0.6200***
Christian Pentecostal	9 (10)	84 (90)	6 (27)	16 (73)	
Christian Catholic	9 (16)	46 (84)	2 (11)	16 (89)	
African Traditional Religion	0 (-)	1 (100)	0 (-)	3 (100)	
Islam	1 (33)	2 (67)	-	-	
None	1 (10)	9 (90)	0 (-)	16 (100)	
Marital Status					
Single	2 (4)	43 (96)	3 (9)	32 (91)	***0.2131***
Married	19 (8)	210(92)	6 (18)	27 (82)	
Separated	0 (-)	3 (100)	0 (-)	1 (100)	
Divorced	2 (29)	5 (71)	0 (-)	2 (100)	
Widowed	3 (19)	13 (81)	-	-	

High knowledge ≥10, Low Knowledge <10

DISCUSSION

In recent years, the rise in public health emergencies has heightened the need to integrate PRSEA as a key component of response efforts starting to protect vulnerable communities. This study assessed knowledge, experiences, reporting mechanisms and barriers to reporting sexual exploitation and abuse (SEA) among the beneficiaries of hygiene kits during the cholera outbreak in Kadoma City.

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In this study, both male and female respondents exhibited low overall knowledge of Sexual Exploitation and Abuse (SEA). While most respondents could correctly define sexual abuse, fewer were able to define sexual exploitation, highlighting gaps in comprehensive understanding of SEA. This may be attributed to limited SEA awareness campaigns and insufficient mainstreaming within emergency response systems. Similar findings were reported in Kurdistan, where community members struggled to define SEA adequately(The Lotus Flower, 2020). Despite these knowledge gaps, respondents in our study identified key enablers and consequences of SEA, including power imbalances and inadequate reporting systems, as well as physical and psychological impacts such as sexually transmitted infections (STIs) and trauma. These findings are consistent with studies from the United Kingdom, Democratic Republic of Congo, and Zimbabwe, which similarly highlighted how structural vulnerabilities and health risks are central SEA issues (DFID, 2018; O'Brien, 2017)

Furthermore, knowledge levels in our study were significantly influenced by the level of education, with respondents who attained advanced secondary (Form 5–6) or tertiary education demonstrating high awareness of SEA. This is consistent with findings by Mlekwa *et al*., (2016), who emphasized education as an important determinant of understanding sexual misconduct. A plausible explanation for this finding is that higher education levels often provide individuals with greater exposure to information and resources that enhance awareness of complex social issues such as SEA(Abeid *et al*., 2015). Additionally, educational institutions may enhance critical thinking, enabling individuals to recognize and understand power dynamics, vulnerabilities, and the consequences of SEA.

In our study, a low proportion of respondents reported experiencing sexual abuse or sexual exploitation during the cholera response in Kadoma. However, some respondents acknowledged knowing community members who had been sexually exploited or who had engaged in sexual relations with emergency response personnel. The low reporting of sexual relations between community members and responders could be attributed to several factors, including fear of retaliation, societal norms discouraging disclosure, unclear reporting mechanisms, or the absence of concrete evidence. These findings are consistent with a recent study on the Syrian earthquake, where a similarly low proportion of respondents reported SEA, despite analyses suggesting a higher actual prevalence due to underreporting and inadequate reporting systems(Said-Foqahaa *et al*., 2023). This phenomenon highlights the pervasive issue of underreporting, often driven by fear, stigma, discomfort, or limited awareness of reporting channels. Such barriers obscure the true extent of SEA incidence, with significant implications for the affected community(Feather *et al*., 2021). SEA experiences erode trust between affected populations and emergency responders, a critical component in maintaining effective public health responses during emergencies (Taylor & Brostrom, 2023). Moreover, SEA constitutes a grave violation of human rights and undermines the integrity and credibility of humanitarian interventions(WHO, 2023).

Regarding available reporting mechanisms in this study, we found that most of the respondents were aware of SEA reporting mechanisms, with more females than males able to identify these channels .Similar findings were reported Bangladesh, where awareness of SEA reporting channels was higher among females, potentially due to a special focus on sexual misconduct against women(IOM, 2022).Most respondents expressed that they could not report SEA with ease. In accordance to a study in the United Kingdom where victims expressed difficulties in reporting SEA incidents due to a lack of faith in resolution and an unsupportive community environment (DFID, 2018).The ease of reporting SEA in Kadoma could facilitate a supportive community, encouraging victims or survivors to come forward and report SEA incidents if they occur.

Furthermore, the barriers to reporting SEA identified were fear of reporting, negative social image, perpetrator victimization, stigmatization, power imbalances and lack of knowledge on reporting mechanisms. Similar findings were found in Zimbabwe, which linked barriers to reporting SEA to low knowledge of reporting channels and fear of retaliation by perpetrators, coupled with power imbalances(UN, 2022) . Additional studies by Taylor & Brostrom (2023)and Carter *et al*., (2021)highlighted that societal tendencies to blame victims based on their attire or perceived behavior create a hostile environment, fear of stigmatization and the lack of a robust justice system making individuals less likely to report SEA incident. Respondents in our study expressed that fear of reporting arises from stigmatization, slander, threats from perpetrators, and power imbalances. Other factors included bribery, death threats, and the belief that individuals of low social status are unlikely to be taken seriously(DFID, 2018).These factors leave the community vulnerable to a continuous

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cycle of sexual misconduct if the barriers are not addressed in Kadoma City.

All the respondents expressed clear preferences for multiple reporting channels to report SEA incidents within the community. Anonymous reporting and toll free hotlines were the most preferred options ,aligning with findings from Cambodia ,where community members preferred suggestion boxes in secluded areas and phone hotlines to maintain confidentiality (Feather *et al*., 2021).This suggests the desire for confidentiality, highlighting the sensitivity surrounding SEA issues and the need for accessible, confidential reporting to overcome stigma or fear.

CONCLUSION

In our study we concluded that high SEA knowledge is limited regardless of gender. There were isolated reports on experiences of sexual exploitation and abuse primarily involving individuals' personal experiences or through knowledge of others who experienced sexual exploitation which indicates a possibility of underreporting. Most respondents were aware of existing reporting mechanisms for SEA and expressed a lack of confidence in the ease of reporting SEA. Major barriers to reporting SEA identified included fear of reporting, negative social image (slander), and potential victimization by perpetrators. Anonymous reporting was the preferred method for reporting SEA in the community due to the sensitive nature of the sexual misconduct, with accessible options such as suggestion boxes and hotlines being highlighted.

RECOMMENDATIONS

We recommend integrating PRSEA mainstreaming into all public health emergency response activities to ensure that safeguarding measures are of utmost priority. This includes raising awareness campaigns on SEA among community members and responders, thereby fostering a supportive environment that encourages reporting. Establishing robust accountability mechanisms is also vital to hold perpetrators accountable, thereby reinforcing trust within the community. Furthermore, we recommend expanding confidential reporting options, such as anonymous hotlines and suggestion boxes in Kadoma City.

Limitations

Due to the sensitive nature of this study, most participants were reluctant to share their experiences openly. This may have limited the depth of insights, potentially leading to underreporting or partial disclosure of key information. Furthermore, the study's imbalance by gender, with more females than males. This could result in skewed perspectives and the generalizability of findings is limited across genders.

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Competing Interests

The authors affirm that they have no financial or personal relationships that could have improperly influenced the writing of this article.

Authors' Contribution

CZ, CM and DC were responsible for conceptualization of the study. CZ, CM, ST, SM, NP and DC were responsible for study protocol development, data collection, analysis of results and drafting of the manuscript. LSC, SO and DC reviewed, edited and approved the final version of the manuscript. All authors agree to be accountable for the content and integrity of the article.

Funding Information

This study was supported by the World Health Organization. The funding source had no role in the study design, data collection, analysis, or interpretation of data.

Data Availability

The authors confirm that the data supporting the findings of this study are available from the authors upon reasonable request and with permission from the Kadoma City Council.

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