



Final Report

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Final evaluation of the 'Towards a Cholera-Free Nation' Project in Zanzibar: 2019-2023



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Gregory Kabadi, Team Leader and Evaluation Expert
Stewart Nyamuranga, WASH and SBCC Expert
Kuziwa Chimunda, Data Analyst
Peoples' Development Form (PDF), Survey Coordinator
Ngonidzashe Marimo, Technical Director
Theresa Marimo, Project Manager.

Executive Summary

Project Description: In support of the Revolutionary Government of Zanzibar’s (RGoZ) efforts to eliminate cholera through the Zanzibar Comprehensive Cholera Elimination Plan (ZACCEP) 2018-2027, UNICEF launched the project titled “Towards a Cholera Free Nation.” With funding from KOICA and co-funding from CDC and UNICEF/UNDP through the Green Shark Challenge funds, the project was implemented in five cholera hotspot districts in Unguja (Mjini, Magharibhi A, Magharibi B) and Pemba (Wete, Micheweni) over five years from May 2019 to December 2023.

The project aimed to improve coordination, advocacy, behaviour change, access to WASH services (infrastructure embedded), and capacity building of health services for better health outcomes, particularly for children. The main outcomes aligned with the three ZACCEP primary pillars: enabling environment, demand creation, and preparedness/response. The project's theory of change targeted institutional, organizational, and individual capacities for cholera prevention and response, aiming for effective cholera response mechanisms and improved sanitation at community and household levels. The project extended its impact through Social and Behaviour Change Communication (SBCC) activities in the remaining six districts of Zanzibar and interventions at the national level to improve the effectiveness of the health system and emergency preparedness.

Evaluation Objectives: The evaluation aimed to generate substantive evidence and lessons learned on the impact, coherence, relevance, effectiveness, monitoring, sustainability, and gender and equity focus of the project. It assessed the project’s performance over five years, covering capacities among government and community systems for continuity, ownership, and sustainability of the project; equitable access to safe WASH and health services; and communities’ adoption of improved WASH behaviours and practices. The findings were intended to inform the ongoing review of the Zanzibar National Water Policy and guide stakeholders, including government ministries, development partners, civil society, and communities, in eliminating future cholera outbreaks.

Methodology: The evaluation was theory-based and reflexive, utilizing a mixed-method approach to collect both quantitative and qualitative data, ensuring gender sensitivity and social inclusion. It involved key informant interviews, focus group discussions, and observations, with data collected from national and district/community levels. A water quality assessment survey was also conducted in project sites. Quantitative data were analysed using both descriptive and inferential methods, while qualitative data were coded and analysed using NVivo 12. The evaluation was guided by UNICEF and UNEG evaluation and research guidelines, adhering to principles of independence, impartiality, credibility, and accountability.

Findings

Relevance

The project's design was highly relevant to the context of Zanzibar, addressing critical areas such as water quality, sanitation infrastructure, and health education. The integration of various interventions demonstrated a comprehensive approach to cholera prevention. The project’s Theory of Change (TOC) was grounded in valid assumptions and causal linkages, ensuring that the interventions were aligned with the rights, needs, and priorities of rights holders. Government ownership and community engagement were pivotal in facilitating successful implementation. The project was flexible to adapt to the changing context to remain relevant including changing delivery approaches and reprogramming budget lines to respond to COVID-19.

However, resource constraints and cultural misconceptions posed challenges that occasionally undermined these causal linkages. The project design could also have strengthened integration of gender to address the deep-rooted social, cultural and gendered norms that negatively impact fulfilment and protection of everyone's right to water and sanitation as identified through the baseline studies.

Coherence

The project exhibited a high degree of coherence, aligning well with Zanzibar's national policies, such as the Zanzibar Cholera Elimination Plan (ZACCEP). Strong multisectoral collaboration, facilitated by coordination mechanisms like the ZACCEP Steering Committee and Task Force, ensured sufficient involvement of stakeholders. This led to a high degree of complementarity with other ongoing WASH and cholera interventions which saw increased integration of cholera elimination interventions into the health, education, tourism, fisheries and environment sectors. The 2nd Vice President's Office working with the Ministry of Health (MOH) and the Disaster Management Commission was especially instrumental in ensuring full participation of government ministries in ZACCEP structures. In contrast, coordination at district and community level was weakened by the lack of clarity and delineation of these multi-sectoral structures and financial and human resources constraints. There were missed opportunities in enhancing coordination as well as deepening cross sectoral collaboration including: collaboration with the Nutrition and Protection sectors in developing joint sectoral plans and interventions; and co-opting of civil society organisations (NGOs, media, universities) and the private sector into the coordination activities of the ZACCEP Structures.

Coverage

The project comprehensively covered the targeted population of 1,056,203 people in five districts and 182 hotspot shehias and their WASH needs. In Zanzibar, households having access to basic water supply increased from 95% at baseline (2019) to 97% at endline (2023), with access to basic sanitation services also increasing from 60% to 80% between baseline and endline, demonstrating the project's effectiveness in meeting the population's needs. Handwashing rates in schools increased significantly, from 45% at baseline (2019) to 80% at endline (2023). The student to drop hole ratio improved from 1:70 at baseline to 1:50 at endline, indicating better sanitation facilities in educational institutions. Household awareness levels on cholera (what is cholera, its symptoms, how it's treated) increased from 50% at baseline (2019) to 85% at endline (2023). Nonetheless, oral cholera vaccine (OCV) coverage was affected especially during the period after pick of COVID-19 and during the nationwide COVID-19 vaccinations.

Effectiveness

The project met or exceeded 24 out of its 31 targets (77%), demonstrating improvements in government and community capacities for cholera prevention and response. ZAWA's capacity in water chlorination was enhanced leading to 794,861 people accessing safe water annually throughout the project years. ZAWA's water supply increased from 47% in 2021 to 70% in 2023¹. There was some improvement in the quality of drinking water due to increased chlorination of the ZAWA piped water system, water vending points and water treatment practices using chlorine tablets at household levels. Analysis of water samples during the evaluation showed that the percentage of water samples with FRC levels less than that of the required standard levels of 0.5mg.l i.e., 0.0%-0.49%, decreased from 97.4 percent (296/304 samples) at baseline to 48.2 percent (150/311) at endline, whilst those above the standard increased from 2.6% percent to 3.5 percent. There was also an improvement in the microbiological quality of water with the proportion of samples found not to have any faecal coliforms across all the five (5) project districts increasing from 70.6 percent at baseline, to 85.6 percent at end line. There were some variations across the two Islands, with Unguja having more samples with no

¹ 2024 The Journey – Investment in the Water Sector 2020-2023, Achievements, Opportunities and Gaps; ZAWA.

faecal coliforms (61%) in Unguja compared to Pemba (39%), revealing the urban-rural disparities in water quality. However, both islands showed an increase in water quality over the period of the project.

The project also resulted in improvements in WASH practices amongst targeted communities across all the districts. Rates of open defaecation decreased from 17 percent at baseline to only 7 percent at endline². The budget allocation for WASH sector increased in absolute terms from 2.8% of the total government budget in the financial year 2017/18 to 17.8% in the financial year 2022/23 despite the increase being limited to the water component than sanitation. The enabling environment for WASH was improved through the development and enforcement of various public health regulations by the MoH Environmental Health Department and the Environmental Management Agency (EMA).

Efficiency

The project efficiently utilized resources, leveraging partnerships with various organizations such as WHO, CDC, and local NGOs. The integration of interventions into existing community structures and the use of local resources minimized costs and maximized impact. Despite financial constraints, the project managed to achieve its objectives through strategic planning and resource allocation.

Impact

The project had a significant impact on reducing the frequency of cholera outbreaks and improving overall public health in Zanzibar. The holistic approach, combining strengthening coordination structures, infrastructure development, social and behaviour change communication (SBCC), and community engagement, resulted in notable improvements in hygiene practices and reduced incidence of cholera. There were no cholera outbreaks or cases, throughout the course of the project largely because of the contributions of the interventions implemented. The project managed to prove how robust the ZACCEP Plan is in eliminating cholera in Zanzibar. However, the existence of some preconditions for cholera in some of the hot spots pose a significant threat of cholera outbreaks in the medium to long-term.

Sustainability

The sustainability of the project's outcomes was supported by strong government ownership and high level of community involvement. The establishment of robust coordination mechanisms and the integration of cholera elimination interventions into other sectoral plans ensured continued support and funding. While the project, to a large extent, was designed and implemented to ensure continuity through entrenching ownership of activities and results by the RGoZ, the evaluation noted some challenges which could undermine sustainability of results achieved. Sustenance of school WASH improvements could be hampered by the limited availability of WASH specific budgets in districts and schools. Communities could face challenges in accessing the SATO Pan, particularly at community levels, and this may make it difficult to replace their latrines in the long-term. The various challenges being faced by Zanzibar Water Authority (ZAWA) such as shortage of electricity and low revenue may limit users to access adequate amounts of safe water both in the short and long-terms. Individual households and water vendors are no longer accessing the free water treatment tablets (Water Guard) as these are unavailable in their local markets. ZACCEP structures face challenges of funding and shortage of skilled human resources which threatens their effectiveness and sustainability. Climate change is also threatening the continuous access and availability of safe drinking water as it is contributing to the drying of water sources mostly used by private households and water vendors. Solid Waste Management (SWM) groups are lacking viable markets to sell products from their projects, and this is threatening the continuation of their various activities. Some communities continue to practice or have resorted back to practicing poor WASH behaviours due to their lower risk perceptions of cholera because, together with covid-19 cases, have since disappeared.

² 2022 TDHS-MIS

Conclusion

The endline evaluation has established that the Zanzibar 'Towards a Cholera-Free Nation' Project is relevant and has proved to be feasible, flexible, acceptable, and implementable in the evolving context of Zanzibar. The project's model has demonstrated the robustness and effectiveness of the Revolutionary Government of Zanzibar's Comprehensive Cholera Elimination Plan (ZACCEP) 2018-2027 in effectively providing coordination mechanisms for cholera interventions, guiding development partners in designing and implementing cholera preventive activities and providing an enabling environment for the elimination of cholera in Zanzibar through its three (3) pillars.

Lessons learned

Below are the lessons that have been learned from the implementation of the 'Towards a Cholera-Free Nation Project' in Zanzibar:

Lesson Learnt 1: The multi-sectoral coordination and implementation nature of cholera prevention and response actions is an effective approach, but attention needs to be paid to areas that can undermine efficiency and effectiveness. This happens where performance of the project is strongly interlinked with the performance of individual sectors and MDAs. The inefficiencies in one sector or MDA may jeopardise project results related not only to their sector or agency, but for the entire project.

Lessons Learnt 2: Introducing new and different vaccines at the same time to the same targeted populations without proper sensitization and planning may result in low vaccination coverage of both vaccines especially if there are strong objections for one of the vaccines.

Lesson Learnt 3: Interventions aimed at elimination of WASH-related diseases such as cholera and covid-19 need to be sustained by continued risk communication and community engagement beyond the project within the relief, recovery, and development continuum.

Lesson Learnt 4: A cholera elimination project premised on a strong gender analysis at design will enhance systematic mainstreaming of gender and with it, substantive WASH and Health outcomes.

Recommendations

Below is a summary of the proposed recommendations to enhance implementation of ZACCEP, or a similar future project.

Recommendation 1: There is need for the Office of the 2nd VPO to take significant steps to address the challenges and inefficiencies within the MDAs that are affecting the effective coordination and delivery of the ZACCEP. The following actions need to be considered:

- Conduct stakeholder mapping of and incorporate potential partners with a stake in cholera elimination in the ZACCEP coordination structures at all levels and develop of Terms of Reference (ToRs) that clearly define each one's roles, responsibilities and functions.
- Advocate for a budget line for multi-sectoral coordination and continuously track the contribution of the various MDAs towards the ZACCEP to ensure that the required resources are mobilized to implement the plan.
- Establish a technical working group for resource mobilization which will develop and oversee implementation of a Resource Mobilization Strategy.
- Enhance coordination at district and shehia levels by building human resource capacity anchored on a sector-wide human resource capacity assessment for cholera elimination amongst the MDAs.
- Support and closely monitor the coordination activities of the ZACCEP structures at district and shehia levels, ensuring the structures are active and performing their expected roles.

Recommendation 2: There is need to further integrate future project's interventions into the sectoral plans of other sectors such as protection and nutrition as this will result in greater synergies and ultimately impact. Evidence from the WASH in Schools interventions can be used to influence the Ministry of Education at national level to adopt the group hand washing and SWASH Clubs model into all of its primary schools, and to also incorporate WASH topics in the curriculum for the training of teachers and teaching of students. Linkages between nutrition and WASH coordination structures and outputs can be enhanced to facilitate integration of WASH in nutrition plans and actions. **Responsibility:** 2nd VPO, UNICEF

Recommendation 3: In addition to sex disaggregated data, there is need for future projects to ensure the collection of disaggregated data in the form of locations (by Island, By District, Urban vs Rural) or diversity at project design, implementation, monitoring and reporting. This includes the inclusion of disaggregated targets and achievements in the results framework. This enables the continuous analysis of equity from project design, during implementation and also at reporting. **Responsibility:** UNICEF, MoH

Recommendation 4: Future projects should consider including interventions which go beyond the distribution of water purifiers (HTH powder and water treatment products), but that also address some of the underlying challenges affecting the overall water supply and sanitation service delivery. This can include the rehabilitation of the ZAWA piping system; strengthening ZAWA's revenue collection system; installing alternative electricity or solar generators; extending water pipeline to unserved areas; developing additional water sources that are resilient to climate shocks; and also improving ZAWA's operations including its financial and human resource capacity for sustained water treatment and quality assurance and other O&M issues. This will improve ZAWA's water production capacity so that it meets the demands of users. **Responsibility:** ZAWA, MoWEM, ZURA.

Recommendation 5: There is need to advocate for the development and adoption of a 'Zanzibar Open Defaecation-Free Strategy' that will clearly outline the policy directives and key strategies to be used to promote ODF, and also the criteria for the declaration and certification for ODF villages. **Responsibility:** MoH, UNICEF

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Acronyms

2ndVPO	2nd Vice President's Office
ANOVA	Analysis of Variance
APHA	American Public Health Association
AWWA	American Water Works Association
CAPI	Computer- Assisted Personal Interviewing
CCC	Core Commitments for Children
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CDC	Centers for Disease Control and Prevention
CTC	Cholera Treatment Center
COVID-19	Coronavirus disease 2019
EE	Enabling Environment
FGDs	Focus Group Discussions
GAC	Global Affairs Canada
GEROS	Global Evaluation Reports Oversight System
GTFCC	Global Task Force on Cholera Control
KIIs	Key Informant Interviews
KOICA	Korea International Cooperation Agency
LGAs	Local Government Authorities
M&E	Monitoring and Evaluation
MDS	Muthengo Development Solutions
MOEVT	Ministry of Education and Vocational Training
MOH	Ministry of Health
MOW	Ministry of Water

NGOs	Non- Governmental Organizations
NVivo	Qualitative Data Analysis Software
O&M	Operations and Maintenance
ODK	Open Data Kit
PDF	People's Development Forum
PWDs	People with Disabilities
RGOZ	Revolutionary Government of Zanzibar
SPSS	Statistical Package for the Social Sciences
SUZA	State University of Zanzibar
TEA	The Evaluation Audience
TEC	Tanzania Episcopal Conference
TOC	Theory of Change
TOR	Terms of Reference
UN-SWAP	United Nations System-Wide Action Plan on Gender Equality
UNDIS	United Nations Disability Inclusion Strategy
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation, and Hygiene
WEF	Water Environment Federation
WHO	World Health Organization
ZACCEP	Zanzibar Cholera Control and Elimination Program
ZAWA	Zanzibar Water Authority

1 Introduction

1.1 Country Context

1.1.1 Socio-economic status

Zanzibar, an enchanting archipelago situated in the Indian Ocean, comprises two main islands, Unguja and Pemba, alongside several smaller islets. This cluster of islands forms part of the United Republic of Tanzania, a unique union between Zanzibar and Mainland Tanzania. Despite this union, Zanzibar maintains significant autonomy, governed by the Revolutionary Government of Zanzibar (RGOZ). This autonomy allows Zanzibar to address its unique challenges and opportunities through tailored governance. Zanzibar's distinct geographic and political status significantly shapes its socioeconomic landscape. The archipelago's main islands, Unguja and Pemba, are renowned for their rich cultural heritage and natural beauty. The union between Zanzibar and the Mainland forms the United Republic of Tanzania, but Zanzibar operates with considerable

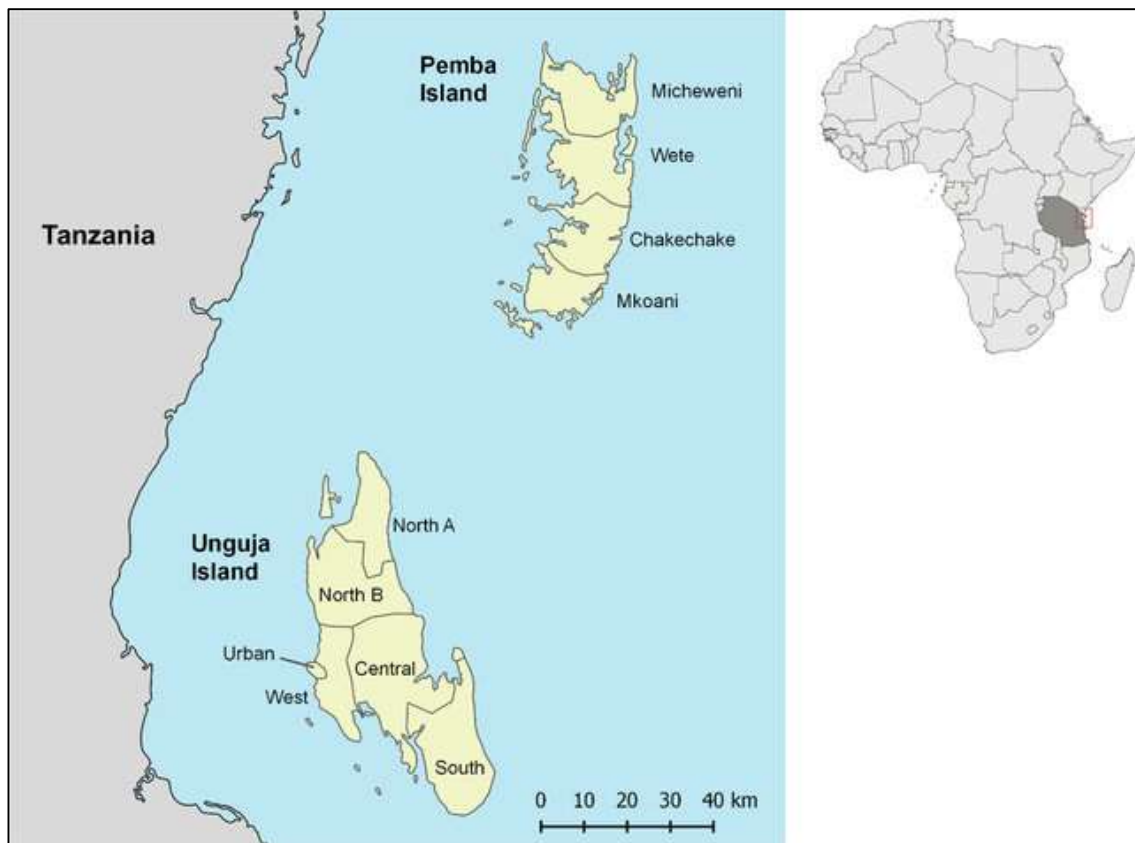


Figure 1: Map of Unguja and Pemba Islands of the United Republic of Tanzania³

Zanzibar's economy is predominantly driven by tourism, agriculture, and fishing. Each sector plays a vital role in the livelihoods of the island's inhabitants and the overall economic stability of the region.

³ Adopted from Mwinyi I Msellem, author of "Use of Routine Health Information System Data to Evaluate Impact of Malaria Control Interventions in Zanzibar, Tanzania from 2000 to 2015" map accessed on 17/05/2024, available at: https://www.researchgate.net/publication/333926516_Use_of_Routine_Health_Information_System_Data_to_Evaluate_Impact_of_Malaria_Control_Interventions_in_Zanzibar_Tanzania_from_2000_to_2015/figures?lo=1

- **Tourism** is a cornerstone of Zanzibar’s economy. The archipelago's allure, stemming from its pristine beaches, historical sites, and vibrant culture, attracts a significant number of tourists annually. This influx provides substantial revenue and employment opportunities, reinforcing the sector's importance to the local economy.
- **Agriculture** is another critical economic pillar, with Zanzibar often referred to as the "Spice Islands" due to its renowned spice production, particularly cloves. Agriculture not only contributes to the economy through exports but also sustains local communities by providing food and employment. Seaweed farming is also a thriving source of employment and livelihood especially for the communities who completely depend on the use of natural resources for their livelihoods and has also become a significant contributor to Zanzibar's economy. In 2023, it contributed around 2% to Zanzibar's GDP⁴.
- **Fishing** also significantly contributes to the archipelago’s socioeconomic fabric. The fishing industry supports numerous families, providing both a source of income and nutrition. The abundance of marine resources around the islands makes fishing a viable and essential economic activity.

The high population density in Zanzibar presents several developmental challenges. Overpopulation strains land resources, housing, and public services, necessitating efficient management and planning. Infrastructure development is a continuous challenge. As the population grows, the need for robust infrastructure, including roads, healthcare, and educational facilities, becomes increasingly critical. Addressing these needs requires substantial investment and strategic planning to ensure sustainable growth. Economic diversification is another pressing issue. While tourism and agriculture are currently the main economic drivers, reliance on these sectors alone is not sustainable. Diversifying the economy is essential to building resilience against economic shocks and ensuring long-term prosperity.

The Revolutionary Government of Zanzibar is actively engaged in various initiatives to improve the islands’ socioeconomic conditions. Efforts to boost tourism, enhance agricultural productivity, and develop public infrastructure are central to these initiatives. Healthcare and education sectors are receiving significant attention and investment. Improving the quality and accessibility of healthcare and education is paramount for the well-being and future prospects of the growing population.

1.1.2 Zanzibar’s Demographic Profile

According to the 2022 population census, Zanzibar is home to 1,889,773 people. This population is nearly evenly split by gender, with 974,281 females (51.6%) and 915,492 males (48.4%). The population density of Zanzibar stands at a notable 530 persons per square kilometer, making it the most densely populated region in East Africa. This high density presents both opportunities and challenges, influencing the region's development dynamics.

Table 1 shows the percentage population of the five (5) out of the eleven (11) districts in Zanzibar targeted by the ‘Towards a Cholera Free Nation’ project⁵.

4 2022: The Role of Deep-Water Seaweed Farming on economic empowerment in Zanzibar; Zanzibar Research Centre for Socio-economic and Policy Analysis (ZRCPC); Policy Note

5 National Bureau of Statistics Tanzania, 2022.

Table 1: Population of the five project districts

District	Total Population
Micheweni	123,379 (6.5%)
Wete	148,712 (7.9%)
Mjini	219,007 (11.6%)
Magharibi A	329,645 (17.4%)
Magharibi B	344,517 (18.2%)
Total	1,165,260 (61.7%)

According to the 2022 National Housing and Population Census Report, the population in Zanzibar is youthful with 47.2 per cent below the age of 18 and 37 percent are between the ages of 15 and 35 years. The population of Zanzibar is pyramid-shaped with a broader base of young people and a narrow tapering apex of dependent elderly, typical of sub-Saharan Africa and of most developing countries. The high proportion of young people tallies with the large percentage of women of reproductive age (15 to 49 years) reported to be 50.4 per cent in 2022. As of 2021, the Gross Domestic Product (GDP) per capita in Zanzibar slightly increased to 1,208 U.S. dollars compared to the 1,099 U.S dollars for the previous years⁶. Despite this impressive economic growth, the percentage of population below the basic needs' poverty line was 25.7 percent in 2023, with some marked rural-urban disparities (33.7percent and 15.5percent rural and urban respectively). Although by end of 2020, multi-dimensional child poverty had declined steadily, 30 per cent of children still live in monetarily poor households; with 34 per cent of children being multi-dimensionally poor⁷.

About 95 per cent of the population lived within 5km radius of a health facility⁸. In Zanzibar society, traditional gender-based roles mean that women, young women in particular, rarely have control over the decisions surrounding their own WASH and health services or that of their children. Husbands, mothers, mothers-in-law and grandmothers all have significant influence on the type of WASH facilities and health care that a young woman and her children will receive. The traditional gender roles have also resulted in women and girls in Zanzibar bearing the larger burden of collecting water, doing domestic chores and caring for the sick, and yet their opinions, priorities and decisions regarding WASH services both at household and community levels are rarely taken into account. There are also many deterrents to women seeking health services, including transport availability and cost, and disrespectful treatment by health workers. There is a limited knowledge among families and communities on appropriate practices on hygiene and sanitation.

1.1.3 WASH and Cholera Situation

According to the Tanzania Demographic and Household Survey (TDHS, 2022), 98% of households in Zanzibar obtain their drinking water from improved sources. These improved sources protect against outside contamination, making the water more likely to be safe to drink. Access to safe drinking water is a critical component of public health and well-being. Additionally, 84% of Zanzibar households have water on the premises. A significant number of households travel less than 30 minutes to fetch water, with drinking water sources located less than 500 meters round trip from their dwellings⁹. This accessibility to water is crucial for daily living and health.

⁶ www.statista.com/statistics/1185214/gdp-per-capita-in-zanzibar

⁷ 2023; The State of Zanzibar's Children; Evidence from the Zanzibar Household Budget Surveys; © Revolutionary Government of Zanzibar and United Nations Children's Fund Zanzibar City

⁸ 2023; National Housing and Population Census Report, National Bureau of Statistics (NBS)

⁹ 2022; Tanzania Demographic and Health Survey; National Bureau of Statistics

Improved sanitation refers to facilities that effectively separate human excreta from human contact, thus promoting hygiene and health. By improving access to and utilization of such facilities, particularly those resilient to climate impacts, the spread of diseases can be curbed, leading to reduced morbidity and mortality associated with sanitation-related issues. Furthermore, the proper utilization of sanitation facilities not only contributes to health outcomes but also yields broader societal benefits, such as advancing gender equality, upholding human dignity, and safeguarding the environment.

In Zanzibar, a notable 91% of households have adopted improved toilet facilities, reflecting a positive trend towards enhanced sanitation practices¹⁰. The most common type consists of pit latrines with slabs (non-washable), accounting for 23% of facilities, followed by flush/pour flush toilets directing waste to a pit latrine (20%), and washable slab pit latrines (17%). Notably, 9% of households still resort to open defecation, with a higher prevalence in rural areas (13%) compared to urban areas (1%). Furthermore, the proportion of children with consistent access to improved sanitation and safe drinking water has not improved in the last 10 years, with over one third (35 per cent) of children live in households that either use an unimproved toilet or share a toilet with other households¹¹. These findings underscore the need for continued efforts to promote improved sanitation practices, especially in areas with lower adoption rates, to achieve comprehensive public health and environmental goals.

On the other hand, cholera is a significant public health disease with economic threat and humanitarian crisis throughout the world. The current cholera pandemic (7th) reached Africa in 1971, Tanzania in 1974 and Zanzibar in 1978, where it was first reported among fishermen. Since 1978, Zanzibar has experienced over 1912 repeated outbreaks of cholera, with a total of 14,364 cases and 210 deaths, giving an average case fatality ratio (CFR) of 1.5%¹³. However, even more devastating was the recent major outbreak of cholera which spanned ten months between September 2015 and July 2016 recording a total of 4,330 cases and 68 deaths with a CFR of 1.6%¹⁴. Most affected areas in the archipelago tended to be those communities facing chronic shortage of safe water and poor sanitary conditions including persistent sewage leakages in urban areas. In terms of the people infected with cholera in the 2015/16 epidemic, there were slightly more males (52.5%) than females (47.5%) in both Unguja and Pemba¹⁵. In Pemba, more than half of the cases were children (58%) from 0 to 15 years, compared to only 29% in Unguja. In Unguja, (25%) aged 16 to 25 years and (41%) from 26+ years made up 2/3 of cholera cases reported in Unguja, while Pemba's (18%) aged 16 to 25 and (24%) aged 26+ were less than half of cholera cases reported in Pemba¹⁶.

The proportion of children under five affected by the diseases varies in by districts within the island from 10% to 31.8% in Pemba to 10% to 20% in Unguja¹⁷. There was a very high level of infection in young children particularly in Micheweni. Although National Guidelines for Integrated Disease Surveillance and Response (IDSR) were developed to guide regular reporting of cholera and other cases from both public and private health facilities, under-reporting was frequent since some of the suspected cholera cases (according to the standard case definition) who are outpatients were not registered as cholera patients. Lack of centralized electronic database, inconsistent data reporting, inadequate coordination mechanism, and the lack of capacity to perform data analysis easily jeopardized efforts of early detection and response actions to cholera in Zanzibar. In addition, there was limited laboratory services at the point of care, and erratic laboratory supplies and reagents

¹⁰ 2020; Zanzibar Cholera Situational Analysis Final Report; Public Health Laboratory

¹¹ 2023; The State of Zanzibar's Children: Evidence from the Zanzibar Household Budget Surveys (2010-2020); © Revolutionary Government of Zanzibar and United Nations Children's Fund

¹² TOR note 17 outbreaks though official documents mentions 19

¹³ Zanzibar Guidelines for the Prevention and Control of Cholera (ZGPCC), June 2016. RGOZ, MoH and WHO, p. 8.

¹⁴ 2018; Zanzibar Comprehensive Cholera Elimination Plan (ZACCEP) 2018-2017; RGoZ

¹⁵ Zanzibar Cholera Situational Analysis Final Report, Public Health Laboratory (PHL-Idc) 2020

¹⁶ 2018; Zanzibar Comprehensive Cholera Elimination Plan (ZACCEP) 2018-2017; RGoZ

¹⁷ 2016; Zanzibar Guidelines for the Prevention of Cholera (ZGPC), RGoZ, MoH and WHO

necessary for confirmation of diagnosis, isolation of causative vibrio type and continuous monitoring of sensitivity pattern.

Several reasons have been attributed for the continued resurgence of cholera cases in Zanzibar. Since the early 1990's the Revolutionary Government of Zanzibar has made efforts to prevent and control cholera epidemics in Zanzibar. However, most of the attempts have been reactive, ad hoc, and unsustainable emergency measures focused on controlling cholera. The rapid growth population has multiplied demand on already stretched WASH and health services. It has also resulted in high population density leading to overcrowding in most areas especially in Mjini and adjacent districts. There is overwhelming evidence on association of overcrowding and spread of cholera infection among the communities.

The growing number of urban slums/squatters with insufficient access to safe water combined with substandard sanitation facilities and unhygienic food practices and behaviors collectively contributed to the rising number of areas where cholera transmission could be sustained. In these same places, poor knowledge about waterborne diseases, like cholera, and un-sustained community engagement efforts impaired prevention and control efforts. Information, education and communication (IEC) activities promoting cholera prevention measures and dispelling untruths, were not sustained after cholera outbreaks. Awareness and engagement interventions were not continuous, and mostly concentrated on IECs, but not on changing behaviors. A Situational Analysis and Epidemiological Study of Cholera Hotspots in Zanzibar carried out in 2020 revealed that drinking water that was collected from varying water sources, locations and districts and analyzed for the presence of microbial indicators of water quality revealed that higher proportion of the samples had *E. coli* (71.7%), coliform organisms (70.6%) and enterococci (81.3%). There were poor solid waste management practices particularly in unplanned urban settlements, where sewage systems were obsolete or nonexistent and unlawful dumping of liquid and solid wastes was common, with less than 50 per cent of solid waste collected by municipal trucks and crudely disposed-off in Kibele dump site.

Inadequate and inequitable access to water and sanitation services at households and institutions, and inappropriate hygiene practices largely contributes to deprivations of children in Zanzibar extending it beyond WASH to impact other sectors such as health, education and nutrition. Before the project, more than 84% households had access to piped water from Zanzibar Water Authority (ZAWA), but daily production was only enough to meet 41% of demand¹⁸. This situation forced households to use alternative water supplies or sources, which in turn put individuals into risk of acquisition of diarrhoeal diseases including cholera.

Analysis of WASH performance indicators in Zanzibar showed large disparities between rural and urban populations, with rural populations being the more disadvantaged. Zanzibar had one of the largest gaps between urban and rural populations in terms of both access to improved water source and improved sanitation when compared to other countries in the region. The critical bottlenecks for the WASH sector included inadequate capacity of government and communities to manage WASH services, inefficiencies in programme implementation at all levels, poor sub-national level coordination and capacity, unavailability of reliable sector data, and sustainable financing especially for sanitation and hygiene. Health facilities (HFs) were unprepared to detect and manage cholera properly and had inadequate cholera supplies. For the most part, regular healthcare facilities are functionally converted into CTCs and CTU operating under the same staff, and as such lacked conducive environments for effective patient care. Although training of healthcare workers was carried out by Ministry of Health and WHO, no cholera-specialized teams and guidelines were created before the project was implemented.

¹⁸ 2018; Zanzibar Comprehensive Cholera Elimination Plan (ZACCEP) 2018-2027; Revolutionary Government of Zanzibar

Several steps and efforts have been made in Zanzibar by both government and the civil society to eliminate cholera. The Government has enacted several rules and regulations to control environmental and sanitation risks that have frequently been the main factors for cholera epidemics in Zanzibar. These include the establishment of The Public and Environmental Health Act no. 11 of 2012, Disaster Risk Reduction and Management Act no. 13 and Regional Administration Authority Act no. 7 of 2014. WASH infrastructure has steadily improved, and a mass oral cholera vaccination effort was introduced in 2010. To further show its political commitment to eliminate cholera, the Government of Zanzibar also launched the Zanzibar Comprehensive Cholera Elimination Plan (ZACCEP) to be implemented within a 10-year period (2018-2027). The overall goal of the plan is to eliminate local transmission of cholera in Zanzibar by meeting set targets and thirteen objectives that will effect change on three pillars:

- Create an enabling environment that promotes the elimination of cholera through policy, legislation, and multi-sectoral coordination;
- Enhance the scope and effectiveness of preventative measures/services; and
- Improve Zanzibar’s capacity to respond and contain localized/isolates outbreaks/ cholera events.

1.2 Project Description

The concept of penning out the Zanzibar Comprehensive Cholera Elimination Plan (ZACCEP) was highly applauded and quoted as a model for the region by the Global Task Force on Cholera Control (GTFCC) at its international meeting in October 2017. With this background, UNICEF firmly intended to support the Government of Zanzibar to achieve its vision to eliminate cholera in Zanzibar in ten years, with the understanding that cholera elimination interventions are developmental and transformational in nature. With funding from KOICA, and co-funding from CDC and UNICEF/UNDP through the Green Shark Challenge funds, UNICEF thus developed a project titled “Towards a cholera Free Nation” aiming for lasting changes in terms not only of eliminating cholera, but also of improving quality of life (refer to Box 1 for the summary of the project).

A second focus of the project was of strengthening coordination platforms for cholera elimination, , increasing access to improved WASH services, enhancing community hygiene and sanitation behaviours and practices, and strengthening advocacy platforms for better health outcomes for the entire population, particularly children. The focus of the project was also to produce tangible and sustainable results, generating learning and evidence for replicating the model in Tanzania mainland and more widely in the region – though this last aspect will not be evaluated on. The project integrated gender, and equity issues by ensuring the participation of men, women, adolescents, and children in schools as well as people with disabilities. Disaggregated data (sex, rural/urban, district) was collected throughout the project, and platforms for community engagement and social accountability were strengthened. The project made efforts to provide opportunities to promote appropriate

Box 1: Project Summary

Total Budget: USD 5,350,000 (USD4,500,000 from KOICA, 750,000 from CDC, and 100,000 from UNICEF/UNDP Green Shark challenge)

Duration: May 2019 to December 2023

Target Districts: Mjini, Magharibi A, Magharibhi B, Wete and Micheweni. The remaining 6 districts were covered by SBCC activities only

Beneficiaries: 1,056,203 people direct beneficiaries and over 660,000 indirect beneficiaries

Implementing/ Technical partners: MOH, Ministry of Education and Vocational Training, 2nd Vice President’s Office, Ministry of Water, Zanzibar Water Authority (ZAWA), State University of Zanzibar (SUZA), Zanzibar Local Government Authorities, WHO, INGOs and CSOs

Scope: 182 cholera hotspot shehias (wards), representing 48 per cent of the 387 Shehias in Zanzibar

measures in tackling the existing barriers that perpetuate gender disparities and exclusion of the marginalized. In 2010, the UN General Assembly recognized access to water and sanitation as basic human rights, and essential to the realization of all human rights. Likewise, two human treaties namely the Convention on the Rights of the Child (CRC) and the Conventions on the Elimination of All Forms of Discrimination against Women (CEDAW), have directly specified the right to water and sanitation as an essential right.

The rights to water and sanitation require that these basics are adequate, accessible, safe, acceptable and affordable for all without discrimination. The project ensured that these fundamental rights were fulfilled through ensuring universal and equitable access to safely managed and affordable water and safely managed sanitation facilities through various interventions for all the targeted beneficiaries in communities, schools and healthcare facilities in the five (5) project districts. The 'Towards a Cholera-Free Nation' project had a duration of five years, commencing from May 2019 and concluding in December 2023. This initiative was primarily focused on addressing cholera in five designated hotspot districts, namely Micheweni, Wete, Mjini, Magharibi A and Magharibi B , which represent a subset of the 11 districts within Zanzibar. It is essential to acknowledge that the project covered the remaining six districts through Social and Behavior Change Communication (SBCC) activities, including national cholera awareness and sensitization campaigns and also from interventions at the national level to improve the effectiveness of the health system and emergency preparedness and response capacity.

The project extended its reach to 182 cholera hotspot Shehias (wards), accounting for 48 percent of the total 387 Shehias in Zanzibar. This outreach was meant to directly benefit a population of 1,056,20319 individuals²⁰, while an additional 660,000 residents indirectly benefited from the national cholera awareness and sensitization campaigns, which included SBCC efforts, along with interventions at the national level to enhance the efficiency of the healthcare system and improve emergency preparedness and response. The main outcomes of the project are aligned to the three ZACCEP primary pillars outlined above, i.e. enabling environment; demand creation and preparedness/ response. More details on the project outcomes, outputs, targets and indicators are shown in Annex 3. The three (3) project outcomes are outlined in the Figure below:

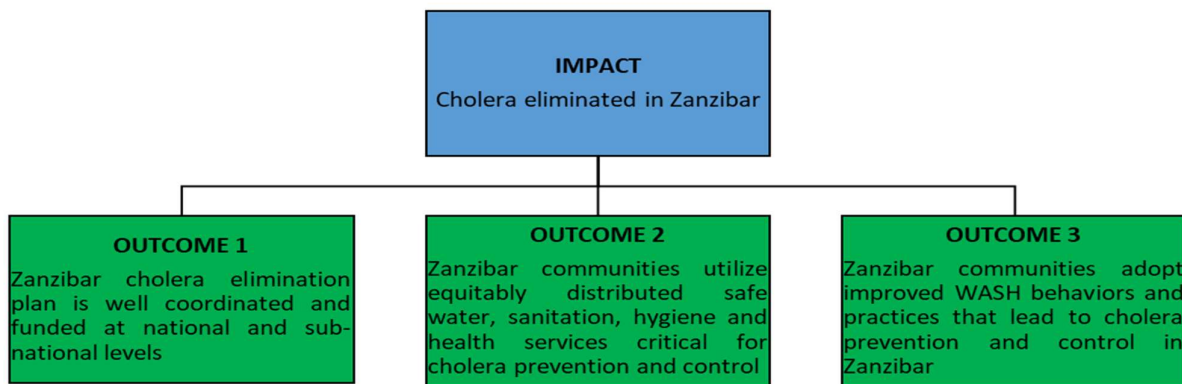


Figure 2: Project’s key results

The project outcomes were supported by five (5) overarching objectives that sought to:

19 Gender disaggregated data not available from project documents
 20 Disaggregated data not available for the target beneficiaries

1. Strengthen coordination of cholera prevention and control through effective, evidence-based, multi-sectoral planning.
2. Improve public advocacy and strengthen partnerships for cholera prevention and control.
3. Contribute to improved access to safe water and sanitation.
4. Strengthen the capacity of the health sector for early detection and response to contain cholera.
5. Increase community knowledge and transform social norms about appropriate practices for the prevention and control of cholera.

UNICEF assumed the role of fund manager for this initiative and had the overall accountability for achieving all the project's outcomes. This accountability extended to UNICEF's implementing and technical partners, which included various government ministries and departments such as the Ministry of Health (MOH), Ministry of Education and Vocational Training (MOEVT), 2nd Vice President's Office (2VPO) - Disaster Management Commission (DMC), Ministry of Water (MOW), Zanzibar Water Authority (ZAWA), Zanzibar Local Government Authorities (LGAs), faith organizations including TEC and Mufti office, technical partners including the State University of Zanzibar (SUZA), UN agencies such as the World Health Organization (WHO), and various non-governmental organizations (NGOs). WHO supported the two rounds of the oral cholera vaccine (OCV) campaign, with UNDP and UNICEF supporting the Solid Waste Management Innovation WASTEX Lab Project, the Center for Disease Control (CDC) overseeing the water quality monitoring component and the Romania's International Development Cooperation supported the Revolutionary Government of Zanzibar (RGOZ) with four compressor trucks for solid waste collection. This evaluation is coming at the end of the project.

1.3 Summary of Project Interventions

The project was well aligned to the ZACCEP 10-year plan, and to the three pillars discussed above. Based on the three pillars of the project, Table 2 provides the strategic interventions implemented by the project as informed by the log frame presented in the TOR.

Table 2: Summary of Interventions for the "Towards a Cholera Free Nation" Project

ZACCEP Pillar	Project Strategic Interventions
1. Enabling Environment (EE)	<ol style="list-style-type: none"> 1) Effective <i>multi-sectoral coordination</i> in eliminating local cholera transmission in Zanzibar. 2) Existence of and adherence to land-use, environmental health and food hygiene <i>regulations</i> to reduce the risk of cholera and other WASH-related diseases. 3) Strengthen epidemiological and laboratory-based <i>surveillance and early warning systems</i> to ensure early detection and timely response to cholera outbreaks. 4) Build <i>capacities</i> of all participating sectors/ministries for implementing the comprehensive cholera elimination plan. 5) <i>M&E system</i> is in place to track cholera elimination progress and to ensure that the plan is regularly updated incorporating changes of risk factors.
2. Demand Creation for Prevention / Resilience	<ol style="list-style-type: none"> 1) Universal and equitable access to safely managed and affordable water for all. 2) Adequate and equitable access to safely managed sanitation facilities for all 3) Solid waste is properly collected, transported and disposed-off. 4) Improve hygiene and sanitation practices through social and behavior change communication that is evidenced based, effective and adapted to the needs of the community. 5) Adequate oral cholera vaccine coverage for all eligible populations.
3. Preparedness / Response	<ol style="list-style-type: none"> 1) Quality of patient care improved by increasing early access to effective treatment to prevent morbidity and mortality at the community and health-facility levels. 2) Case finding, documentation, response, and reporting of cholera response activities improved at all levels.

ZACCEP Pillar	Project Strategic Interventions
	3) Ensure adequate stocks of cholera treatment supplies and other key resources are rapidly available in the case of a cholera outbreak.

1.4 Project Theory of Change (TOC)

The evaluation team has reconstructed the project's theory of change based on the review of the documents received and discussions with key stakeholders. The project's theory of change aims to eliminate cholera outbreaks in Zanzibar by addressing three key capacities:

1. Institutional capacities for prevention and response at national and sub-national levels;
2. Organisational capacities through improvement of infrastructure, equipment, and staff capacities e.g., in the ZAWA; and
3. Individual capacities of households to prevent cholera by transforming knowledge and behaviours for improved WASH practices.

Through these capacities, Zanzibar would have more effective cholera response mechanisms (including early response and management at all levels) and have safe water and improved sanitation at community and household levels. These results will then lead to fewer or no cholera outbreaks and reduced case fatality rates. Figure 2 is the schematic representation of the TOC which also presents and the assumptions underpinning the causal linkages towards achieving the desired outcomes of the project. The theory of change statement can be summarised as:

If:

Cholera management and coordination mechanisms are strengthened and supported by adherence to environmental health and food hygiene regulations and improved knowledge and capacity of cholera prevention among government, key influencers and communities;

and if

there are improvements in health facility and community level case management, surveillance and early warning systems, and oral cholera vaccines are adequate for all eligible populations at risk, with households and communities having increased access to safe water supply and sanitation services, and comprehensive knowledge on cholera prevention and control knowledge;

then,

there will be equitable utilisation of safe water and sanitation and access to health services for cholera management and prevention, with communities adopting improved WASH behaviours and practices that lead to cholera prevention and control which will lead to the elimination of cholera outbreaks in Zanzibar.

See Annex 2a for the ToC diagram.

As outlined in the project's proposal, the causal linkages in the TOC are premised on the following assumptions:

- There will be enough skilled human resources from government and local authorities to steer the project;
- Availability of timely and sufficient funding for project activities;

- Availability of effective coordination mechanisms to steer the project activities; and
- There will be no emerging of other outbreaks or disasters which may divert resources and hamper the implementation of the project.
- Political stability will prevail on Zanzibar's two Islands.

Table 3 provides details of the linkages between the immediate outcomes (project outputs) and intermediate outcomes and results (outcomes) in the Theory of Change, by corresponding objectives.

Table 3: Link between project objectives and the TOC

Original result/ objective	Contributing results in TOC
<p>Objective 1: Strengthened coordination for cholera prevention</p> <p><u>Underlying assumption for Objective 1</u> is that there is effective multi-sectoral planning leads to improved coordination.</p>	<ul style="list-style-type: none"> • Increased multi-sectoral engagement and commitment to cholera prevention. • Functional coordination mechanisms that enhance communication and collaboration. • Increased awareness and knowledge among stakeholders on the significance of coordination in cholera prevention. • Improved communication channels that facilitate the exchange of information and coordination efforts. • Established protocols that ensure transparency and accountability in the coordination process.
<p>Objective 2: Improved public advocacy and strengthened partnerships for cholera prevention and control.</p> <p><u>Underlying assumption for Objective 2</u> is that there is public advocacy and strengthened partnerships contribute to increased support.</p>	<ul style="list-style-type: none"> • Increased awareness among the public about the importance of cholera prevention measures. • Enhanced community involvement and ownership in cholera prevention efforts. • Increased collaboration and information exchange among stakeholders. • Enhanced advocacy skills among partners, leading to more impactful awareness campaigns. • Improved policy environment that facilitates effective cholera prevention and control measures. • Established community networks that actively contribute to awareness and prevention efforts. • Expanded media coverage and public discourse on cholera prevention.
<p>Objective 3: Contribute to improved access to safe water and sanitation</p> <p><u>Underlying assumption for Objective 3</u> is that there is improved access to safe water and sanitation reduces the risk of cholera transmission</p>	<ul style="list-style-type: none"> • Upgraded or new WASH infrastructure contributing to improved access. • Increased community involvement in sanitation improvement activities. • Positive changes in behaviour and practices related to water and sanitation. • Increased access to safe and reliable water sources. • Enhanced access to improved sanitation facilities. • Improved access for all community members, including vulnerable populations. • Increased community capacity to manage and sustain WASH infrastructure.
<p>Objective 4: Strengthened the capacity of the health sector for early detection and response to contain cholera.</p> <p><u>Underlying assumption for Objective 4</u> is that there is a well-equipped health sector is crucial for early detection and response.</p>	<ul style="list-style-type: none"> • Improved skills and knowledge among healthcare professionals in cholera management. • Functional cholera treatment centres capable of handling cases promptly. • Adequate and timely availability of medical supplies during cholera outbreaks. • Improved capacity for early detection of cholera outbreaks. • Increased awareness among the public, leading to early reporting of cholera cases. • Improved data management capabilities for informed response strategies.

Original result/ objective	Contributing results in TOC
<p>Objective 5: Increased community knowledge and transform social norms about appropriate practices for the prevention and control of cholera.</p> <p><u>Underlying assumption for Objective 5</u> is that there is an informed community with transformed social norms contribute to effective cholera prevention.</p>	<ul style="list-style-type: none"> • Increased knowledge among community members about cholera prevention. • Shift in community behaviours towards more hygienic practices. • Increased community trust and adherence to recommended practices through influential figures. • Extended reach of cholera prevention messages through school communities. • Increased acceptance and adoption of prevention practices due to cultural alignment. • Empowered communities with a sense of ownership in prevention efforts. • Regular monitoring of attitudinal shifts to inform targeted interventions. • Gradual shift in social norms towards practices that prevent cholera transmission. • Sustained awareness and engagement within the community.

1.5 Project Stakeholders

As stipulated above, the “Towards a cholera Free Nation” project had several stakeholders at national- and district-level. These included UN agencies, international organisations, NGOs, Government Ministries, Departments and Agencies (MDAs) and community-based stakeholders. Table 4 shows stakeholders engaged in the project and their corresponding roles.

Table 4: Partnership arrangements and roles

Stakeholder	Role of Stakeholders in the Project
Fund and Technical Managers	
UNICEF	Fund and Technical Manager accountable to donors and manages all project activities
WHO	Fund and Technical Manager on OCV and cholera epidemiological surveillance
UNDP	Fund and Technical Manager on solid waste management interventions under the WASTE X Project
CDC	Fund and Technical Manager on water quality monitoring
Technical and Implementing Partners	
Waste X	Centre of Excellence (CoE) laboratory situated at the State University of Zanzibar (SUZA) responsible for the design and implementation of innovative pilots on solid waste management
Environmental Engineering & Pollution Control Organization (EEPCO)	Implementing partner on sanitation/ CLTS activities
Brooklyn Economic Consulting Ltd	Technical partner on solid waste management interventions
Tanzania Communication and Dev Center	Technical partner on SBCC activities
D-Tree International	Technical partner on health systems strengthening
Public Health Laboratory (PHL-Idc)	Technical partner for the situational analysis/ baseline survey for the project
Government Ministries, Departments and Agencies (MDAs)	

Stakeholder	Role of Stakeholders in the Project
ZACCEP Steering Committee	Reporting to the 2 nd VPO's, the committee consists of selected government ministries and is responsible for multi-sectoral coordination on cholera issues
ZACCEP Task Force	Technical Task Force responsible for provision of technical support to the ZACCEP Steering Committee to which it reports to.
Rapid Response Teams (RRTs)	Consists of selected MDAs at national and subnational levels and is responsible for coordinating cholera response interventions
Zanzibar Water Authority (ZAWA)	ZAWA is a government agency mandated with identification, conservation and protection of water. Under this project, it is responsible for the provision of safe water supply to users
Zanzibar Municipal Council	Government Local Authority responsible for ensuring proper solid waste management within its areas of jurisdiction.
Ministry of Health (Curative Services, Environ Health, Health Promotion, Epidemiology & Disease Surveillance)	Government Ministry and its respective departments and agencies responsible for water supply and sanitation services, enforcement of by-laws, hygiene promotion and addressing negative social norms, Risk communication and community engagement, / SBCC, epidemiology and surveillance, cholera prevention, CTU/CTCs and case management.
Central Medical Stores	Government agency responsible for the procurement, storage, distribution and management of cholera supplies, including drugs.
Health Care Facilities/CTC/CTU	Facilities established and managed by the Ministry of Health and responsible for the treatment and management of cholera-affected patients
Ministry of Education (Primary Schools)	Managed by the Ministry of Education, primary schools selected under the project are responsible for implementing health and hygiene promotion activities through group hand washing and SWASH clubs
Environmental Management Authority (ZEMA)	Government agency responsible for land use and environmental health regulations enforcement
Disaster Management Commission (DMC)	Consists of various MDAs at national and subnational levels and is responsible for coordinating cholera-related response actions at.
Community-based Stakeholders	
Key Influencers (Interfaith Leaders, Shehia Leaders, special women groups, role models/ champions.))	Key influencers on cholera prevention and response actions in their respective religious sects and Shehias.
Shehia Committees	Lead various community initiatives, including health and hygiene activities in their respective shehias.
Community Health Volunteers (CHVs)	Responsible for community mobilisation and educating communities and households on cholera issues.
Water Vendors	Responsible for selling water within council by-laws and ensuring that the water meets national quality standards.
Food Vendors	Responsible for selling food within local by-laws and environmental health regulations.
Solid Waste Management (SWM) Groups	Responsible for household waste collection and piloting of SWM initiatives.
Community Groups/ CBOs	Rally communities and their members towards practicing proper health and hygiene behaviours.
Households	Carry out cholera prevention and control activities in their respective households

2 Evaluation Purpose and Objectives

The primary focus of the evaluation was to undertake a final evaluation of the “Towards a cholera Free Project” in Zanzibar (as part of the ten-year government Plan for Cholera Elimination ie ZACCEP 2018-2027) in order to generate substantive evidence and lessons learnt on the impact, coherence, relevance, effectiveness, monitoring, sustainability, gender and equity focus of the project (please refer to Annex 1 for the complete TOR). The evaluation, which was commissioned by UNICEF Tanzania, is a summative evaluation whose aim is to achieve the following, among others:

- document project achievements in terms of outputs, outcome, impact, and lessons learnt.
- determine which aspects of the programme worked well, and why
- generate learning and evidence to inform replication, scaling-up and/ or modification of the project model in Zanzibar, Tanzania mainland and beyond.
- inform the ongoing review of the Zanzibar National Water Policy and other WASH-related policies and legislation.
- help determine how the Revolutionary Government of Zanzibar (RGOZ) and its Ministries, Departments and Agencies (MDAs), and other stakeholders that include development partners, civil society, bilateral donors and communities can help in eliminating future cholera outbreaks. More details on the evaluation audience and users, and how they will stand to benefit from the evaluation is detailed in section 2.3.

2.1 Evaluation objectives

The evaluation:

1. Evaluated the project performance over five years covering three main outcomes notably: Capacities among government and community systems for continuity, ownership, and sustainability of the program, including coordination and funding at national and subnational levels; Equitable access to safe WASH, and health services; and Communities’ adoption of improved WASH behaviors and practices.
2. Generated substantive evidence on the impact, coherence, relevance, effectiveness, monitoring, sustainability, gender and equity focus of the project.
3. Documented the key findings, success, best practices, challenges, lessons learnt and recommendations for sustainability, replication and scale-up of the project in Zanzibar and beyond.

2.2 Evaluation Scope

Programmatic Scope: The evaluation was conducted as an independent examination of the background, assessment, activities, processes, and resources deployed by UNICEF and its key implementing and technical partners, whose roles are detailed in Table 3. The evaluation covered all three pillars of the programme. It examined the standard and quality of facilities and WASH and health services provided by the project, encompassing all three project outcomes: Enabling Environment, Preparedness/Response, and Demand Creation for Prevention/Resilience. Information was gathered from direct and indirect beneficiaries, technical ministries, departments, and other key stakeholders. Evidence was collected primarily through an extensive desk review of program documents and available data, complemented by water quality assessments and information gathered directly from key stakeholders at national and local levels. The evaluation focused on determining which aspects of the programme were effective or ineffective, and why. The evaluation did not cover regional replication of the programme but focused on conditions for replication in Mainland Tanzania and beyond.

Chronological Scope: The evaluation covered the 'Towards a Cholera Free Nation' project, which spanned five years from May 2019 to December 2023.

Geographical Scope: The evaluation focused on the direct activities conducted in the five project districts: Magharibi A, Mjini, Magharibi B, Micheweni, and Wete. Although the project included all 11 districts of Zanzibar for the SBCC campaigns, the additional six districts were not covered by this evaluation due to time constraints (data collection was conducted over a two-week period), costs, and budgetary limitations. This exclusion did not significantly affect the evaluation outcomes, as there were no differences in the actual SBCC activities carried out across all 11 districts.

Gender, Equity, Disability, and Human/Child Rights Considerations: The evaluation included an analysis of how the project integrated the participation of men, women, adolescents, and children in schools, as well as people with disabilities. Equity was assessed at two levels: first, by determining the facilities instituted and their ability to reach the most vulnerable; and second, by evaluating the accessibility and utilization of the WASH and health services promoted by the project for the most vulnerable, including those with disabilities. Efforts were made to gather disaggregated quantitative and qualitative data from vulnerable groups, including people living with disabilities. The adequacy of evidence used in project design decisions was reviewed to ensure an equity-focused project design. Mainstreaming equity in project implementation was assessed by examining how disaggregated data (by age, sex, island, rural/urban, district, ward) was collected, analyzed, and used to inform project implementation.

In 2010, the UN General Assembly recognized access to water and sanitation as basic human rights, essential to the realization of all human rights. Similarly, two human rights treaties — the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) — explicitly specified the right to health, water, and sanitation as fundamental rights. The UN Standard Rules for the Equalization of Opportunities for Disabled Persons and the Convention on the Rights of Persons with Disabilities also outlined the rights to health, water, and sanitation for people living with disabilities. These rights necessitate that water and sanitation services are adequate, accessible, safe, acceptable, and affordable for all, without discrimination. The 2030 SDGs Agenda committed to realizing human rights for all, achieving gender equality and empowering all women and girls (SDG 5), and reducing inequalities to ensure that 'no one is left behind' (SDG 10).

Regarding human rights, gender, equity, inclusion, and accountability, the project was assessed on the following issues:

- The extent to which it actively identified and addressed the different needs and priorities of women, girls, men, and boys, as well as other vulnerable groups, throughout the design, management, and implementation of the project.
- The extent to which it addressed equity and empowered women and girls.
- The extent to which it integrated the realization of the right to safe, adequate, accessible, secure, appropriate, affordable, and dignifying water and sanitation services, particularly for the most vulnerable population groups, from its development through its implementation.
- The unintended negative effects of the project's interventions on human rights, how these were mitigated to the greatest extent possible, and whether the duty bearers assumed accountability for any negative unintended effects that occurred.

The scope of questions and issues addressed by the evaluation are presented in the Evaluation Framework under Annex 2.

2.3 Evaluation Audience and Users

Zanzibar Ministry of Health: As a primary user, the Zanzibar Ministry of Health relies on this evaluation to gauge the effectiveness of the project in contributing to public health goals, particularly in cholera

prevention and control. The evaluation will therefore inform them about the project's alignment with their health policies and initiatives and helps in decision-making for future health programs.

Zanzibar Ministry of Finance and Planning: This ministry plays a vital role in allocating resources and budgeting for health and development programs. The evaluation is essential for them to assess the financial efficiency and effectiveness of the project. Results of this evaluation will thus inform them about resource allocation for similar projects and aids in financial planning.

UN Agencies (UNICEF, WHO, UNDP): As key fund and project managers who seek to understand the project's overall impact and effectiveness. The agencies will therefore utilize the evaluation to make informed decisions on future project strategies and to meet their accountability requirements to stakeholders.

Korea International Cooperation Agency (KOICA): KOICA Tanzania, being a funding agency or partner, is keen on the project's outcomes and results. Results of this evaluation will assist KOICA in evaluating the project's performance, its alignment with their strategic objectives, and whether the funds were allocated effectively. This informs their future funding decisions and helps them justify resource allocation.

Development Partners and other non-governmental organisations stand to benefit from the results of the evaluation as well on the use of various approaches used by the project in prevention of cholera in communities and other water points. They will also benefit in SBCC approaches used by the project for creating national cholera awareness and sensitization campaigns in enhancing the efficiency of the healthcare system and improving emergency preparedness and response.

Communities and CSOs serve as integral components of the evaluation audience and users, providing diverse perspectives, ensuring accountability, and contributing to the sustainability and effectiveness of the "Toward a Cholera Free Nation" project in Zanzibar.

3 Methodology

3.1 Evaluation Approach

3.1.1 Evaluation Design

The evaluation was theory-based and reflexive (before and after project) for specific activities. The theory-based approach enhanced the evaluation's ability to fully explore the causality of the project interventions. This approach was also used to ascertain the validity of the project design in achieving the intended objectives. By utilizing a theory-based approach, the evaluation aimed to provide a deeper understanding of the project impact phenomenon and enhance the validity and generalizability of the study. The evaluation was also utilization-focused, ensuring the participation of relevant stakeholders in the implementation of the evaluation, including in planning and validation processes including validating recommendations.

Furthermore, the evaluation was conducted using a gender-sensitive and socially inclusive mixed-method approach to collect both quantitative and qualitative data. This included conducting a gender analysis, providing alternative participation avenues, engaging marginalized groups, training the evaluation team, and adopting an intersectional perspective.

A child-sensitive and child-centred approach was also employed in applying these methods. This meant that the tools and data collection approaches ensured that all children were able to fully participate in the process and that the evaluation did no harm to them. We adhered to ethical guidelines, particularly those outlined in the Ethical Research Involving Children (ERIC) guidelines. Issues such as "Informed Consent" were included to ensure that informed consent was obtained not only from parents or guardians but also, to the extent possible, informed assent from children themselves. Additionally, observational methods that were unobtrusive and respectful of children's privacy were incorporated.

The evaluation was designed on the premise of a contribution analysis approach, which did not seek attribution but rather assessed how the project contributed to observed outcomes. Across all evaluation criteria, the evaluation explored the extent to which the project design mainstreamed human rights, gender equality, disability, and equity.

3.1.2 Evaluation Guidance

The evaluation was guided by the following UNICEF and UNEG evaluation and research guidelines:

1. United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation in the UN System 2016, including impartiality, independence, quality, transparency, and consultative processes.
2. Ethical Guidelines for UN Evaluations.
3. UNICEF Ethical Guidelines and standards for research and evaluation, and Ethical Research Involving Children.
4. UNEG guidance on integrating human rights and gender equality and the UN System-Wide Action Plan (UN-SWAP) on gender equality.
5. UNICEF Guidance on Gender Integration in Evaluation.
6. UNICEF-adapted evaluation report standards and the Global Evaluation Report Oversight System (GEROS).
7. UNICEF Guidance Note on Adolescent Participation in UNICEF Monitoring and Evaluation.
8. Disability-Inclusive Evaluations in UNICEF: Guidelines for Achieving UNDIS Standards.

3.1.3 Evaluation Principles

Based on the above guidance documents, the evaluation adopted the following principles:

Independence, impartiality, and conflict of interest: As independent evaluators, the evaluation team had no interest in the outcome of the evaluation and had not been involved in the project's implementation ensuring conclusions are based on an independent opinion.

Credibility: the evaluation team ensured that evaluation results are of high-quality based on a sound and tested methodology, which is comprehensive, evidence based, uses a mix of qualitative and quantitative methods appropriate to this assignment, and includes participation of key stakeholders and beneficiaries and triangulation of findings between various sources of data. Analysis tools were used to ensure all qualitative and quantitative data was considered in the evaluation's findings and conclusions.

Accountability: All evaluation outputs were validated with stakeholders of the programme providing them an opportunity to agree, disagree or seek clarifications on the findings and recommendations. Whenever there were disagreements in the findings, evaluators sought additional evidence to retract the finding or strengthening their argument. In this way evaluators are held to account for their findings and that the evaluation conclusions remain evidence based.

Transparency and Communication: We conducted the evaluation in a transparent manner ensuring that all stakeholders and beneficiaries understand the purpose and scope of this review process and are engaged and committed to the review's success. We also communicated and consulted the team in charge of the evaluation on a regular basis to update on progress and to alert the team of any challenges which we may encounter to remedy them as quickly as possible.

Quality: Evaluation results are of high-quality based on a sound and tested methodology, which is comprehensive, evidence based, uses a mix of qualitative and quantitative methods appropriate to this assignment, and includes participation of key stakeholders and beneficiaries. The structure and content of the report is strongly influenced by UNEG Norms and Standards for Evaluation and UNICEF adapted evaluation report standards and GEROS.

Inclusiveness: all categories of beneficiaries of the project contributed to the evaluation. As described in the methodology section, this takes into cognisance, disaggregation of age and sex and disability.

Honesty and Integrity: All findings and conclusions are evidence based. Where evidence is inconclusive this is highlighted in the findings.

Gender equity and human rights lens: We applied a gender equity and human rights lens on the design, execution, analysis, and presentation of the evaluation results, across all the defined and agreed OECD evaluation criteria as detailed in section 3.1.1.

3.2 Ethical Considerations

This endline evaluation was conducted after being approved by the Zanzibar Health Research Institute (ZAHRI) (REF Number: ZAHREC/4/REC/FEB/2024/01). UNICEF Guidelines on Ethical Research Involving Children and the UNICEF AGORA course on Ethics in Evidence Generation was adhered to as follows:

Risk or harm: No risk identified in participating in the study. The data was elicited by trained personnel. All elements and in particular the field work, was administered consistent with the Procedure for Ethical Standards in Research, Evaluation and Data Collection and Analysis (UNICEF, 2015) to ensure the highest ethical standards at all stages. We were guided by the principle of "do no harm" to identify and avoid risks to participants, and in particular, the adolescents. In order to prevent the analysis from causing damage to the participants, especially adolescents and their parents/caregivers.

On the collection of personal data, we adhered to both local and international data protection legal regulations, such as the Federal Data Protection Act (BDSG) and the EU General Data Protection Regulation (GDPR). Participants' personal information was encoded or removed from public view as part of human subjects' protections.

Voluntary participation and informed consent: Participation in the evaluation was entirely voluntary, and individuals had the right to withdraw their participation at any stage without penalty. Participants were provided with the freedom to decide whether to participate without any coercion or negative consequences. Verbal informed consent was obtained from all key informants and FGD participants.

Confidentiality: The team took seriously its commitment to ensure full confidentiality of information at each phase of the assessment. Informed consent for participation in the research included a clear, accessible provision pertaining to confidentiality. Research assistants were trained in the confidentiality protocol. During the transcription phase, only codes were used, and no names mentioned. After the transcription, the records themselves were erased. Confidentiality of information was respected also in the process of data storage. After the end of the analysis all the documents containing data (datasets and transcripts) were stored under a password on a protected hard drive and erased from all other places. During the phases of processing the data and quoting statements by the participants, due attention has been paid to ensure that the quotes do not include attribution or allow identification of the individual respondents.

3.3 Evaluation Methodology

Evaluation evidence was gathered through various data collection methods, including: 1) Documentary review, 2) Key Informant Interviews, 3) Focus Group Discussions, and 4) Water sample collection.

3.3.1 Documentary review

The evaluation team conducted document review with the primary objective of understanding the project implementation, changes over the evaluation period, and any issues important for determining the evaluability of the project and the design of the evaluation and the performance of the project. The documents reviewed included project documents, project proposals, donor annual reports, and government reports from the Ministry of Health (MoH) and the Office of the 2nd Vice President. A list of the documents reviewed is shown in Annex 5.

3.3.2 Quantitative evaluation

3.3.2.1 Secondary Data analysis

Existing quantitative data sources were used to investigate the factors and interventions contributing to the elimination of cholera in Zanzibar. The following data sources were used:

- Tanzania DHS-MIS 2022 Final Report and dataset;
- MOHSWEGC data;
- Implementing partner reports;
- Project monitoring reports;
- ZBS reports (households and budget expenditures);
- PORALGSD reports on the project;
- HMIS reports;
- The latest water quality and latrine coverage data compiled in the HMIS system;
- Database of all water vendors and institutions comprising ZAWA sampling points, schools, and healthcare facilities' water tanks in the five project districts;
- KOBO database with the project's monitoring data;
- Data from private water vendors (latest data sets);
- DHIS-2 WASH data collected from July 2021 to July 2022; and

- Geographic Information System (GIS) data on WASH infrastructure and population distribution.

The evaluation used a combination of micro datasets and analysis of required indicators from reports when these datasets were not available. For the micro datasets, the evaluation team cleaned, organized, and integrated these data sets to create a comprehensive dataset for analysis. The evaluation team conducted a performance assessment by comparing pre- and post-intervention data.

3.3.3 Sampling and sample sizes

Water quality assessment design and sampling strategy

The evaluation collected random water samples from households and community water points, such as food vendors, mosques, schools, healthcare facilities, and Madrassa, to analyze for the presence of Free Residual Chlorine (FRC) and indicator pathogens in household and water collection points. The survey adopted a cross-sectional design and collected random water samples from households and vendors to analyse the presence of free residual chlorine and faecal coliforms in households, schools and communal water collection points. The assessment targeted all five project areas. For comparability purposes, the endline sample design mirrored that of the baseline.

The sample size to assess the presence of free residual chlorine and faecal coliforms was based on a 95% level of confidence, with an allowable margin of error set at 0.06 and a 1% non-response rate. Other parameters included maximizing variance for categorical data ($P = 0.5$) and a design effect of 1.1, primarily due to clustering. Based on the proposed formula, the resultant sample size for assessing residual chlorine and indicator pathogens was 620 (310 samples for each water quality test) in the five project districts.

The sample size was allocated in each district based on Probability Proportionate to Size. To ensure proportional representation by project districts, we proposed allocating the number of Shehias proportionally based on the total number of Shehias in each district. The weight for each district was calculated by dividing the total number of Shehias in each district by the total number of Shehias in the five districts. Assuming ten (10) water sources in each Shehia, a total of 31 Enumeration Areas (Shehias) were selected and distributed in each district based on the number of Shehias in each district.

The evaluation collected an average of 40-60 samples per day to ensure coverage and transportation within the stipulated 6-hour time frame. A random selection of 310 water samples was collected for the Free Residual Chlorine (FCR) test, ensuring representation in terms of geographical location (district, Shehias), water source type (improved and unimproved), ownership (ZAWA, vendors, communal), and delivery points (tap, wells, storage tanks/containers, pumping stations, buckets). Another 310 water samples were taken for the faecal coliform tests. The evaluation adhered to all safety, quality control, and regulatory guidelines throughout the sampling, transportation, and analysis process to guarantee the reliability and validity of the results. The water testing program extended for 12-16 days based on the local geography of Zanzibar. Water safety assessments were undertaken in a total of 107 households (HH) and 65 communal water sources as detailed in Table 7.

Identification and verification of water source sites

The identification and verification of water collection sites were conducted through collaboration with the ZAWA focal person, community leaders, teachers, health workers, and household members. The enumeration area (EA) was considered as the Shehias, which are commonly used in Tanzania. In enumeration areas with multiple water sources, a maximum of 5 samples were collected based on potential risk locations such as waste dumps, areas near open sewage or defecation sites, flooded

areas, etc. Samples were collected from various sources including taps, wells, storage tanks, pumping stations, and buckets.

The study team and the designated official from each Shehia conducted field visits to map the sampled areas. This mapping process facilitated the identification of water sources and delivery points, public toilets and latrines, schools, health facilities, markets and food vendors, solid waste dumps, and potential cholera-at-risk areas (such as open defecation sites and flooding spots). Based on this exercise, a list of facilities to assess or inspect in each Shehia was generated for the water quality assessment. Random selection of water samples in each enumeration area was conducted using a random generator.

Table 5 illustrates the key parameters used for sampling Shehias in this evaluation.

Table 5: Sampling selection of Shehias

District		Number of Shehias	Weight	Sampled Shehias
Unguja	Mjini	56	0.307692	10
	Magharibi A	31	0.17033	5
	Magharibi B	34	0.186813	6
Pemba	Micheweni	25	0.137363	4
	Wete	36	0.197802	6
Total		182	1	31

We utilized stratified random sampling techniques to select Shehias in the project districts. In this report, we referenced the baseline report and cholera prevalence rates from the literature to illustrate our approach to sampling the Shehias for this evaluation (refer to results in the next Chapter).

Table 6: Sampled Shehias by district

Mjini	Magharibi A	Magharibi B	Micheweni	Wete
Jang'ombe	Mtoni	Mgogoni	Maziwang'ombe	Kojani
Urusi	Welezo	Kinuni	Kiuyu Mbuyuni	Chwale
Chumbuni	Mtoni Kidatu	Melinne	Makangale	Mpambani
Mchangani Mjini	Bububu	Tomondo	Mjini Wingwi	Kiuyu Minungwini
Amani	Mtopepo	Dimani		Kizimbani
Magomeni		Kijitoupele		Kisiwani
Shaurimoyo				
Kwamtipura				
Seblen				
Nyerere				

Table 7 provides the water sample locations and water source types

Table 7: Survey targets and coverage

Source and Location	Target samples		Collected samples	
	Faecal coliforms	Free Residual Chlorine	Faecal coliforms	Free Residual Chlorine
Communal Water Sources				
Boreholes	15	15	19	19
Taps	36	36	32	32
Bucket	5	5	3	3

Source and Location	Target samples		Collected samples	
	Faecal coliforms	Free Residual Chlorine	Faecal coliforms	Free Residual Chlorine
Storage tank	9	9	9	9
Households				
Mjini	34	34	33	33
Magharibi A	16	16	17	17
Magharibi B	20	20	18	18
Micheweni	13	13	16	16
Wete	24	24	29	29
Other sources				
Schools	34	34	33	33
Mosques	22	22	24	24
Madrassa	15	15	18	18
Health care facilities	22	22	17	17
Food vendors	45	45	44	44
Total	310	310	312	312

The water survey collected 312 samples for both residual chlorine and faecal coliforms, exceeding the target of 310 samples.

3.3.4 Qualitative Evaluation

Key informant interviews

This evaluation included interviews with a total of 58 out of the targeted 62 key informants, with 13 at the national level and 49 at the district and community level. Key informants reached by the evaluation are presented in Table 8

Table 8: Key informants interviewed

KIs conducted	National	Mjini	Maghari bi A	Maghari bi B	Micheweni	Wete	Urban	Achieved	Target
Zanzibar Water Authority	1		1					2	2
District Medical Officer (DMO)		1	1	1	1	1		5	6
Community Health Volunteers			2	2	2	2	2	10	10
Disaster Management Commission	1							1	1
Environment Health Officer			1	1		1		3	2
Religious leader		1		2	1	1		5	5
Shehia Leader		1		1	1	1		4	5
SWASH Teacher		1	1	1	1	1		5	5
Water Vendor		2	2	2	1	1	1	9	10
Fund/ Technical Managers (UNICEF,WHO,UNDP,CDC)	4							4	4
Technical and Implementing partners	2							2	3
Government Ministries, Departments & Agencies (MDAs)	5					3	1	5	9
Total	13	6	8	10	7	11	3	58	62

Focus group discussions: This evaluation conducted a total of 30 focus group discussions. Of these, 11 were with community groups - 6 with female participants, 4 with male participants, and 1 with a mixed group of men and women. An additional 10 focus groups were held with school clubs, split evenly

between 5 groups of boys and 5 groups of girls. The remaining focus groups included 5 with solid waste groups and 4 with parents and caregivers.

Table 9: FGDs conducted

FGs conducted	Male	Female	Mixed	Achieved	Target
Community groups	4	6	1	11	10
School SWASH clubs	5	5		10	10
Solid Waste Management groups			5	5	5
Parents and caregivers			4	4	4
Total	9	11	10	30	29

Observations: In addition to the previously mentioned data collection methods, this evaluation also employed the observation method. It provided direct and reliable information on WASH behavioural practices and the presence, quality, appropriateness, and use of WASH infrastructure constructed through the project. The evaluation team conducted observations using checklists at various sites, including water points (10) (during water sample collection), schools (8) and health WASH facilities (3), households (22), and food vendor markets' (6) WASH facilities.

3.3.5 Data Management and Analysis

General Quantitative Analysis: Quantitative data from both primary and secondary sources were analyzed using SPSS version 26 using descriptive and inferential analyses. Descriptive statistics addressed whether there were significant changes in outcome variables between baseline and endline. When the quantity, quality, and comparability of the data allowed, correlation techniques such as Chi-square analysis for categorical variables and t-tests for continuous variables were applied. Data analysis adhered to UNICEF's data quality standards, and all data collection and analysis were disaggregated by key demographic characteristics, including age, gender, and location.

Water sample test quantitative analysis: The water sample test analysis included both free residual chlorine analysis and indicator pathogen analysis following standardized protocols for FRC analysis and appropriate microbiological techniques.

Qualitative data analysis: Audio recordings were transcribed, translated into English from the local languages, and coded by two independent coders using NVivo 12 (QSR International, Melbourne, VIC, Australia). NVivo was essential for integrating large datasets from various sources. Coders discussed discrepancies until consensus was reached. Codes were grouped and linked to the evaluation matrix, and emerging themes were identified. Analytical memos were written for each theme. During the write-up, themes and sub-themes were illustrated with verbatim quotes.

3.4 Limitations to the evaluation

The primary limitation of the evaluation was the comparability of baseline and endline performance, as the endline survey focused solely on the qualitative interviews, water quality assessment and secondary data reviews rather than including a Knowledge, Attitudes, and Practice (KAP) survey. While the water quality assessment could be compared between baseline and endline, there was limited scope for comparative assessment of KAP indicators. To address this limitation, the evaluation recreated baseline data using various data sources previously mentioned, including data predating the program and recently collected data from 2022 or preferably the end of 2022 or in 2023. Comparisons of indicator performance were made using similar methodologies and similarly calculated indicators. Assessment

of equity was also limited as disaggregated data in the form of locations (By Island, by District, Urban vs Rural) and diversity was largely missing from the secondary data sources provided.

4 Findings

This section presents the findings of the evaluation. The findings are organized according to the evaluation criteria outlined in the evaluation framework (Annex 2) and answers the evaluation questions for each criterion.

4.1 Relevance

Evaluation question: Was the project's design, causal linkages and assumptions valid for the context of Zanzibar?

Finding 1: By using multiple but integrated interventions to address cholera prevention and public health improvements identified at baseline, the project design demonstrated a comprehensive approach that acknowledged the multifaceted nature of cholera outbreaks.

The causal linkages in the project's design were relevant, targeting critical interventions such as strengthening multi-sectoral coordination, water quality, sanitation infrastructure, and health education across multiple settings (rural and urban communities, schools, health centres, food vendor markets and local authorities). This multifaceted strategy ensured that each component contributed to the overall effectiveness of the project. For example, the construction of toilets and handwashing facilities directly addressed sanitation needs, while educational initiatives enhanced public awareness and practices around hygiene.

'From the way the project was designed, it had all the key components necessary for cholera prevention. So, I think each intervention played its role and function and together the results that we saw were contributed by each of them.' Field Office, UNICEF Zanzibar

Finding 2: The assumptions underlying the project's Theory of Change were largely valid and aligned with the operating context of Zanzibar.

As presented in the project's proposal, the main assumptions of the 'Towards a Cholera-Free Nation Project' were:

- The Revolutionary Government of Zanzibar (RGoZ) sustains its high political will to eliminate Cholera in Zanzibar
- The RGOZ sustains allocations of sufficient budgets to ensure sustainability of interventions
- Key donors remain committed in providing financial and technical support for implementation of the ZACCEP.

Government ownership and commitment at high levels provided essential support and legitimacy to the project. Through the ZACCEP Coordination Structures and the MDAs, indeed the RGoZ sustained its political will and involvement throughout the project period. This is despite the human and financial resources inadequacies faced by the multi-sectoral structures faced in steering the project. The 2nd Vice President's Office continued to provide support and guidance to ensure that the project was effectively coordinated, implemented and monitored through the ZACCEP task force, and steering committee meetings. This includes convening the meetings, ensuring that all members fully participated, and also following up on any agreed resolutions. The strong government ownership and involvement at both national and sub-national levels through the Disaster Management Commission and Rapid Response Teams was crucial for the project's success, and its sustenance.

The key donors to the project, KOICA, CDC and UNDP (Co grant manager of the Green Shark Challenge Fund) remained committed to funding the project throughout its life cycle. This commitment was also reflected in their flexibility to allow reprogramming of their funds towards the Covid-19 emergency.

Evaluation question: How responsive was the design of the project to the rights, needs and priorities of men, women, adolescents, and children in schools as well as people with disabilities, and to changing circumstances?

Finding 3: The project's design did take into account of a range of cross-cutting issues, including gender equality, disability, adolescents/ youths and environment. Efforts were also made to ensure the collection and analysis of disaggregated data during assessment, monitoring and implementation. However, other disaggregated data in the form of locations (by Island, By District, Urban vs Rural) or diversity to inform equity analysis were largely missing.

The project took deliberate efforts in identifying the needs and priorities of the different right-holder communities, groups, including for children, men and women in the design of the project. Efforts were made to ensure the collection and analysis of sex-disaggregated data during assessment, monitoring and implementation, including the strengthening of platforms for engaging women and youth groups. By carrying out a 'Situational Analysis and Epidemiological Study of the Cholera Hotspots in Zanzibar, the project managed to not only identify cholera hotspots (districts and shehias), but also to characterise the past outbreaks regarding their demographics (sex and age), cholera risk factors for the different demographics, and predisposing factors and interventions most effective in cholera control amongst the different gender groupings.

Findings from previous outbreaks revealed that children, adolescents, and women constituted the greatest population at the highest risk of cholera in Zanzibar. Table 10 is an example of the characterisation of the 2015/16 cholera outbreak. The characterisation of this outbreak was able to reveal that there were slightly more males (52.5 percent) than females (47.5 percent) in both Unguja and Pemba¹. In Pemba, more than half of the cases were children (58%) from 0 to 15 years, compared to only 29% in Unguja. It was also learnt that the proportion of children under five affected by the diseases varies in and by districts within the island from 10% to 31.8% in Pemba to 10% to 20% in Unguja. It was therefore concluded that the very high level of infection in young children particularly in Micheweni Pemba deserves special attention and interventions.

The project also carried out additional situational analysis and made references to past surveys with the aim of getting insights into the different needs and priorities of men, women and children. This includes the School Water, Sanitation and Hygiene (SWASH) Assessment carried out in 2018 and a KAP Formative study that informed the development of the Zanzibar Cholera Elimination Social and Behaviour Change Communication (SBCC) Strategy developed in 2020. Despite their comprehensive nature in providing the needs and priorities of the different rights holders, the evaluation noted that results from the situational analyses came at a time when the project was already in its second year of implementation with the hotspots, beneficiaries and interventions having already been pre-determined.

Table 10: Population affected by cholera

2015/16 Cholera Outbreak Overview

Duration: Sept 19, 2015 to July 14, 2016

UNGUJA		Gender		Age						Duration			Treatment			Lab	
Deaths	Districts	Total cases	M	F	≤5	6-15	16-25	26-49	50+	1st case	Last case	# weeks	A	B	C	Samples Taken	Results cholera
26	Magharibi A	1,330	684	646	208	261	316	429	116	19-Sep-15	14-Jul-16	42	12	904	413	32	13 positive
	Magharibi B																
11	Mjini	565	320	245	56	106	165	157	81	20-Sep-15	14-Jul-16	42	17	395	153	22	14 positive
1	Kati	135	62	73	27	25	22	43	18	25-Sep-15	23-May-16	39	16	76	43	7	4 positive
7	Kaskazini A	342	177	165	46	62	94	97	43	13-Jan-16	22-May-16	18	6	174	162	4	3 positive
4	Kaskazini B	202	114	88	27	40	55	54	26	23-Sep-15	24-May-16	39	34	111	57	9	6 positive
	Kusini	78	35	43	12	14	20	22	10	2-Dec-15	10-May-16	22	17	46	15	0	
49		2,652	1392	1260	376	392	672	802	294		Average	33.7	102	1,706	843	74	40 positive
			52%	48%	14%	15%	25%	30%	11%				4%	64%	32%	3%	54%

Duration: November 1, 2015 to July 10, 2016

PEMBA		Gender		Age						Duration			Treatment			Lab	
Deaths	Districts	Total cases	M	F	≤5	6-15	16-25	26-49	50+	1st case	Last case	# weeks	A	B	C	Samples Taken	Results cholera
3	Wete	470	259	211	100	170	91	78	31	1-Nov-15	10-Jul-16	35	0	123	347	43	33 positive
9	Micheweni	860	452	408	274	292	128	105	61	15-Nov-15	7-Jul-16	33	0	314	546	26	13 positive
7	Chake Chake	300	149	151	35	76	82	73	34	8-Dec-15	7-Jul-16	31	0	52	248	28	28 positive
	Mkoani	48	27	21	5	15	9	9	10	8-Dec-15	31-May-16	30	0	0	48	8	5 positive
19		1,678	887	791	414	553	310	265	136		Average	32.3	0	489	1,189	105	79 positive
			53%	47%	25%	33%	18%	16%	8%				29%	71%	6%	75%	

“Districts were selected for intervention based on their high vulnerability to cholera, determined by historical data and trends in those areas. This resulted in the selection of specific districts that were most at risk. In Pemba, there are two districts, and in Unguja, there are three districts.” Disaster Management Commission, Zanzibar.

Although sex-disaggregated data seemed to have been collected and analysed during the assessments, monitoring and implementation of the project, collection of other disaggregated data in terms of locations (By Island, By District, Urban vs Rural) seemed to be limited right from project design into its implementation. For example, the indicators in the results framework did not present the targets by Island nor district. Collection and analysis of disaggregated data by location during implementation also seemed to be limited.

There seemed to be no strategies to respond to specific gender issues undermining cholera prevention in Zanzibar which were recognised in both the School WASH assessment and Baseline Survey. The result of this was the non-systematic integration of gender in project implementation. The evaluation recognises the empowerment of women, children and adolescent which resulted from the project including:

- capacitation of CHVs with knowledge, skills and material and financial resources on cholera prevention, most of whom were females (>80percent), became a source of pride for them as they led various community initiatives and SBCC activities;
- SWM Groups consisting of mostly female youths (>59percent) were employed through collection of household solid waste;
- female university students pioneered some innovations on managing solid waste through the State University of Zanzibar’s Centre of excellence;
- women who are themselves custodians of domestic hygiene were empowered from receiving chlorine tablets and health and hygiene education that came through the project and they were also freed from the burden of caring for cholera or diarrhoea patients from their families;
- adolescents were given the opportunity to air their views through the U-Report; and
- female pupils in primary schools had their knowledge and skills on health and hygiene improved through the SWASH Clubs.

More benefits could have been derived by including gender mainstreaming in the design so as to address the deep-rooted social, cultural and gendered norms that negatively impact fulfilment and protection of everyone’s right to water and sanitation as identified in the KAP Study and Situational

Analyses. For example, technical support could have been provided to the MDAs on gender responsive WASH services and infrastructure for them to appreciate its importance for cholera elimination.

Finding 4: The project's design and implementation were flexible to incorporate lessons learnt and emerging issues.

The project was quick to address and incorporate any emerging issues during the course of its implementation. For the first two years (2019-2020), the project found itself being implemented in the midst of the Covid-19 pandemic which was also affecting Zanzibar's two islands. The pandemic affected the project in two ways; i) the pandemic became the first government priority, resulting in overstretching of government workers and their resources towards the pandemic, thus diverting their attention away from the project ii) activities which needed face-to-face interactions and gatherings could not take place, including joint monitoring and coordination of activities. However, the evaluation noted that the project was flexible enough to adjust to this emergency. Adjustments were made in the following ways:

- The project period was amended to take into account the time Zanzibar had been affected by the pandemic. Under the new arrangement, the implementation period was adjusted from May 2019 - December 2021, to May 2019 - December 2023.
- The project's budgets were reprogrammed to accommodate adjustments in the project period with the same level of funding from KOICA. USD 128,000 was reprogrammed to contribute towards the COVID-19 emergency response, benefitting an additional 310,407 people.
- UNICEF contributed USD 495,288 from its own funds in the year 2021 to cover unfunded activities which had arisen as a result of budget gaps caused by the reduction of the KOICA contributions.
- For gatherings that were limited by social distancing arrangements and lockdowns, the project used remote monitoring through virtual facilities; online coordination meetings, and the use of photographs to capture key program milestones.

The project also reflected its flexibility in other ways:

- Having noted the impact of hand washing and the glaring need for hand washing facilities in primary schools through the 2018 National WASH Assessment whose results came when the project had kicked-off, the targeted number of schools to benefit from the group hand washing facilities was changed from an initial seven (7) to all the 122 schools in the 5 project districts. An additional 50 schools were added to these to cover the SWASH Clubs.
- Signing of the project grant was delayed by close to six (6) months as it took place in May 2019, instead of January 2019. As this largely affected the project's expenditure patterns and most of the start-up results for the first year, there was some reprogramming of both the project activities and funds. Most of the first-year activities were moved to the second and third years.
- Having noted the inadequacy and low capacity of human resources amongst the MDAs to liquidate/ utilise funds and implement cholera activities, the project was quick to employ alternative measures such as engaging local NGOs through Partnership Cooperation Agreements (PCA) or contracting. For example, the transfer of improving WASH services in Health Care Facilities (HCFs) was contracted to a local NGO due to delays in implementation by MOH. The project was also flexible enough to supply six laptop computers and six motorcycles to ZAWA to ensure they had adequate working tools.

4.2 Coherence

Evaluation question: What steps were taken by key implementing agents e.g. MOH, Disaster Management Commission in the 2nd Vice President Office to ensure the integration of the different project components or ministry departments and agencies (MDAs) to ensure maximum coverage?

Finding 5: The key implementing agents, such as the Ministry of Health (MOH) and the Disaster Management Commission in the Office of the 2nd Vice President, took several significant steps to ensure the integration of different project components and collaboration among ministries and agencies.

The Second Vice President Office (2nd VPO) which oversees the implementation of the multi-sectoral interventions to eliminate cholera in Zanzibar ensured that the various ministries which were part of the ZACCEP Coordination Structure fully participated in the quarterly and bi-annually coordination meetings. Through the able leadership of the 2nd VPO, the various ministries also collaborated with each other through joint monitoring activities and in the implementation of project activities related to their sector ministries, agencies and departments.

The 2nd VPO also ensured that resources for the implementation of the ZACCEP continued to be mobilized and closely monitored as per the approved ZACCEP budget plan. Districts, through their MDAs were encouraged to contribute funds for the implementation of ZACCEP in their respective sectors. The Disaster Management Commission (DMC) was able to coordinate and monitor the project's cholera elimination plans and activities of the different MDAs at district level. The Ministry of Health through its departments (Health Promotion Unit, Epidemiology and Disease Control, Curative Services and Environmental Health) not only provided secretariat services to both the Steering Committee and the Task Force, but also the technical support to the UN agencies, NGOs, universities and the various MDAs in the planning, monitoring and implementation of the various activities of the project at national, district and community levels.

“The implementation of ZACCEP was divided among different sectors, each handling specific responsibilities. Our commission focused on two main areas: coordination and project evaluation. We managed coordination through task force meetings and steering committee meetings, ensuring that all stakeholders were involved. The actual interventions, such as water chlorination and health promotion, were handled by the relevant sectors, like ZAWA for water and the Ministry of Health for health-related activities.” Disaster Management Commission, Zanzibar.

Evaluation question: Is there any evidence of any cholera elimination interventions that have been integrated into other sectoral plans?

Finding 5: There is very strong evidence that the project was able to integrate cholera elimination interventions into the health, education, tourism and environment sectors, resulting in greater synergies, and ultimately impact. However, there was room for the project to further collaborate and integrate its interventions with other sectors such as Protection, Nutrition, among others.

In Education, the project was able to integrate its interventions into the Ministry of Education's sectoral plans using schools as entry points for WASH interventions that included training of teachers in WASH, establishment of SWASH Clubs and the construction of group hand washing facilities in 122 schools across the five project districts. The ZACCEP Steering Committee and Task Force, also provided advisory support and key decision-making particularly on the WASH in Schools intervention. Because of the support and engagement through the ZACCEP Steering Committee, the Education sector was able to contribute financial resources towards the construction of latrines in 105 schools. However, the project could have used the evidence from the success of the WASH in Schools interventions to influence the Ministry of Education at national level through the ZACCEP Coordination Structures to adopt the group hand washing and SWASH Clubs model into all its primary schools, including the incorporation of WASH topics in the curriculum for the training of teachers and teaching of students.

Sectoral plans and interventions were integrated into the health sector through the various departments of the Ministry of Health i.e., Health Promotion Unit, Epidemiology and Disease Control, Curative Services and Environmental Health. Key interventions included the oral cholera vaccination campaign, strengthening of cholera epidemiological surveillance, capacitating medical laboratories in early detection, and enforcement of public health regulations. About 142 health workers (58 in Pemba and 84 in Unguja) were trained in cholera case management and other health issues related to cholera.

Cholera interventions were also integrated within the tourism sector including the training and sensitization of tourism industry actors, hotels disseminating cholera related information to tourists through information, education and communication materials as well as the recycling of solid waste and wastewater they were generating in Zanzibar. In the Environment sector, The project was able to factor its interventions through the Zanzibar Municipal Council and the Environmental Management Agency (EMA). The project established SWM groups, and the Centre of Excellence at the State University of Zanzibar was supported to pilot some innovations namely charcoal production, compost making and PVC-sand paving brick moulding. The sector also introduced Environmental Cleaning Days or Cleaning Campaigns, every last Saturday of each month in support of cholera elimination and enforcement of land-use and environmental by-laws and regulations regarding the illegal dumping of solid and liquid waste. However, the role of EMA in the project could have gone beyond the enforcement of regulations to also include: 1) monitoring the environmental impacts of the project interventions; 2) offering advice on the necessary mitigatory actions.

Having seen that fishing was contributing to rampant open defecation, the project engaged and collaborated with the Ministry responsible for Fisheries. Interventions implemented include:

- Construction of communal toilets close to fishing centres for use by fishermen
- Triggering fishery communities through the CLTS approach

Evidence has shown that in emergencies like cholera and covid-19, women and children's risks and exposure to violence, abuse, neglect and exploitation are further increasedⁱⁱ. Violations may take place in health care centres, during distribution of WASH and health supplies, at water points, in schools and sometimes directly due to humanitarian workers. Although there was a training on 'Accountability to Affected Populations' at the beginning of the project targeted at all stakeholders, the project seems to have missed the opportunity to integrate or mainstream protection and security interventions in its design and throughout its monitoring and implementation. The project could have included feedback and referral mechanisms for individuals with complaints, or for those requiring psychosocial support, or for potential victims of abuse and exploitation. It could also have included access to services for survivors of gender-based violence through, for example, religious leaders and CHVs.

There is little evidence on the integration of the project with the Nutrition sector. Apart from having included some of the nutrition-sensitive interventions like hand washing with soap and food hygiene into ongoing nutrition programmes, the project could also have collaborated with this sector in developing joint sectoral plans and interventions through the Joint Nutrition and WASH Clusters, or other existing multi-sectoral coordination structures between the two sectors.

Evaluation question: How was the project effectively coordinated to ensure effective participation and complementarity of all MDAs and international organisations?

Finding 6: The project was effectively coordinated at national levels, through the strengthening of an already existing government-led ZACCEP multi-sectoral coordination mechanism which involved a wide range of stakeholders. The coordination mechanisms ensured the effective participation and complementarity of all MDAs and development partners. However, district level coordination through the Disaster Management Commission was less effective.

The ZACCEP coordination structure was discussed and agreed in 2017. At the time of the project inception in 2019, the coordination structure was in place but faced teething challenges in its full operationalisation. Strengthening the already existing and government led coordination structure was a good strategy as it fostered ownership and sustainability. Figure 3 shows the structure and composition of the ZACCEP Coordination Structure.

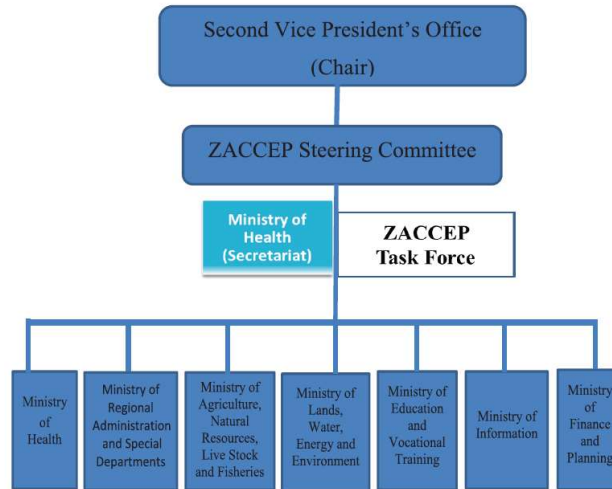


Figure 3: ZACCEP Coordination Structure

Source: Zanzibar Comprehensive Cholera Elimination Plan (ZACCEP) 2018-2027

Leadership at the highest level in government, through the Second Vice President Office (2ndVPO), provided a sound platform for leadership of coordination structure. The evaluation noted that the

<p>"First and foremost, multisector collaboration was excellent; it didn't leave anyone behind. All sectors that were considered important and strong actors were well coordinated and fully participated in all the activities." Field Office, WHO Zanzibar.</p>	<p>"First, let me say that the process of preparing the comprehensive plan to eliminate cholera in Zanzibar began as a collaborative effort. Initially, health issues were handled solely by the health sector, which faced many challenges. Eventually, we realized the need for a multi-sectoral approach to eliminate cholera, leading to the creation of the Zanzibar Comprehensive Cholera Elimination Plan (ZACCEP)." Disaster Management Commission, Zanzibar.</p>	<p>project was able to strengthen and support the ZACCEP Coordination Structure to fully execute its roles in cholera elimination through the provision of both technical and financial support. With this support, meetings were more consistent and conducted as per schedule, and guidance and technical support on</p>
<p>"Coordination was crucial for the success of this multi-sectoral plan. We received support from WHO, which included technical assistance and an opportunity to visit Zambia to learn from their successful cholera elimination strategies. We adapted best practices from Zambia and mainland Tanzania to improve our coordination and implementation strategies." Disaster Management Commission, Zanzibar.</p>		

cholera prevention and control was provided to key sectors and MDAs and also monitored the project's performance towards the implementation of ZACCEP. The Taskforce made key recommendations to address challenges and bottlenecks affecting implementation progress of the project and factored in emerging issues. Follow up on the key actions and recommendations made to the MDAs ensured that there was full accountability on their different roles and responsibilities. The strengthened coordination led to better planning for cholera prevention and control. For example, the committee gave a directive for all districts to have channel separate budgets for cholera elimination through their respective MDAs. As a result of this directive, MDAs allocated a total of USD176,206 and USD263,600 for the implementation of ZACCEP in their respective areas in the 3rd quarter of 2020 and 4th quarter of 2021 respectively.

Although coordination seemed to be very effective at national level, district and local level coordination mechanisms were not. For example, annual project reports indicate that no district coordination meetings were held in the first three years of implementation, with only about one meeting being held for the remainder of the two years. Reasons for this could not be clearly established, but could have been as a result of lack of financial or human resources, or both.

The coordination structures also faced numerous challenges that affected their full functionality with Pemba more affected than Unguja in part to the absence of some of the MDAs on the Island, compared to Unguja where most of the Head Offices of the MDAs are present. Meagre funding affected operations of the ZACCEP structures at district and shehia levels. Allocations for the WASH Sector from the government's fiscus remained low with the effect more severe during COVID-19 when resources were-directed to fight the pandemic. Inadequate human resource capacity (numbers and skills) was a challenge within the ZACCEP structures and among the MDAs. This compromised their effectiveness in carrying out their mandate as well as leading to delays in liquidating funds disbursed from UNICEF, affecting further disbursements. Logistical challenges due to insufficient vehicles, fuel and the absence of travel allowances. A reshuffling of government ministries after the election led to some trained officials being reassigned to other districts or MDAs starving the targeted cholera hotspot districts of the needed capacity. Overburdening of government officials by bringing in additional roles on cholera elimination which overlapped with their core responsibilities and key result areas.

In order to avoid any overlap and duplication of efforts with projects funded by other donors, there was a deliberate mapping of potential collaborations with existing projects and partners. As the lead of the Zanzibar WASH Sector, UNICEF maintained its primary role in supporting the RGoZ to convene all relevant partners and implementers, to increase synergies and minimize duplication of interventions through the WASH Cluster and other Technical Working Groups.

Finding 7: The hierarchy and membership of the multi-sectoral coordination structures were clearly defined in the ZACCEP and the ToRs, but the roles, responsibilities and functions of the different sector ministries and members were not defined.

The effectiveness of ZACCEP coordination structures was strengthened by robust multi-sectoral collaboration, which ensured comprehensive involvement of relevant stakeholders. Consistent monitoring and reporting mechanisms helped the structures to maintain oversight and responsiveness.

The ZACCEP Coordination Mechanisms outlined the hierarchy, composition, and functions of the Task Force and Steering Committee at the national level in a clear manner. However, the clarity and delineation of these structures at the district and community levels were lacking. To improve their effectiveness, it was essential to similarly define the hierarchy, composition, and roles of these structures at the district and community levels within the multi-sectoral coordination framework. This would ensure consistency, streamline operations, and facilitate coordinated efforts across all levels of implementation. Each entity was assigned specific tasks related to cholera prevention and control, which facilitated streamlined operations and accountability. At the baseline, only 50% of stakeholders reported clear understanding of their roles. By the endline, this figure had increased to 80%, indicating significant improvement in the clarity of roles and responsibilities. However, the roles and responsibilities of the different sector ministries, departments and agencies, at both national and subnational levels were not clearly defined. .

Evaluation question: What could the DMC/2nd VPO as a coordination agency done better to ensure the coherence of the project while taking into consideration the specificity of the various partners (MDAs)?

Finding 8. Although the ZACCEP Coordination Structures were effective in steering the ‘Towards a Cholera-Free Nation’ Project, the 2ndVPO/DMC could have taken a number of steps to further ensure the coherence of the project while taking into consideration the specificity of the various partners (MDAs).

These steps could have potentially included:

- Mapping of all stakeholders and MDAs that have a potential in contributing towards the elimination of cholera, and development of Terms of Reference (ToRs) that clearly define each one’s roles, responsibilities and functions.
- Advocating for a budget line for multi-sectoral coordination and continuously tracking the contribution of the various MDAs towards the ZACCEP to ensure that the required resources were mobilized to implement the comprehensive cholera elimination plan.
- Conducting a sector-wide human resource capacity assessment for cholera elimination amongst the MDAs, and closely monitoring the utilisation of funds disbursed to the MDAs for cholera elimination.
- Supporting and closely monitoring the coordination activities of the ZACCEP Structures at district and shehia levels, ensuring the structures were active and performing their expected roles.
- Inclusion of NGOs, private sector, media and universities in the ZACCEP structures at all levels beyond UN agencies (UNICEF, WHO and UNDP) to make technical and financial contributions.
- Absence of some of the MDAs in Pemba could have been resolved by seconding other MDAs to take on the roles of those which were not present on the Island.

Evaluation question: What is the coherence of the “Towards a Cholera-Free Nation” project with national policy?

Finding 9: The ‘Towards a Cholera-Free Nation’ project was strongly aligned with Zanzibar’s national priorities and policies, and with UNICEF’s national and global priorities.

The project is fully aligned with the Government of Zanzibar’s commitment to end cholera through the ZACCEP Ten Year Plan (2018-2027). The project supported the ZACCEP by addressing critical areas such as improving water quality and WASH infrastructure at both community, municipality and institutional levels. The project’s emphasis on community engagement and education also complements other WASH interventions, enhancing overall effectiveness and sustainability.

The project’s interventions are in line with Zanzibar’s Water Policy and Act of 2006 which saw the formulation of ZAWA, and whose overall objective is ‘the provision of access to clean and safe water to meet social and economic needs in line with environmental practices.’ The project saw the capacitation of ZAWA which oversees ‘the construction, operation and maintenance of water supply facilities to ensure the provision of sufficient quantities of safe water to its users’ in line with its mandate as stipulated by the Water Act (2006). It also positions well with the Zanzibar Water Investment Programme (2022-2027) which is geared towards promoting investment in the water sector, strengthening governance, mobilising resources and ensuring the optimal supply of safe water to all people of Zanzibar. The massive investment in WASH infrastructure is also aligned to the Zanzibar Development Plan (2021–2026) and the Zanzibar Development Vision 2050 which aim to promote the investment in appropriate high quality and facilitative inputs, technologies, research’ among other things.

The project also aligns well with Zanzibar’s priority of fostering a blue economy by protecting the marine environment through the sustainable use of biodiversity, carbon sequestration and coastal resilience. The projects thus supported the ‘Blue economic Policy’ through the promotion of innovations in managing solid waste whilst at the same time creating employment for the youths. Through working

with fishing communities and the tourism industry in the eradication of open defecation and the adoption of good solid waste management practices, the project significantly contributed to this blue economy vision.

The project is well aligned with UNICEF's national and global priorities. At the global levels, the project's Outcomes 2 and 3 are well aligned to the UNICEF's Strategic Plan (2022-2025) Goal Area 4 that seeks to ensure that 'Every child has access to water, sanitation and hygiene and lives in a safe and sustainable climate and environment.' The outcomes of the project also align well with the UNICEF's Global WASH Strategy (2016-2030) and the Sustainable Development Goals (SDGs), in particular Goal 6. The main objective of the WASH Strategy for achieving universal and equitable access to adequate safe water, sanitation and hygiene and ending open defecation are all aligned to interventions of the Towards a Cholera Free Nation project. The project also aligns with the Global Task Force on Cholera Control's (GTFCC) 2030 Road Map which envisions a world in which cholera is no longer a threat to public health and aims to eliminate the disease by 2030.

At regional level, the project's Outcome 1 aligns well with the UNICEF's Eastern and Southern African Region's Strategic Framework for Cholera (2018 – 2022) which provides effective strategies for more effective and coordinated cholera preparedness, response and prevention activities - before, during and after a cholera outbreak. At the national levels, the project positions well with both the 2016–2021 and the 2022-2027 UNICEF Tanzania Country Programmes and its priorities for WASH in Zanzibar and Tanzania mainland.

4.3 Coverage

Evaluation question: Was the targeted population properly covered? Were the population, community structures, shehia committees and stakeholders made aware of the ZACCEP and were they able to access services and participate in programme activities?

Finding 10: The "Toward a Cholera Free Nation" project was able comprehensively cover the targeted population of 1,056,203 people in the five districts and the 182 hot spot shehias (which represented 48 per cent of the 387 shehias in Zanzibar). An additional population of over 660,000 people in the remaining six districts in Zanzibar indirectly benefitted from the national cholera awareness and sensitization campaigns.

The "Toward a Cholera Free Nation" project was able to comprehensively cover the targeted populations in the identified cholera hotspots. The selection criteria for the ZACCEP project was designed to ensure the prioritization of the most vulnerable and needy districts, shehias and population groups (see earlier discussion on Finding 6). They were selected based on previous cholera data and situational analyses indicating higher susceptibility to cholera outbreaks.

"Certain districts were selected for intervention based on their high vulnerability to cholera, determined by historical data and trends in those areas. This resulted in the selection of specific districts that were most at risk. In Pemba, there are two districts, and in Unguja, there are three districts." Disaster Management Commission Member, Unguja.

"The project districts were selected due to the occurrence of cholera outbreaks. Not all Shehias were included in each selected district however, instead only Shehias that were cholera hotspots were selected. However, there were some of other Shehias that we selected because you had some indications of cholera and we had to include them into the sample, mostly those Shehias that were neighbouring hotspot Shehias." Disaster Management Committee Member, Pemba.

The project's vaccination efforts were extensive, reflecting a significant commitment to preventing cholera outbreaks for these vulnerable populations and districts. Although coverage of the oral cholera vaccine (OCV) was high in the first round (above 95 percent), coverage for the second round was low at 65 percent²¹. The high coverage for the first OCV round was achieved through the collaboration of multiple sectors and the extensive use of community health workers to facilitate the vaccination process and educate the public on its importance. The rate for the second round was low as it coincided with the introduction of the covid-19 vaccine which was largely shunned by communities as there were fears that it caused infertility. The low rate, combined with the evidence that OCV provides moderate to high-levels of protection against cholera for at least three years, another round of OCV vaccination was necessary to be conducted amongst the populations at risk in 2023/24.

“Regarding the Oral Cholera Vaccine (OCV) campaign for instance in the first round, coverage was excellent and exceeded what we had planned for. However, when the second round began, there was a decline due to the introduction of the COVID vaccine. So, the interference of these two vaccines is what caused the problem. The vaccine was initially accepted well. What happened later during the second round was not that it wasn't accepted, but there was some fear within the community that it might be the COVID vaccine. Hence, it was accepted, but there was poor coverage due to this fear.” Field office, WHO, Zanzibar.

The targeted population's needs were also fairly covered in terms of their WASH needs as seen by the increase in WASH coverages and hand washing rates (see section 1.16 on Effectiveness). Health and medical supplies were also procured and prepositioned in health care facilities in the most vulnerable hotspots, with needy communities and the water utility receiving sufficient water treatment tablets and chemicals.

The project utilized a mix of strategies to engage community structures, shehia committees, and stakeholders effectively. Community engagement was facilitated through multi-sectoral collaboration, leveraging existing networks and local governance structures to disseminate information and ensure accessibility of services. However, there were instances where initial community resistance was observed, which necessitated persistent engagement and education to overcome hesitancy. Nonetheless such community and school engagement significantly improved WASH conditions in schools.

Finding 11: ZACCEP was well known among stakeholders, particularly at national and district levels due to the deliberate efforts by the project to enhance awareness.

Multiple actions seemed to have been employed to raise awareness of ZACCEP among stakeholders and communities. The evaluation established that the ZACCEP was well known amongst stakeholders, particularly those at national and district levels. This was partly because most of them were involved in the development process and launching of the ZACCEP. The Plan had been developed through wider consultations and debates among the different MDAs and other stakeholders, hence this broader awareness. Government stakeholders who were involved in the coordination of the project at all levels seemed to also have greater awareness of the Plan. The use of mass and print media also seem to have worked in increasing awareness among communities and other government stakeholders.

Although the awareness of the ZACCEP was high at national and district levels, stakeholders at community levels rarely knew of the Plan, particularly in the project's two rural districts. They neither knew the existence of the Plan nor its intended purposes. The project could have used the CHVs, Shehia Health committees and the Religious Leaders to spread the awareness of ZACCEP at community levels, particularly in rural areas. Those interviewed seemed not to be able to distinguish between the ZACCEP

²¹ 2022 KOICA GDEF Annual Report

Plan and the 'Towards a Cholera-Free Nation' Project. They assumed that the project was itself the ZACCEP. The lower levels of education among these communities may have further contributed to this lack of awareness.

"Yes, awareness levels of the ZACCEP is very high, particularly among us the government workers. I'm not really sure, though I doubt if our communities know about the ZACCEP." DMC, Pemba

"There are plans being implemented and I think these plans will help our country against cholera. This project has been implemented to ensure we eradicate cholera in our areas by keeping the environment clean. The project coordinated various activities on hygiene and sanitation." Community Group, Females, Chumbuni, Unguja.

"Yes, it is a project to eradicate the disease of cholera by ensuring that we have a clean environment around our community." Community Group, Males, Mtoni –Chemchem, Unguja.
"This is a long-term project being supported by UNICEF to ensure that Zanzibar eliminates the problem of cholera in its areas of Pemba and Unguja." SWASH Club, Boys, Kojani Primary School.

4.4 Effectiveness

Evaluation question: Have the stated project goal, specific objectives, and indicators – as shown in the project logical framework – been achieved and if so, to what extent?

Achievement of targets

Finding 12: The project made significant achievements meeting or exceeding at least 77% per cent of its targets.

Annex 3 presents analysis of project performance against set targets in the results framework. Out of the total 31 targets, the project was able to meet 24 out of 31 targets (77.4 per cent) and only 3 targets (9.7 per cent) were not met (see summary in Figure 5 below). Performance on 4 (12.9%) out of the 31 targets could not be ascertained as there was no data available to verify them during this evaluation.

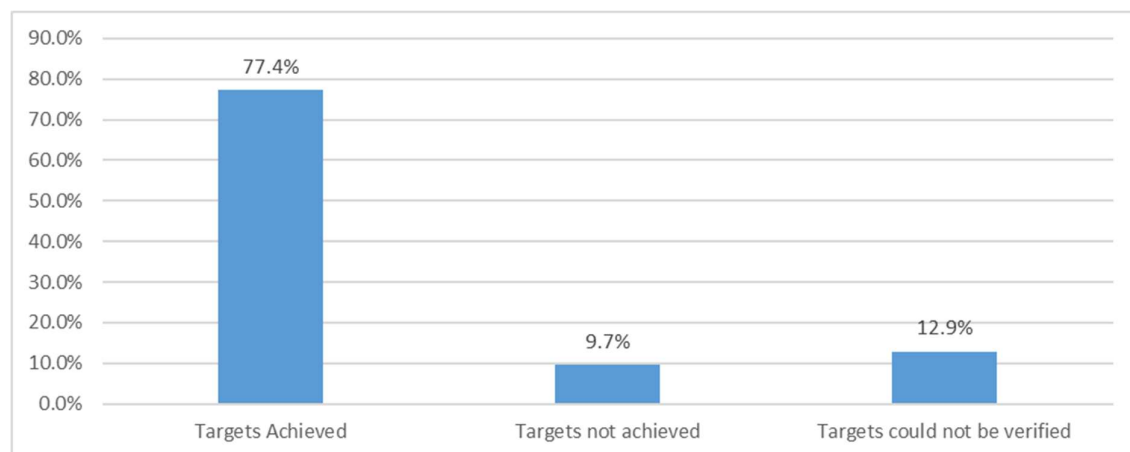


Figure 4: Achievement against targets

Source: Project documents

Finding 13: Over the five-year period of project implementation, there was a demonstrated improvement in performance among the three (3) main outcomes of the project, notably i) capacities among government and community systems for continuity, ownership, and sustainability of the program, including coordination and funding at national and subnational levels; ii) equitable access to safe WASH, and health services; and iii) communities' adoption of improved WASH behaviours and practices.

(i) Capacity among government and community systems to eliminate cholera

The ZACCEP Coordination Structures and the Rapid Response Teams (RRTs) were capacitated in the planning, development and implementation of cholera prevention and response actions in their respective jurisdictions. The capacities of the ZACCEP Coordination Structures were strengthened not just through the various trainings and financial support they received, but also the learning and exchange visit to Zambia that was facilitated by WHO.

The water treatment chemicals (4,500kgs of calcium hypochlorite) given to ZAWA and aqua tablets distributed to water vendors and households enabled a total of 794,861 people to access safe water throughout the project years. ZAWA's reports indicate that their water supply increased from 47% in 2021 to 70% in 2023 as a result of the project²². The water utility was also capacitated on routine water quality monitoring and reporting using the KOBO platform through the various trainings. Proper water resources management and water user collection fees was strengthened through the registration and mapping of water vendors and boreholes.

"The project supported ZAWA in different ways. We were supported with water treatment chemicals such as Chlorine were for the purpose of ensuring that all people in Zanzibar get access to safe and clean water. This increased our capacity to provide water, and we have not had any cholera cases. Another form of support we received was training where our staff were trained on water chlorination and water quality monitoring." **Senior Manager, Zanzibar Water Authority, Unguja.**

There has been an increase of budget allocation to the WASH sector from 2.8% of the total government budget in the financial year 2017/18 to 17.8% in the financial year 2022/23²³. However, this increase has been limited to the water component of the sector and does not include sanitation.

²² 2024 The Journey – Investment in the Water Sector 2020-2023, Achievements, Opportunities and Gaps; ZAWA.

²³ 2023 KOIKA GDEF Annual Donor Progress Report

TRENDS IN BUDGET ALLOCATION

Between FY 2017/18 up to 2022/23, the budget allocation for water (MOWEM/ZAWA) sector fluctuated significantly, increasing from 2.8% in FY 17/18 to 17.7% in FY 22/23

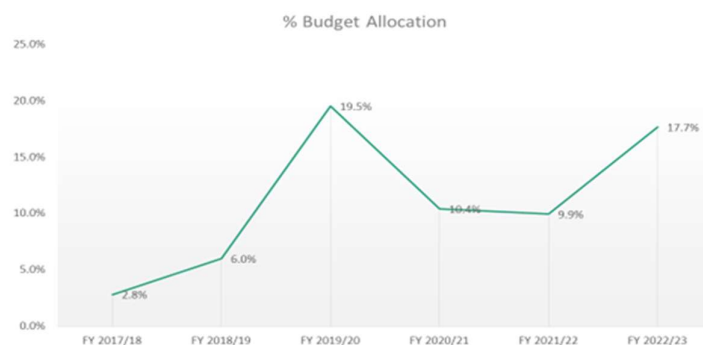


Figure 5: Trend of water sector budget allocation in percentage of the government budget

Source: Project documents

Although the overall budget for the Ministry of Water, Energy and Minerals (MOWEM) for the fiscal year 2022/23 in the national budget decreased from 7 percent to 6 percent during the fiscal year 2022/23, the water component received the larger chunk of the budget, constituting 84 per cent (US\$42,732,287), with a significant allocation to ZAWA for development expenditure, totalling US\$40,000,000 (see Table 11).

Table 11: MOWEM Budget Composition by Sub-programme FY 2022/23 in USD.

Sub-programme	Recurrent	Development	Total Allocation	Budget Allocation (%)
Management of Water supply	2,463,173	40,269,114	42,732,287	85%
Management of Energy and Mineral	377,290	6,976,384	7,353,675	15%
Supervision and Strengthening of Minerals and Minerals Services	19,045		19,045	0%
Total MOWEM	2,859,508	47,245,498	50,105,006	

Source: 2023 KOICA GDEF Annual Progress Report, UNICEF Tanzania.

Through various advocacy efforts, the project influenced the enforcement of public health regulations and facilitated the development and drafting of a Water, Sanitation and Hygiene Policy together with the accompanying strategies on Implementation, Monitoring and Evaluation, Communication and Resource Management through a multi-stakeholder consultative process. Once it is adopted and launched, it is hoped that the policy will create a conducive environment and guide the WASH sector in the implementation of WASH interventions.

About 100 health centres and 20 CTCs had their capacity to manage cholera outbreaks improved through receiving cholera supplies and equipment. Health workers expressed that they now had comprehensive knowledge and work tools, equipment and supplies in preparedness, response and management of cholera and acute watery diarrhoea outbreaks, compared to what they had before the project.

“We received a lot of support from the project, both in terms of training, materials and medical supplies. We received cholera beds, protective clothing, antibiotics, flow charts and various

other materials. We also got trainings and mentoring visits from our supervisors, and this has greatly improved our knowledge on cholera case management.” Health Care Workers, Kizimbani, Wete District, Pemba.

Through various trainings, Community Health Volunteers (CHVs) were capacitated on cholera prevention and response, and this was complimented with material support in the form of work tools and educational materials which has enabled them to extend risk communication and community engagement in the shehias as noted by the following CHVs:

“We reached out to the community in different ways including door to door campaigns, community or shehia meeting campaigns, public announcements, community radios, community football competitions, community traditional (local) dancing groups and distribution of leaflets at gathering centers like shopping centers, mosques, churches and in households. All these strategies worked well, resulting in people improving their knowledge on cholera and changing their behaviours.” **CHV, Kizimbani, Wete, Northen Pemba.**

“I started community sensitizations through involving parents, conducting community and household visits, attending addressing marriage ceremonies, Mosques visits, Shehia meetings and school campaigns. I also participated in community radio programs, public announcements campaigns and social and behavioral change communications programs. I distributed stickers with cholera prevention messages to the community.” **CHV, Welezo, Magharibi B, Unguja.**

A national WASH-MIS was successfully set up through the integration of WASH indicators into the digital District Health Information Software 2 (DHIS 2), with 17 government officials trained as system users. Interviews with key informants revealed that the system, particularly through its dashboard, facilitated the effective and timely collection, analysis and availability of WASH data which in turn aided timely and effective decision making by both policy-makers and implementers. They are anticipating that their capacitation on the integrated disease reporting and surveillance (IDRS) will further reduce on the time needed to respond, report and response to any future cholera cases from the initial two weeks to one month, to a period of only 72hours.

“Yes, with all the trainings we received on surveillance and reporting, we are confident that we will be able to act and respond on any suspected cholera cases on time.” **District Medical Officer, Mjini District, Pemba.**

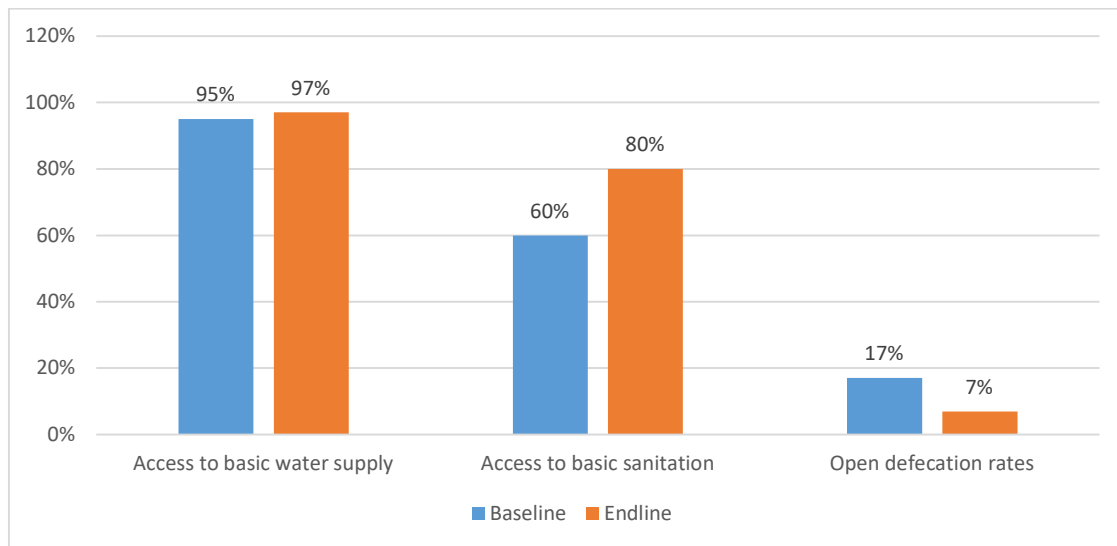
“Surveillance, logistics and supplies are being closely monitored. We have weekly surveillance reports that we monitor, and we compile daily reports that are distributed weekly through the MoH and the WHO. Additionally, there are coordination meetings where we discuss the surveillance reports. If there's a place experiencing diarrhoea, we then suspect it might be cholera cases. So, every time, we collect, analyse, and interpret our diarrhoea-related cases, and then appropriate actions are taken.” **Field Office, WHO Zanzibar.**

Three (3) innovations on managing solid waste in urban areas were successfully piloted by the Centre of Excellence established at the State University of Zanzibar, namely charcoal production, compost making and PVC-sand paving brick moulding. Trained SWM groups were implementing these innovations in managing solid waste in their respective communities which contributed to the government’s blue economy policy in which waste is controlled to avoid marine pollution, However, stakeholders mentioned that the disposal of diapers still remains a major challenge as users continue to dump them in public areas where children end up playing with them. Another challenge noted was the shortage of garbage trucks to widen solid waste collection and management.

“Our challenges are mainly around shortage of financial resources and equipment such as garbage collection trucks. In addition, the proper disposal of diapers still remains a challenge as communities dispose of them in public places where children end up using them.” Zanzibar Municipal Council, Unguja.

(ii) Equitable access to safe WASH and health services

Households having access to basic water supply increased nationally from 95% at baseline (2019) to 97% at endline (2023), with access to basic sanitation services also increasing from 60% to 80% between baseline and endline²⁴. The rates varied across the two rural districts²⁵, for example, the percentage of households with improved sanitation increased from 7% in 2020 to 74% in 2022 for Micheweni and 2.8% to 76%²⁶ in Wete in the same period.



Source: 2022 THDS-MIS

Figure 6: Comparison of WASH Service Levels at Baseline and Endline

Although these were national figures from the 2022 TDHS, estimated figures drawn from the WASH-MIS show that the percentage of households in the five (5) project districts with basic sanitation services was only 61 percent against the target of 75 percent. The rates varied across the two districts, for example, the percentage of households with improved sanitation increased from 7percent in 2020 to 74 percent in 2022 for Micheweni and 2.8 percent to 76 percent in Wete in the same period.

There were no significant differences between the baseline and endline figures for basic water supply services as the project’s interventions focused more on ensuring water safety rather than construction of new or rehabilitation of aged water infrastructure. The significant differences for sanitation services were contributed by the newly constructed latrines mostly in the two rural districts of Micheweni and Wete as indicated above. Communities indicated that this increase was as a result of the awareness campaigns and the wider adoption of the SATO Pan which raised the demand for latrine construction.

Although there has been a corresponding decline in the open defecation rates in Zanzibar from 17 percent in 2015/16 to 7 percent at endline, only 87/388 (22.4 percent) targeted villages in the two districts of Wete and Micheweni had achieved ODF at endline (2023). Rates of open defecation varied across the two districts, with the rate being reduced from 53% to 26% in Micheweni (27percent

²⁴ 2022 Demographic and Health Survey and Malaria Indicator Survey; Office of Chief Government Statistician Zanzibar

²⁵ The CLTS/sanitation component was only implemented in the two rural districts of Micheweni and Wete

²⁶ 2023 KOICA GDEF Donor Annual Progress Report

reduction), and from 35% to 24% in Wete (11percent reduction) in the period of 2020/21 to 2023²⁷. The fishing communities continue to contribute more to the high open defecation rates.

Handwashing rates in schools increased significantly, from 45% at baseline (2019) to 80% at endline (2023). The student to drop hole ratio improved nationally from 1:70 at baseline (2019) to 1:50 at endline (2023), indicating increased access to improved sanitation facilities in educational institutions.¹³ Stakeholders attributed this to the contribution of the project in the five districts and the influence it had on leveraging resources in the construction of additional WASH facilities across all the eleven districts.

WASH facilities (Incinerators, water tanks and hand washing basins) installed across seven HCFs facilities ensured that safe infection and prevention control measures were instituted in the facilities. Healthcare workers and more than 59,505 patients benefited from the use of improved WASH facilities through the rehabilitation of toilets and bathrooms, upgrading water pipes and handwashing basins, installation of elbow taps, and the drilling of new boreholes.

(iii) Knowledge on cholera and adoption of improved WASH behaviours and practices

The project resulted in improvements in WASH practices amongst targeted communities across all the districts. Although the actual percentage population of people who wash their hands with soap at critical times nor those who could recall four (4) key cholera messages could not be ascertained at endline, focus group discussions with school children and community groups indicated that most of them could recall key cholera messages (what is cholera, signs and symptoms, prevention and treatment methods), how to make Oral Rehydration Solution (ORS) at home, appropriate water treatment methods, food safety measures, and critical times for hand washing and how to wash one's hands with soap. However, water treatment using aqua tabs (Water Guard) was shunned by most communities due to the bad smell and change in the taste of the water. Although the baseline had indicated that up to 10percent of the population in rural areas said they would seek care from a traditional healer and almost double this proportion (18 per cent) seek relief from faith healers, the endline established that these figures had gone to almost nil. All community members interviewed indicated that they will seek advice from health workers in the event of a family member being ill. The perception that cholera only occurs during the rainy seasons seemed to also have been cleared by endline. However, regarding solid waste management practices, a comprehensive assessment of the solid waste management situation in Zanzibar carried out in 2023 indicated that waste sorting practices were carried out by only 14% of the population, while the majority, 86%, did not engage in waste sorting.

“Cholera is a diarrhea disease caused by someone indirectly ingesting feces. It transmitted in areas where people do not have toilets, so they defecate in the bushes. The presence of feces in that environment will attract flies, which when they land on the feces carry them and in those areas and when a fly with defecation lands on food, it leaves cholera bacteria.” **SWASH Club Members, Girls, Unguja.**

“The symptoms of cholera are diarrhea and Vomiting. For drinking water to be safe to drink, we must first boil it, filter it, treat water with medicine, cover it, and store it in a safe place so that it should not be infected with dust or any dirt.” **Community Group, Females, Nyerere, Mjini.**

“To treat our water, we can either boil it, filter it or use Water Guard. However, most of us here are unwilling to use Water Guard as it causes our water to taste bad and produce a bad smell.” **Community Group, Females, Shaurimoyo, Unguja.**

²⁷ 2023 KOICA GDEF Donor Annual Progress Report

“Fruits should be washed and food should be eaten whilst its still hot all the time. Food should also be covered to keep away flies.” **Community Group, Mtopepo, Unguja.**

“The ZACCEP has led to substantial improvements in the community's WASH practices and public health outcomes. Though the project faced some initial difficulties in changing rural people's behaviors, the comprehensive approach involving community sensitization, training, and regulatory enforcement has ultimately resulted in the desired positive outcomes, as evidenced by the elimination of open defecation and cholera outbreaks in the community,” District Environmental Health Officer, Wete, Pemba.

(iv) Level of improvements in water quality meeting national standards (microbiological and free chlorine residual (FCR) levels)

Finding 15: Although there were no water samples collected that reached the standard Free Residual Chlorine (FRC) Levels (FRC) levels of 0.5mg/l at both baseline and endline, the evaluation established that overall, there was some improvement in the quality of drinking water due to increased chlorination of the ZAWA piped water system, water vending points and water treatment practices using chlorine tablets at household levels.

This is indicated by the mean FRC levels of the water samples having increased from 0.05mg/l (N=304; 95% CI = 0.03-0.06) at baseline (2019) to 0.0806mg/l (N=312; 95% CI = 0.013-0.246) at end line (2023). This was statistically significant indicating some marked improvement in the FRC quality levels. However, the absence of any water samples with the required standard of FRC of 0.5mg/l at both baseline (2019) and endline (2023) is still a cause for concern as it shows that user populations in the five districts are still drinking water which is below the national quality standards in terms of its residual chlorine levels.

The evaluation further revealed that the percentage of water samples with FRC levels less than that of the required standard levels of 0.5mg.l i.e., 0.0%-0.49%, decreased from 97.4 percent (296/304 samples) at baseline (2019) to 48.2 percent (150/311) at endline (2023), whilst those above the standard increased from 2.6 percent to 3.5 percent (see Figure 8).

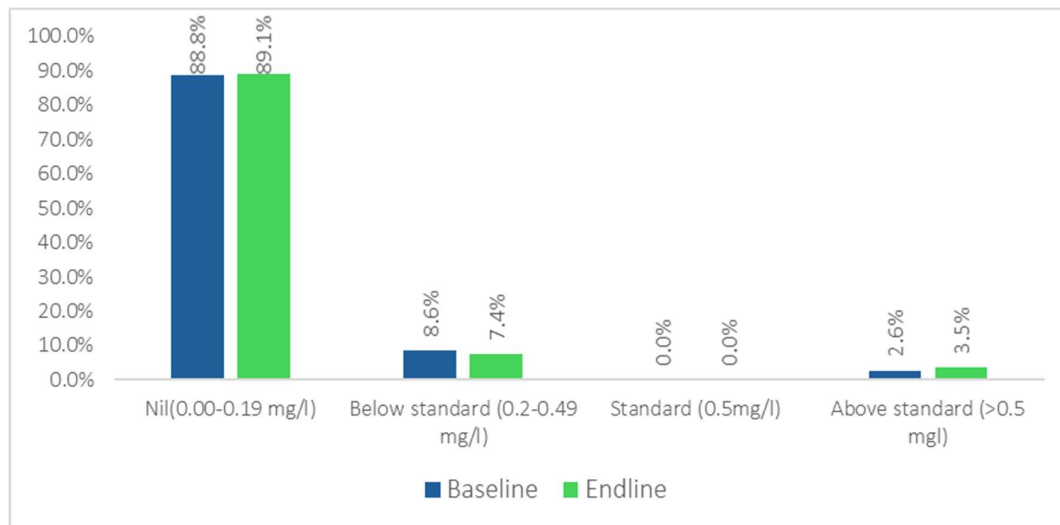
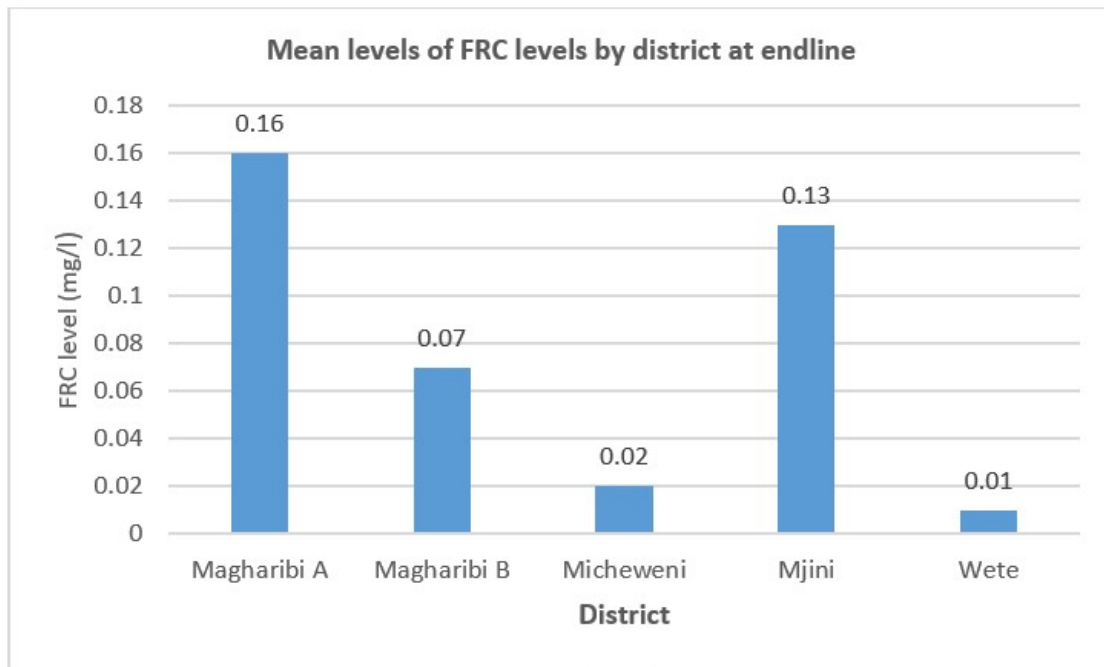


Figure 7: FRC levels of water samples collected at baseline and end line
 Source: End line data and baseline report

There was a varied level of free residual chlorine present on water collected from the five districts; with Magharibi A and Mjini (0.16 and 0.13) having the highest mean levels and Micheweni and Wete (0.02 and 0.01) having the least levels (see Figure 9). This was almost similar to the results that came from the baseline survey which indicated that the presence of low free residual chlorine was predominantly observed in Michweneni (FRC=0.02mg/l) and Wete (FRC=0.01mg/l) districts (see Figure 9 below). A further analysis indicates that urban districts (Magharibi A, Magharibi B, Mjini) seemed to fair better in terms of the FRC levels than the two rural districts (Micheweni, Wete), as also was the situation at baseline (2019).



Source: End line data

Figure 8: Mean levels of FRC by district at endline

Analysis by water source type and locations further reveals that ZAWA water (taps, storage tanks), water vending points (boreholes) and institutions (boreholes; food vending points; health centres, madrasa, mosques) contributed more to the high mean levels of FRC in the water, indicating the impact of the project’s interventions. (see Table 12).

Table 12: FRC by water source type and location

Water source type	Mean FRC (mg/l)	Standard Error of Mean (95% CI)	Lower bound	Upper bound
Borehole	0.01	0.01	-0.0020563	0.023109
Bucket	0.2	0.1	-0.0033216	0.396655
Food vendor	0.03	0.01	0.0133933	0.053879
Health centre	0.07	0.03	0.0118068	0.12584
Household	0.06	0.02	0.034703	0.094761
Madrasa	0.06	0.04	-0.0198707	0.147648
Mosque	0.06	0.03	-0.0091291	0.126629

School	0.1	0.05	-0.0025143	0.197666
Storage tank	0.31	0.24	-0.1500327	0.778922
Tap	0.18	0.08	0.0254538	0.334546
Total	0.08	0.01	0.0532758	0.107882

Source: End line data

The capacitation of ZAWA through the procurement of water treatment chemicals seemed to have contributed to these improvements. There were also some indications of slightly high FRC levels at household levels (buckets) indicating the high water treatment practices at that level due to the freely distributed chlorine tablets (Water Guard).

The trend analysis of Free Residual Chlorine (FRC) levels in the Zanzibar Piped Network from August 2021 to December 2023 reveals an overall improvement. In 2023, FRC levels above the standard (>0.5mg/l) increased by 21 percentage points compared to 2021. In 2022, there was a significant 35 percentage point increase, reaching 46%. However, the 2021 data was collected from August to December, while 2022 and 2023 used full-year data. After the 2022 peak, FRC levels declined slightly but remained higher than 2021. Disaggregation by water source shows major improvement in treatment tanks, increasing from 12% in 2021 to 84% in 2023 (See Figure 10 and 11).



Figure 9: FRC levels (2021-2023)

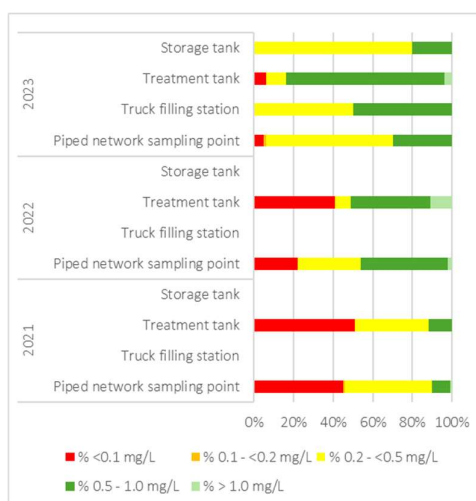


Figure 10: FRC levels of water samples (2021-2023)

Source: ZAWA Water Treatment Database

Finding 16: Overall, and as a result of the project’s interventions on water quality improvements, there was an improvement in the microbiological quality of water with the proportion of samples found not to have any faecal coliforms across all the five (5) project districts increasing from 70.6 percent at baseline, to 85.6 percent at end line.

There were some variations across the two Islands, with Unguja having more samples with no faecal coliforms (61%) in Unguja compared to Pemba (39%), revealing the urban-rural disparities in water quality. There were statistically significant differences in the improvements of water quality across the districts, with Magharibi A having had the highest number of faecal coliforms at baseline (81.8%), but had improved to only 20% at end line. There were also significant improvements for the water quality in Wete and Micheweni districts. Overall, the water quality in the rural districts remained comparatively lower than in the urban districts.

The samples collected indicate that there was a significant improvement in the reduction of the mean coliform counts found in the water samples from 80.4 FCU/ml at baseline to only 2.651FCU/ml at end line (N=312, CI=95%). However, of the 14.4% of the samples found to contain faecal coliforms, all of them had counts which went beyond the WHO threshold (<1 FCU/100ml). Figure 12 indicates the results of the comparison of the faecal coliform counts at baseline (2019) and endline (2023) by district.

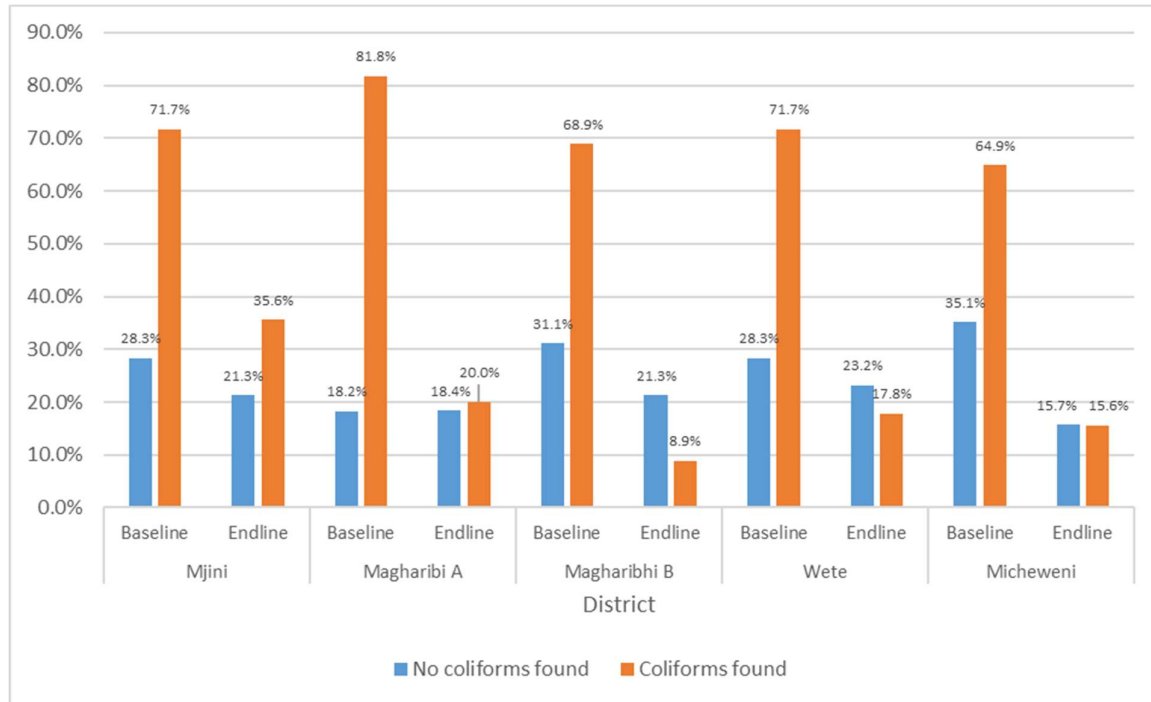


Figure 11: Faecal coliform counts by district at baseline (2019) and endline (2023)

Source: Baseline and end line survey data

Results of the evaluation also indicate that the quality of the water varied by water source type and locations. Improved water sources (boreholes, taps) and institutions (schools, madrasa, mosques, and storage tanks) significantly showed the absence of faecal coliforms as at baseline (2019). Table 13 and Figure 13 show a summary of the faecal coliform counts by Island, district and water sample source.

Table 13: Faecal coliform counts by Island, district and water sample source .

	Number of Samples found with Faecal Coliform (FCU/100mL)	Number of Samples found without Faecal Coliform (FCU/100mL)	Total number of Samples	% of Samples found with Faecal Coliform (FCU/100mL)	% of Samples found without Faecal Coliform (FCU/100mL)
Island					
Pemba	15	104	119	12.61	87.39
Unguja	30	163	193	15.54	84.46
District			Unguja		
Magharibi A	9	49	58	15.52	84.48
Magharibi B	4	57	61	6.56	93.44
Micheweni	7	42	49	14.29	85.71

	Number of Samples found with Faecal Coliform (FCU/100mL)	Number of Samples found without Faecal Coliform (FCU/100mL)	Total number of Samples	% of Samples found with Faecal Coliform (FCU/100mL)	% of Samples found without Faecal Coliform (FCU/100mL)
Pemba					
Mjini	16	57	73	21.92	78.08
Wete	8	62	70	11.43	88.57

Source: End line survey data

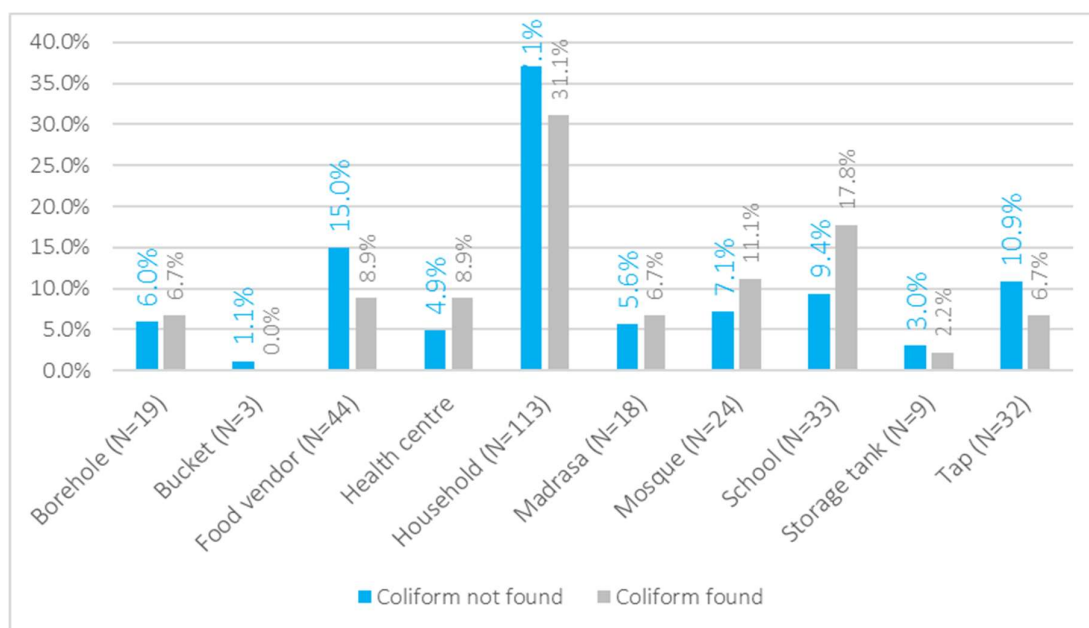


Figure 12: Faecal coliform counts by sample source

Evaluation question: To what extent did the direct results of the interventions contribute to the sustainable achievement of the ZACCEP?

Finding 14: To a very large extent, the direct results of the interventions (outputs) contributed to the sustainable achievement of ZACCEP 2018-2027 objectives which advocate for cholera elimination.

The project was launched as part of UNICEF's continued commitment to support the Government of Zanzibar to achieve its vision to eliminate cholera in Zanzibar following the development and adoption of the Revolutionary Government of Zanzibar's Comprehensive Cholera Elimination Plan (ZACCEP). The development of the project was a first step to support the implementation of this plan, and hence it followed the blueprint's theory of change (ToC), including the approaches, objectives and interventions. A review of the project documents, including the proposal and the ZACCEP Plan clearly indicates that the project was fully aligned to the national plan. An assessment of the contributions of the project's interventions to the ZACCEP are indicated in Table 14.

Table 14: Contribution of the project to ZACCEP objectives

ZACCEP Pillars	Objectives and	Assessment of the extent of contribution of project interventions to ZACCEP
Objectives: Elimination of cholera in Zanzibar over a ten year period (2019-2023)		The project sought to eliminate cholera in a 5 year period (2019-2023). It had 5 overarching objectives and 3 main outcomes which are aligned to both the ZACCEP's objectives and pillars. There were no cholera outbreaks or cases during the 5 year

ZACCEP Pillars	Objectives and Assessment of the extent of contribution of project interventions to ZACCEP Pillars
through a set of 13 objectives and 3 pillars.	project period. Thus, both the project objectives and outcomes to a <u>large extent</u> contributed to the ZACCEP's objectives.
ZACCEP Pillar 1: Creating an enabling environment that promotes the elimination of cholera through policy, legislation, and multi-sectoral coordination.	The project ensured that there was effective multi-sectoral coordination through the ZACCEP coordination structures at both national and sub-national levels; promoted adherence to environmental health and food hygiene regulations for buildings and among food vendors and communities; strengthened epidemiological and laboratory-based surveillance and early warning systems through trainings and equipping of HCWs and HCFs to ensure early detection and timely response to cholera outbreaks; built the capacities of MDAs and communities on cholera prevention and response through various trainings ; and came up with a digital and robust WASH-MIS system. The project also managed to advocate for the development of a revised WASH Policy, which the government is currently working on. To a <u>large extent</u> , these project's interventions and results were well aligned with this pillar.
ZACCEP Pillar 2: Enhance the scope and effectiveness of preventative measures/services,	The project implemented a range of activities to support this pillar. It ensured that communities at risk of cholera accessed safe water and improved sanitation facilities through capacitation of ZAWA, water vendors and households in water treatment, solid waste management was improved through low-cost innovations, WASH practices were improved through social and behaviour change communication activities and oral cholera vaccine was given to the most at risk populations. The contribution of the interventions to this pillar were <u>to a small extent</u> . The coverage of the OCV was not very high, and elimination of open defecation was a challenge.
ZACCEP Pillar 3: Improve Zanzibar's capacity to respond and contain localized/isolates outbreaks/ cholera events.	Quality of patient care was improved by increasing early access to effective treatment and capacitation of HCW and HCFs and cholera supplies, and equipment was prepositioned in at most risk areas. To a <u>large extent</u> , these project's interventions and results were well aligned with this pillar.

Factors which facilitated the attainment of project results

Several factors facilitated the achievement of results and can be summarised as follows:

- Collaborative partnerships and effective coordination among the different stakeholders;
- District and shehia competitions;
- Strengthening and enforcement of public health regulations and community laws; and
- Sound social and behaviour change communication (SBCC) initiatives.

These are detailed below.

Collaborative partnerships and effective coordination among the different stakeholders: This was through private sector partnerships and joint assessments, planning, implementation and monitoring activities amongst the different MDAs and implementing partners. For example, the Waste X Laboratory collaborated with partners such as WaterAid Tanzania and BORDA of Germany that resulted in the implementation of a US\$244,000 Decentralized Wastewater Management System (DEWATS) with a capacity to treat 15,000 litres of wastewater per day in Magaribhi A district. Through the partnership with Romania's International Development Cooperation, the government was supported with four compressor trucks for solid waste collection, at an estimated cost of USD 194,206. Integration of the project interventions in various sectors as detailed earlier significantly improved the effectiveness of the project.

“The teamwork and combined efforts have led to significant achievements, such as no cholera cases reported since the plan's implementation. Activities like vaccination, water chlorination, and behaviour change campaigns in communities have been crucial in achieving these results. Additionally, improving water availability and access has greatly contributed to reducing cholera-related challenges.” Disaster Management Commission, Zanzibar.

District and Shehia Competitions: The launching of competitions among districts and shehia based on improvements in WASH (Water, Sanitation, and Hygiene) practices and other results was also a contributing factor that motivated communities and helped to drive progress through the rewarding of best performing communities and those who came out with innovations. This was more so for the communities which lagged behind on the construction of latrines and on other hygiene promotion issues.

Strengthening and enforcement of public health regulations and community laws: Another key driver mentioned by various stakeholders was the formulation and enforcement of by-laws and environmental regulations particularly at household, community and institutional levels, and coming up with an agreed set of communal rules that govern households and individuals and overseen by community/ Shehia and Religious Leaders. The project also ensured that all construction and buildings adhere to Public Health Regulations and waste is managed properly in all public offices and facilities. The community's active participation in developing and enforcing the WASH-related communal rules and norms helped to drive the desired behavioural changes and cholera elimination. For example, regulations were enforced in public markets to ensure food vendors followed laid out laws related to food vending. Enforcement of by-laws were also made for households and communities which resisted to construct latrines.

"Formulation of laws and regulation at community level via village meetings where we agreed to work as a team in digging pits for latrines and assisting the most vulnerable households without toilets went a long way in accelerating the achievement of eliminating ODF. In addition, the school, madrassa and religious programs contributed a lot to the behavioural changes and to the elimination of cholera." Community Health Volunteer, Northern Pemba, Micheweni in Shehia Makangale.

Sound social and behaviour change communication (SBCC) initiatives: The evaluation team noted that the implementation of sound SBCC interventions contributed to a large extent to the increased knowledge and utilization of WASH services and also to the adoption of good WASH practices by the targeted communities. This followed the implementation of an evidence-based SBCC strategy which ensured the translation of programme inputs into technically sound and culturally appropriate print and audio-visual SBCC messages, training packages for community health volunteers (CHVs) and SBCC activities which reached out to appropriate audiences through a mix of media.

"Yes, our social mobilisation activities and home visits have been very effective. The majority of people in our communities are now practicing proper handwashing practices at critical times, there is no more open defecation, they all know how to treat their drinking water and how to manage their solid waste. And even normal diarrhoea and other waterborne diseases prevalence have decreased significantly." **Community Health Volunteer, Kisimbani, Wete, Pemba.**

Factors which inhibited the attainment of project results

Various internal and external challenges and factors were faced which militated against the achievement of the planned project objectives. These are summarized below.

Covid-19 Pandemic and General Elections: Although Covid-19 had a positive effect on enhancing WASH behavioural practices, the evaluation noted that attainment of other results was mostly affected by the COVID-19 pandemic due to restrictions on gatherings and movement, budget reductions and a change in government priorities towards responding to the pandemic. Even at a time when the pandemic was subsiding, the Island experienced other disease outbreaks notably measles, and the threat of Polio and

Ebola Virus Disease (EVD). In addition to the pandemic, the project was also affected by the National General Election campaigns that ran from August to October 2020. The campaigns impeded effective and timely implementation of project activities because of security concerns, gathering restrictions and unavailability of government and community leaders on project activities as they prioritized the election campaigns.

Poor and resistant communities, coupled with interference from politicians: Attainment of open defecation-free status remained a great challenge for the project across the two districts of Micheweni and Wete where community-led total sanitation (CLTS) was the main approach for motivating households to construct latrines using their own resources. Apart from the outbreak of covid-19, latrine construction was the main contributor to the low numbers of open defecation-free villages. Interviews with key informants revealed that most communities were resistant to contribute to latrine construction as they felt that it was the responsibility of government to build the latrines for them as was in the past. This was further worsened by some politicians who kept on promising free latrine construction materials for their own political mileage.

“Construction of latrines by poor households was a major challenge as most them failed to even to pay the Tsh7,000.00 (US\$2.80) to cover cement, sands and installation expenses of the SATO pans they received for free.” **Community Health Volunteer, Kisimbani, Wete, Pemba.**

Reshuffling of government staff and inexperienced workers: Stakeholders interviewed noted that a new section namely the Emergency Operating Centre (EOC) was established during the course of the project within the Preventive Medicine Department of the Ministry of Health and assigned the role of overseeing the implementation of ZACCEP. However, the section had new staff who had little or no experience in project implementation leading to delays in rolling out some of the project activities. The inconsistent availability of government staff members for ZACCEP meetings and for other project activities, in part due to commitments to other priorities, as well as being attributed to shortage of human resources, was also a contributory factor.

Myths and misconceptions about cholera in general, and about the cholera vaccine in particular: As noted earlier, the vaccination coverage for the oral cholera vaccine (OCV) declined in the second round as there were some misconceptions around the cholera vaccine as some community members felt that it came in as a population control tool by causing infertility and impotence. Other myths and misconceptions identified at baseline persisted at endline. These included that cholera is a through witchcraft or supernatural causes, it is God’s will or curse, and that it only occurs during rainy season and that precautions should only be taken during such seasons.

‘Initially, there was reluctance toward vaccination, but we achieved about 95% coverage in the first round. However, the second round saw only 63% coverage due to misconceptions about the vaccines being for COVID-19. The vaccine significantly reduced the prevalence of cholera by almost 65percent. Areas with high population density and poor sanitation remain vulnerable, but the vaccine has been a game-changer in preventing cholera,’ **WHO Focal Person.**

“There were rumours concerning the cholera vaccines provided. The community members believed that the vaccines would make them more infertile, impotence and less likely to get pregnancy. But through different meeting seminars we conducted, the community awareness's increased and adhered and adhered to receive the vaccines and now the community is free from cholera disaster.” **Community Health Volunteer, Shehia Makangale Shehia, Micheweni, Pemba.**

Delayed start of the project: Signing and implementation of the project was delayed by close to six (6) as the signing of the project grant took place in May 2019. This affected project expenditure and most of the start-up results for the first year, with some of the activities having had to be reprogrammed.

Outdated WASH Policy and Inefficiencies within MDAs: The project came at a time when the WASH sector was being guided by an outdated policy which had been enacted in 2004. The policy could not support current sector requirements as there had been a lot of changes and advancements, couple with increased demand from growing sectors. The project had to rely on a number of policies and legislation scattered around the various ministries, departments and agencies. This made it difficult for the project as there was no single policy within the sector to guide the project.

“One of the major challenges we faced is that we had to implement the project using an outdated Water Policy which had been launched way back in 2002. As it is, we are in the process of assisting the RGoZ in coming up with a revised Water, Sanitation and Hygiene (WASH) Policy.”
UNICEF Programme Officer, Dar es Salaam.

Due to the multi-sectoral nature of the project, its performance was strongly interlinked with the performance of individual MDAs. For example, the inefficiencies of the water sector led by ZAWA which is currently under-funded, has various O&M challenges and lacks an updated water policy created a lot of bottlenecks for the project.

Low revenue collection and shortage of electricity to pump water: Shortage of electricity to power water to residents remains a major challenge, contributing to less treated water being availed to residents. ZAWA faces significant challenges to effectively collect revenues, as evidenced by the decline in water sales and service charges. Revenue collection reached only 43% in the financial year 2020/21²⁸.

“We now have almost all the equipment we need as an institution - chlorinators; enough water tanks, generators etc but electricity is our main challenge. The electricity that we receive is too low to run our generators. We need almost 380 KV to 400KV electricity to run our generators effectively but we don't have a reliable source of energy, so it makes it difficult to supply water to all people at once. Our daily production of water covers almost 70% of people's demand in our District. So, we still have shortage of water for our people, and this has greatly contributed by insufficient electricity. Hence some people resort to using untreated water.” Manager, Zanzibar Water Authority, Magharibhi A District, Unguja.

Long recruitment and contracting process within government and the UN: The recruitment of key staff and implementing partners (IPs) took too long, with some IPs coming in as late as December 2019, some nine months after the project had kicked-off. This affected some of the project activities such as the baseline survey, the formative KAP study and the development of evidence-based comprehensive SBCC strategy for cholera prevention and control. The project could have included an inception phase to take into account of all these contractual issues, including the signing of the Grant Agreement.

“The process of recruitment and contracting were inherently long but necessary for acquiring competent staff and implementing partners. For example, new staff and the Implementing partner to implement SBCC were all engaged in the second week of December 2019. This delayed project implementation and had negative repercussions on some activities...”
Programme Officer, UNICEF Tanzania Office.

Beneficiaries' perceptions on the quality of WASH and health services availed, including on issues of equity

²⁸ 2021 KOICA Annual Donor Progress Report; UNICEF Tanzania

Finding 17: WASH services, facilities and materials availed through the project generally enabled envisaged WASH behaviors.

There were mixed reactions from both beneficiaries and stakeholders regarding the effectiveness of the WASH facilities and materials in enabling the required WASH behaviors. On the positive side, most of the community members and school children were able to access and utilize the availed WASH facilities and services, such as handwashing stations, improved latrines, water treatment tablets and water vending points. This, in turn, contributed to the adoption of critical WASH practices, leading to the elimination of cholera and reduction in other waterborne diseases. However, the responses also highlighted some gaps and challenges:

Affordability issues: The cost of constructing WASH facilities using the SATO pans posed a barrier for some low-income households, limiting their ability to install and access these essential services. Enforcement of by-laws on these households to construct these facilities may have forced them to divert their little income away from critical items such as food and education.

"...we faced challenges with latrine construction as the poor could not afford to pay the TSh7,000 (US\$2.80) for the construction of their latrines, even when they were given the SATO Pans for free." **Community Health Volunteer, Wete, Pemba.**

Accessibility issues: In certain areas, the constructed WASH facilities and water vending points were not fully accessible to vulnerable groups, such as the elderly, children, and people with disabilities, hindering their ability to utilize these resources. Students in primary schools visited also indicated that the group hand washing facilities constructed were insufficient considering their numbers, and this is causing congestion at the facilities often leading to bullying and fighting particularly among boys. In addition, although water is almost always present at the hand washing station, access to soap seemed to be limited.

"The support we received was not adequate. For example, the hand washing facilities for girls are only five and these are not enough at all as there are many girls, causing us to congest them during group hand washing times." **SWASH Club, Girls, Konjani, Pemba.**

"The HW facilities are also not enough, so students end up fighting for space for them to wash their hands. Some end up being bullied." **SWASH Club, Males, Male, Konde, Unguja.**

"Access to some constructed facilities like toilets, hand wash points and solid waste management centers is limited. Rural people were difficult to change their behaviors especially based on WASH practices due to low understanding and poverty. But through seminar trainings, community workshop's demonstrations and support given from the project implementers enabled them to change at large quantity." **Community Health Volunteer, Magogoni Shehia, Magharibi B**

"No, some facilities like water vendor points were not accessible to vulnerable people like the elderly, children and the disabled due to the distances they had to travel and some of them could not afford the money needed for the electricity." **Environmental Health Officer, Wete, Pemba.**

Evaluation question: To what extent did the project integrate human rights and the participation of men, women, adolescents, and children in schools as well as people with disabilities

Finding 18: Although the project may have led to the fulfilment of the targeted population’s right to safe water and improved sanitation, little attention was given to identifying and addressing other imminent and emerging human rights violations of the rights-holders.

Overall, the project ensured that the basic right to water and sanitation of the targeted beneficiaries was met, including for the vulnerable groups. The increased access to safe water and improved sanitation indirectly led to the realisation of their other rights as enshrined in other treaties such as the Convention on the Rights of the Child (CRC), the Conventions on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of Persons with Disabilities, which have also directly specified the right to health, water and sanitation as an essential right. The rights to health, water and sanitation require that these basics are adequate, accessible, safe, acceptable and affordable for all without discrimination. Although these rights were fully met in terms of the *safety* and *acceptability* of the WASH services availed by the project, there were instances where some poor households and vulnerable groups had challenges in *accessing* some of the WASH services as noted earlier. The cost of the SATO Pans were prohibitive to some poor households in enabling them to access improved sanitation facilities.

ZAWA’s internal challenges continued to result in urban communities connected to their pipelines not accessing *adequate* supplies of safe water. Nonetheless, at service delivery levels, all categories of users, regardless of any socio-economic status received WASH services, without discrimination.

The project used numerous platforms to engage men, women and children. Children were engaged via the WASH in Schools interventions which saw the training of teachers, incorporation of WASH topics into the school curriculum, construction of hand washing facilities and the establishment of SWASH Clubs. Adolescents were engaged through the U-Report where they were able to express their views, and through the SWM Groups where they were involved in spearheading the collection of household waste whilst creating employment and generating income for themselves. Youths participated in the project through the State University of Zanzibar (SUZA) where they were given the opportunities to come up with innovations on upcycling solid waste into marketable products.

Men were engaged as latrine builder masons and through the CHVs in home visits where they received education on health and hygiene. Women, as custodians of household hygiene, were reached through the various community groups and networks, including community hygiene clubs, women’s madrassa groups, where they were equipped with education and skills on safe water handling, water treatment, cholera issues and on food hygiene. Community engagement was facilitated through the use of CHVs, religious leaders and key influencers, and also through the leveraging of existing networks and local governance structures to disseminate information and ensure accessibility of services.

Sex-disaggregated and disability-friendly WASH facilities in the form of school hand washing facilities and household latrines were constructed. School hand washing facilities were constructed with rumps to allow ease of use by children with disabilities. This was the same for household latrines and communal toilets at food vendor markets.

4.5 Efficiency

Evaluation question: Did the timeliness and adequacy of interventions facilitate the realization of the envisioned causality chain?

Finding 19: The evaluation revealed that most of the project’s interventions were delivered within the intended or reasonably adjusted timeframes which met the demands of the evolving context in

Zanzibar. Inclusion of an inception phase to allow for preparatory activities to pave way for the actual implementation could have improved the project's efficiency.

The ability to deliver interventions within the intended timeframes was influenced by logistical and resource constraints. For example, the timely provision of equipment and resources was often hampered by budget limitations and supply chain issues, affecting the speed and efficiency of implementation in certain areas. Perceptions from beneficiaries and stakeholders indicated mixed views on the timeliness of the interventions. Some stakeholders felt that interventions such as the provision of chlorinated water and the construction of handwashing stations in schools were timely and met immediate needs, contributing significantly to cholera prevention efforts. However, there were also challenges mentioned, particularly in the early stages of the project, where gaps in awareness of the project and capacity among the population and service providers delayed the full effectiveness of the interventions.

“Generous and timely support from Donors enabled efficient and effective implementation of the planned activities.” Field Office, UNICEF Zanzibar.

The adequacy of the interventions was generally perceived positively, particularly by district and national stakeholders. The comprehensive approach, which included both soft interventions (such as knowledge and skills training) and infrastructure improvements (like the construction of WASH facilities and the provision of handwashing materials), was seen as crucial in addressing the multifaceted nature of cholera prevention. The multi-settings approach, which extended interventions across schools, communities, and health facilities, was particularly effective in ensuring broad coverage and impact. Training provided by the project was viewed by schools, community members and CHVs as adequate. However, material support was seen otherwise. For example, of all materials received by the schools, brooms and hand washing facilities were perceived to be inadequate.

“The support we received was not adequate. For example, the hand washing facilities for girls are only five and these are not enough at all, causing us to congest them during group hand washing times.” SWASH Club, Girls, Konjani, Pemba.

“The equipment is not enough, the number of students is large compared to the equipment brought here, for example, buckets, and waste bins. So, we have to use our hands to handle the waste, something that we are risking ourselves in getting cholera. Brooms for cleaning the classrooms are not enough, so you find that we have to wait for others to finish the cleaning. The HW facilities are also not enough, so students end up fighting for space for them to wash their hands.” SWASH Club, Males, Male, Konde, Unguja.

“Although we have schools, we faced financial challenges. The funds we received were through UNICEF, but sometimes it took time to access them or the amounts were insufficient, so implementation became challenging.” SWASH key informant, Unguja.

4.6 Impact

Evaluation question: What evidence is available that the action taken contributed directly or indirectly to reduce or prevent the spread of cholera in the short, medium and long-term?

Finding 20: The evaluation established that there were no cholera outbreaks or cases, and the case fatality rate (CFR) remained at zero percent throughout the course of the project largely because of the contributions of the interventions implemented.

All key informants interviewed agreed that the project interventions had contributed to the absence of cholera outbreaks during the project period. This was largely because of the range of interventions implemented at both national and sub-national levels which addressed the root causes of the previous outbreaks.

"The activities implemented by the project were a success as there has not been any serious cholera suspect or that have been reported during and after the end of the project, and yet previously before the coming in of the project we had severe cholera outbreaks in Micheweni district. Even the prevalence of diarrhoea and other waterborne diseases has significantly decreased." **Community Health Volunteer, Makangale Shehia, Micheweni District.**

However, the evaluation noted that the evidence on the past trends of past cholera outbreaks seems to also indicate the presence of other external factors that contributed to the absence of any cholera outbreaks or cases during the course of the project. Figure 13 shows how cholera outbreaks have emerged since the 2015/16 outbreak.

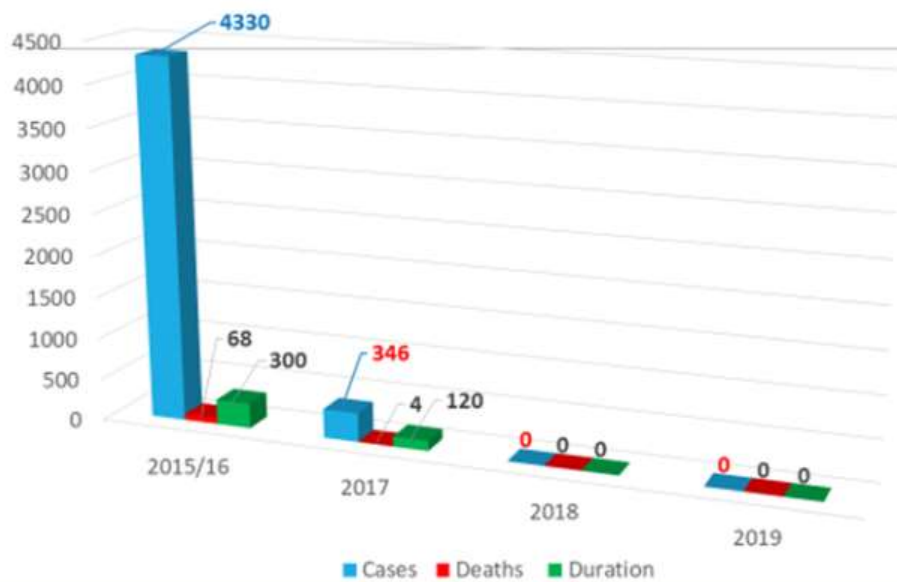


Figure 13: History of cholera outbreaks in Zanzibar

Source: 2023 KOICA GDEF Annual Progress Report, UNICEF

The intensified commitment and proactive actions of the Revolutionary Government of Zanzibar since the 1990s seem to have led to increased implementation of actions to prevent, control, and ultimately eliminate cholera on the Islands. These include the enactment of several rules and regulations to control environmental and sanitation risks that had frequently been the main factors for cholera epidemics in Zanzibar and the Cabinet’s decision to eliminate cholera and to establish a Multi-Sectoral Task Force for elimination of cholera in Zanzibar, among others.

The evaluation also noted that the existence of some preconditions for cholera in some of the hot spots pose a significant threat of cholera outbreaks in the medium to long-term. These include the following:

Poor WASH Practices: The endline established that some communities across the project districts continue to practice or have resorted back to practicing poor WASH behaviours which may pre-expose them to cholera and other WASH related diseases. Community members indicated that most of them have lost the motivation to continue practicing proper hand washing and food handling practices as both cholera and covid-19 cases have disappeared. Although focus group discussions with school children and community groups indicated that most of them could recall key cholera messages appropriate water treatment methods and food safety measures were not fully recalled or understood.

This was also corroborated by the 2022 DHS-MIS whose figures indicated that the percentage population that treat their water at home using an appropriate treatment method remained stagnant at around 24percent. Communities also indicated that they were unwilling to use chlorine tablets (Water Guard) due to its smell and the change in the taste of the water.

Key observations on some of the households, food/fruit vendor markets, schools and health care WASH facilities visited revealed the following: 1) the absence of soap or ash at hand washing facilities; 2) some HWF s were no longer functional e.g. at Wete Food Vendor Market; 3) markets had no public bins for waste collection, and some solid waste remained uncollected at the time of the evaluation (See figure 15); 4) Disposal of diapers is still a challenge, particularly in urban areas; and 5) A few of the school toilets visited had inadequate (high students to drop-hole ratios) and dilapidated toilets which were in a state of disrepair.



Figure 14: Uncollected solid waste at Wete Food Market, Wete Town, Pemba

“There's a significant challenge we face concerning the use and disposal of diapers. People just throw them anywhere, and sometimes children play in such areas. So, this is an area where we need the help of municipalities and councils to find proper disposal sites, and they should handle the rest.”

Health Promotion Office, Ministry of Health Health Promotion Unit, Pemba.

High Diarrhoea Cases: Although trends showed that there was a decrease in the number of acute diarrhoea cases across the project implementation years, the evaluation however noted a worrying number of cases towards the end of the project. For example, project documents revealed that a total of 15,338 cases of Acute Diarrhea Diseases (ADD) were reported in the period from January to March 2023 compared with 17,106 cases reported in the same period in 2022. The high number of cases may be a clear sign of the existence of pre-existing conditions for cholera in the medium to long-term. Although discussions with both key informants and community members revealed that care seeking practices had improved, the endline also established that there are some households who are still shunning to seek advice from health workers or treatment from health centres. Reasons for this were not clearly established, but this was also corroborated by the 2022 TDS-MIS which showed that ‘advice or treatment was not sought for 36percent of children with diarrhoea in the 2 weeks before the survey.

Evaluation question: *To what extent did the project contribute to the reduction of the time taken by Ministry of Health (MoH) to detect, respond and report on cholera cases?*

Finding 22: While there was no cholera outbreak during the project period to ascertain the capacity of the MOH to respond within the required timelines, stakeholders and communities had the potential to do so as a result of the support they received from the project.

The evaluation could not ascertain the extent to which the project contributed to the reduction of the time taken by MoH to detect, respond and report on cholera cases as there were no cases during the project period. However, communities and stakeholders are confident that they are now fully capacitated with the knowledge, skills and materials that will enable them to detect within 72hours, respond within 72hours and report within 24hours on any cholera cases that may occur.

“Yes, I believe that the project significantly contributed to the reduction of in the time taken to detect, respond and report on cholera cases. The majority of communities are now fully aware and able to distinguish between cholera symptoms and general diarrhea, as well as where to take a cholera suspect for advice or treatment, and the way to handle a person with diarrhoea case at household before taking them to the hospital.” **District Environmental Health Office, Magharibi A District, Unguja.**

“The project has contributed to the elimination of cholera and a reduction of time taken by MoH to detect and respond cholera cases by supporting the establishment of the Public Health Emergency Operational Units, strengthening surveillance systems, data collection and management, training of CHVs on how to identify suspected cholera patients and how to report any cholera suspected cases.” **District Medical Office, Kizimbani, Wete District, Northern Pemba.**

“Yes, as the majority of communities are now aware and able to distinguish between cholera patient symptoms and normal diarrhea cases, as well as where to take a cholera suspected case and the way to handle a victim with normal diarrhea case at household before going to hospital,” **District Health Promotion Unit, Micheweni District, Pemba.**

From interviews with stakeholders and community representatives, the evaluation noted that the project significantly contributed to the reduction in time taken by the MoH to detect, respond and report on cholera cases. This was achieved through strengthening surveillance systems implemented at all levels from national to community levels.

“It's a time when we're very serious about tracking diarrhoea cases because diarrhoea cases can easily turn into cholera. And the good thing in Pemba is that we have a laboratory with the capacity to test any suspected cholera cases.” **District Medical Office, MOH, Health Promotion Unit, Unguja.**

“On the epidemiology side, we have intensified our surveillance. We're also increasing our surveillance during the current period, especially with the rainy season upon us. There's also cross-border surveillance because Zanzibar has open borders, so all entry points have increased surveillance. We're doing well with surveillance, and we report every week.” **Programme Officer, WHO, Zanzibar.**

Evaluation question: Did the project result in the knowledge and wider acceptance of ZACCEP?

Finding 23: The evaluation established that the project resulted in the wider knowledge and acceptance of the ZACCEP particularly at national and district levels. However, the knowledge of ZACCEP at community levels was limited.

The low educational levels at community levels may have played a part as it may have had been difficult for the communities to link the project with ZACCEP. This may have been different with stakeholders at national and district levels who were fully involved in not only developing the ZACCEP, but also its coordination, implementation and oversight.

"Yes, as now the community awareness on WASH [Water, Sanitation, and Hygiene] practices is higher than before the coming of the ZACCEP project." **Environmental Health Officer, Wete, Pemba.**

Unanticipated positive results from the project

The project has had several positive ripple effects beyond its initial scope. Some of the unanticipated positive results include the following:

Reduction of the prevalence of other WASH-related diseases: Apart from eliminating cholera in Zanzibar, the project also saw the reduction in the prevalence of other WASH-related diseases, including COVID-19 and Acute Watery Diarrhoea. The project's activities' contributed to the lowering of covid-19 cases. This shows that the project's interventions have had a more comprehensive positive effect on community health.

"Through the project implementation we have discovered the decrease in disease associated with diarrhoea, bilharzia and COVID-19 among others." **District Environmental Health Officer, Wete, Pemba.**

Creation of Employment for Young People: Apart from the generation of useful products from solid waste, the initiatives on SWM further empowered young people, particularly females, and generated employment, indicating that the project had a broader impact beyond public health as was originally anticipated. The project has resulted in the conversion of solid waste into usable products like charcoal and manure. Additionally, in 2022 alone, the seven groups consisting of 1,070 young people (of which 60percent are females) managed to collect Tsh. 70,285,500.00 (US\$30,153) through household waste collection fees. In addition, one of the groups, the Tomondo Group, managed to secure a loan from CRDB bank, enabling them to acquire a solid waste collection truck valued at USD 11,765.00 further boosting their businesses.

"Yes, the project did have some unintended results. It did assist in not just cholera prevention, but in also halting the spread of other diseases such as malaria, trachoma, skin diseases, and other WASH-related diseases. The improvements in the collection of solid waste, and its conversion into usable products like charcoal and manure went a long way in preventing these diseases. In addition, strong team work and collaboration amongst different ministries and departments has been created through the project as never before," **District Health Promotion Unit , Micheweni, Pemba.**

Increased hand washing with soap practices: The emergence of the COVID-19 pandemic posed challenges to the smooth execution and timing of several major project activities due to stringent WHO regulations, particularly those related to movement restrictions and social distancing requirements. However, the compliance with hand washing protocols and the use of face masks resulted in increased installation of hand washing facilities at household, community, institutional and public facilities. It further led to increased rates of hand washing with soap. Additionally, the El Niño contingency plan prioritized disseminating preventive measures against cholera.

Strengthening of team work and collaboration among MDAs: The project has also fostered strong team work and collaboration among the various government ministries, departments and agents (MDAs), UN agencies, universities, media organizations and NGOs, which was previously lacking. This has further effected the leveraging of resources amongst different sector ministries and departments.

"Working together as different government MDAs, UN agencies, NGOs, the media, universities and the private sector has really strengthened our relations, team work and collaborations. This was previously lacking." **Disaster Management Commission Member, Pemba.**

Unanticipated negative results

As noted earlier in this section, the installation of the group HW stations raised the demand for hand washing among students, and in the process causing congestion with some schools reporting that this is leading to fighting and bullying particularly among male students. Also as noted under this section, the disappearance of cholera and COVID-19 was reducing risk perception leading to reversal of good WASH practices.

4.7 Monitoring

Evaluation question: Which tools have been developed to monitor the progress and impact of the project? Were they used effectively? How can they be improved?

Finding 24: The project put in place systems to track implementation progress. However, availability and use of tools varied across interventions and beneficiary groups.

The project used a mix of pre-existing and project facilitated monitoring systems for disease surveillance and ascertaining effectiveness of interventions. Pre-existing systems included the DHIS2, Education Management Information System (EMIS), and the Jamii ni Afya digital monitoring platform. The noted earlier the project facilitated development of the WASH MIS, KOBO Collect platform, Routine Water Quality Monitoring²⁹, Joint Field Monitoring Visits, and Annual Progress Reports. The project incorporated advanced digital tools for monitoring, such as the WASH dashboard within the DHIS2 system, the KOBO platform and mWater. As noted earlier capacity of government staff to use the newly developed system had been established albeit with variations across different stakeholder groups or components of the project. At community level, monitoring tools mainly used by CHVs (e.g. sanitation village registers) focused primarily on water supply and sanitation. Other community cadres – SWASH club coordinators, SWM groups, water vendors and religious and shehia leaders – charged with implementing some of the project’s activities did not have any monitoring tools

“We needed to test water quality, but as DMC, we lacked the necessary equipment to determine it. We wanted to ensure that the water we tested at ZAWA tanks is the same water reaching the citizens.” **Zanzibar Disaster Management Committee Member.**

Although there were no specific M&E review meetings reported during the evaluation, it was evident from ZACCEP steering committee meetings’ minutes that M&E and data use was integrated into various project coordination and progress review meetings. At the District level, information systems could have been enhanced to track enforcement of public health regulations and changes in WASH behaviors at school, health care facility, community and household levels. There seemed to be no routine end use monitoring of both WASH and medical supplies distributed to MDAs, communities and health care facilities.

“No, there were no monitoring tools for me as a religious leader.” Shehia Leader, Unguja

“I did not have any monitoring tools to monitor the SWASH clubs activities and the behavioural changes amongst the students. I only relied on observing their group hand washing practices after toilet use and before eating their lunch food.” SWASH Coordinator, Micheweni, Pemba.

“Yes, we had some tools for keeping records of meetings and attendants. We also kept records of people who were receiving Water Guard, and SATO pans. Also, we played a great role for keeping records for the different project’s activities. We have requested for some software

²⁹ There were reports that reagents and water testing kits, or resources for outsourcing testing were inadequate.

system for the data collection rather than doing it manually.” **Community Health Volunteer, Mjini, Unguja.**

“Yes, the Ministry of Health personnel trained us on how to use Kobo Collect to gather data. Additionally, we employed physical observation in areas where certain activities were taking place.” **Health Office, Zanzibar Municipal Council.**

“Yes, monitoring and evaluation were conducted through our task force and steering committee meetings, which included representatives from all sectors. These meetings allowed us to assess progress, identify gaps, and plan improvements collaboratively.” **Disaster Management Commission, Zanzibar.**

Monetary incentives reinforced commitment by government workers and CHVs to project activities and monitoring. However, this is not a sustainable strategy as withdrawal of the monitoring incentives for government workers in the later phases of the project demotivated them to fully participate in the activities. This particularly so as ZACCEP activities were viewed as additional labour to what they were contracted to do.

“During the first stage of the project, we were performing well because UNICEF staff were paying us for monitoring activities, but when we entered the second phase, we were not being paid. So, the motivation for work decreased because we were not being compensated. In the first phase, they used to provide us with fuel, allowances, and things were going well. Although we still monitored the activities, our enthusiasm was not the same as in the first stage.” **Health Officer, Zanzibar Municipal Council, Unguja.**

Evaluation question: Were appropriate and relevant indicators developed for the project? How were they linked with ZACCEP?

Finding 25: The evaluation noted that the indicators for the project were to a large extent adequate and relevant as there were aligned to the project’s ToC and results framework, and also linked with the ZACCEP Plan. However, there are some missing key indicators which could have potentially strengthened the project’s results framework and aligned it with the ZACCEP.

Most project indicators were aligned with both the results framework and the ZACCEP as the project was designed as an offshoot of ZACCEP itself. However, the evaluation noted that the indicators were only available at outcome levels with none being present at impact levels. The project should have developed an overall M&E framework which would have guided the development and defining of the different indicator sets, including their means of verification. Apart from the ZACCEP, the indicators could also have been aligned to the Joint Monitoring Programme (JMP) as this would not only have made the standardisation of the indicators easier, but also made the project to contribute to JMP and SDG reporting.

Although relevant for the project, some of the indicators seem not to be aligned with their respective outcomes. For example the indicator ‘Time taken by MoH to detect, respond and report on cholera outbreak’ and ‘Number of cholera outbreaks during the project lifecycle’ are not aligned to outcome 1 (Zanzibar cholera elimination plan is well coordinated and funded at national and sub-national levels), but rather to the impact level (Cholera eliminated in Zanzibar). On outcome 2, ‘Zanzibar communities utilize equitably distributed safe water, sanitation, hygiene and health services critical for cholera prevention and control’ the project could have included ‘the number of villages attaining ODF’ as elimination of OD was a key intervention in the project. As strengthening of public health regulations was one of the key components for the project, there seems to be no indicators related to this. The

project could have tracked the number of regulations enacted or amended and the number of cases or fines enforced.

Evaluation question: How have lessons learned from various monitoring / evaluation sessions been incorporated into the program, and shared with partners?

Finding 26: The lessons learnt, and evidence gathered through the various monitoring systems and tools was to a great extent used effectively by the project managers and its stakeholders to track progress, inform ongoing programming, advocate for policy changes and lobby government on WASH issues affecting women and children.

Officers at district and national levels from the Health Promotions Unit, Environmental Health and Epidemiology reviewed and analyzed the data coming from their respective Shehias or Districts through the various digital and paper-based platforms. They then shared their dashboard data and findings with their respective Directors on a quarterly basis for them to plan and take action. The dashboards helped to highlight progress around key indicators. Information gathered from the dashboard, complimented by media monitoring reports and feedback collected from communities was used to compile district and national reports, and also MoH Bulletins, which were then presented at the ZACCEP Task Force Meetings, Community Health Technical Working Group (TWG), WASH TWG meetings. Media monitoring reports were used to reflect on the publicity of cholera elimination interventions and the absorption of the key messages. Decisions on the project were based on information from these and other data sources mentioned earlier. For example, having observed that latrine construction amongst communities was very slow, community by-laws were strengthened, and communities were advised to excavate pits in groups. Through routine water quality monitoring, the project was able to not only identify free residual chlorine and microbiological quality of water, but also increased the number of trained operators having learnt that the main reason for not treating water or having low FRC levels among water vendors was the absence of a committed alternate operator to stand in when the trained operator was off duty or on another task. Evidence from the monitoring system was also used to inform advocacy as evidence gathered through the project was used to influence government to develop a revised WASH Policy and to also adopt a digital WASH-MIS. The project also managed to advocate for the allocation of districts funds for cholera elimination activities through their MDAs.

Knowledge products were also developed that included policy briefs, informational materials and a range of other social and behaviour change communication materials which were shared mostly through print, social and mass media channels. Dissemination of knowledge products could have been enhanced by leveraging on UNICEF's and other partners' knowledge sharing platforms, channels and products. Other platforms for knowledge sharing could have been explored such as seminars, national and global WASH commemorations and exhibitions.

4.8 Sustainability

Evaluation question: Did the project prepare an efficient exit strategy in which local implementing agencies were identified appropriately

Finding 27: The nature of the project's design and implementation was premised on sustaining the interventions and results. However, it could have benefited from the development and implementation of a sustainability or exit strategy, framework or plan.

Stakeholders interviewed believe that almost all of the project's interventions were designed and implemented with a sustainability lens in mind. However, monitoring of sustainability was weak in the project including actions to reinforce continuity of the actions. This could have been enhanced by the

establishment a sustainability or exit strategy or plan. Some of the benefits from this strategy are as follows:

- Through involvement of all stakeholders, including communities, the project would have made deliberate efforts to include all activities and issues that impacted on sustainability
- The plan would have made the tracking and monitoring of sustainability in real-time, rather than to rely on assumptions that the activities implemented are themselves sustainable
- It would have been easier to measure the extent to which the project was mainstreaming sustainability in its design and implementation. This includes the earlier identification and addressing of challenges and bottlenecks militating against ensuring sustainability.
- The strategy would have made it easier to identify the local implementing agencies which would be charged with ensuring the smooth continuity of the project's interventions when it ended, including their specific roles and responsibilities.

Evaluation question: Was the project designed and implemented to ensure continuity, ownership, and sustainability of the activities implemented and results achieved?

Finding 28: As noted under Finding 27, the project, to a large extent, was designed and implemented to ensure continuity, ownership, and sustainability. However, there was no structured oversight or monitoring of sustainability resulting in some activities and results across the three pillars not being sustainable beyond the project.

The project proposal clearly incorporates interventions that will ensure the continuity, ownership, and sustainability of the results achieved – implementation through ZACCEP structures and enhancing capacities for continued improved service. Most of the interventions were incorporated into ongoing projects being implemented by UNICEF. However, as mentioned earlier, the project could have benefited from the development and implementation of a sustainability or exit strategy.

Sustainability of WASH services: WASH services are sustainable when they are owned, managed and maintained by the respective users or utilities. The evaluation established that the WASH facilities that were promoted or provided by the project in the form of latrines for individual rural households, hand washing facilities for schools, and water supply systems for health care facilities, are all being owned by the respective households and institutions. There was awareness on their responsibility for maintaining the facilities using their own resources with majority highlighting their ability to do so. The urban water utility (ZAWA) also owns all the rehabilitated water infrastructure, chlorinators and chemicals that were procured through the project. As noted earlier access to the SATO Pan at community levels will be a challenge.

“We are confident that those who constructed latrines will be able to maintain them. We will continue assisting those who do not afford to construct their own latrines. Our tippy taps are cheap and easy to maintain.” Community Group, Males, Kojani, Pemba.

The evaluation noted that school hand washing facilities are ‘fit for purpose’, and the project encouraged schools to have separate WASH budgets. However, the presence of separate WASH budgets varied across the districts and schools, with some indicating that they still do not have the separate budgets while others use innovative means to fundraise for WASH including fines for students or use student contributions earmarked for infrastructure development and maintenance. For example, at Kombani Primary School, students are required to contribute TSh100.00 (US\$0.04c) per term. However, these funds are not ring fenced and are available for other initiatives within the school, hence may not be available for WASH when needed.

“I also think that our school will be able to maintain and repair the HW facilities on our own without any external support. We have been giving donations to buy hygiene equipment. Every

student is required to give one hundred Tanzanian shillings every time we open a school.”
SWASH Club Members, Boys, Kojani, Pemba.

Due to a number of internal and external challenges faced by ZAWA (mentioned earlier) residents are, in the short and long term, facing challenges in accessing safe water as it is unable to pump adequate treated water. However, the enlisting of the services of an independent consultant to evaluate ZAWA and provide recommendations for enhancing its performance, including increasing revenue collection, will go a long way in identifying the major bottlenecks being encountered by ZAWA and to recommend any remedial actions in addressing these.

“We have powerful generators; we have enough water tanks and we have almost everything as an institution, but electricity is our main challenge. The electricity that we receive is too weak to run our machines hence led to shortage of water in some places. We have powerful machines that need almost 380 KV to 400KV of electricity to run effectively but we don't have reliable source of energy, so it makes it difficult to supply water to all people at once hence some people start to use untreated water.” **Senior Manager, Zanzibar Water Authority, Unguja.**

Households reported not being able to access water treatment tablets (Water Guard) through retailers or pharmacies. UNICEF, through its other projects, supported a supply chain and market review of the availability of aquatabs and is now working with MOH to finalize the ‘Aquatab Business Guidelines’ which will among other issues outline the regulatory issues for the sale of aquatabs by private companies. However, even with the availability of these aquatabs, communities indicated that they are unwilling to use chlorine tablets (Water Guard) due to the smell and the change in the taste of the water.

“Actually, here in Zanzibar water is free though users only contribute a fee of up to TSh5,000 (US\$2.00) per house monthly for electricity to pump the water, though some might contribute and some do not contribute. The cost isn't enough to run the service it only suits to power the motor pump only. Most people also do not like the Water Guard that I give them as they say it smells badly and changes the taste of their water.” **Water Vendor, Magharibi A.**

Climate change is also threatening the continuous access and availability of safe water to the targeted populations in the five districts, as is it is contributing to the drying of water sources mostly used by private households and water vendors. For example, in 2023 alone, a total of ten (10) water sources used by water vendors were reported to have dried upⁱⁱⁱ.

Although the SWM groups and the Centre of Excellence are continuing to play a vital role in promoting solid waste management in urban areas through household waste collection and the piloting of SWM innovations, lack of viable markets to sell their products threatens the continuation of their various activities. In addition, when the project ended, some households are now refusing to pay the required fees to have their waste collected – this is despite the market survey showing 89% of heads of households being willing to pay for refuse collection with costs between USD 0.43 – 1.73 per month. Since the money is used to pay the cost of fuel for garbage collection trucks and the waste collectors, this therefore further threatens the continuation of refuse collection by the SWM groups. The inadequate capacity of the local government authorities (LGAs) to collect and transport refuse to the final disposal sites also threatens the sustainability of proper solid waste management in the short and long terms.

“Waste collection activities have become weak because people no longer pay the costs of waste collection. At first, people were giving their contributions of TSh3,000.00 (US\$1.20) per month

but some have been refusing to pay it. Also, some households have a habit of throwing the waste away, even though we have set up a polo for them to deposit the waste, so when you go to pick up the waste, you get the extra work of collecting the waste thrown away by the members of the household. Others are dumping the waste in the ocean, especially at night, as one of the ways to avoid paying the waste collection fee.” **Solid Waste Management Group, Women, Mtoni Chemchem, Unguja.**

Sustainability of WASH behavioural practices: The project, to a large extent, resulted in the increased knowledge and good practices related cholera among targeted communities through employing a number of social and behaviour change communication approaches and use of multi-media channels to transmit targeted cholera messages. Targeting primary school children was a good strategy of ‘catching them young’ and instilling good WASH behavioural practices among children who may in turn act as agents of change within their households and communities. Studies have shown that targeting children with hygiene promotion often leads to significant health impacts given that much of the attributable disease burden is concentrated in that age group.

“We targeted primary school children, and our goal was for these behavioral changes to continue for a long time. I believe because of their young age, these changes are now ingrained in them. When you visit a school, especially primary schools, and you want to shake a child's hand, they might say, 'Teacher, you haven't washed your hands.' The children now understand that as soon as they arrive at school, or before they eat their food, or after visiting the toilets, they must wash their hands.” **SWASH Coordinator, Wete, Pemba.**

“Our Islamic religious culture of washing hands before praying will to a great extent help in sustaining the hand washing behaviors of my congregates.” **Interfaith/Religious Leader, Shekhe, Magharibhi B, Unguja.**

However, the endline also established that some communities across the project districts continue to practice or have resorted back to practicing poor WASH behaviours which may pre-expose them to cholera and other WASH related diseases.

“...however now that cholera and covid-19 are gone, there has been some laxity among communities and schools to practice proper hand washing.” **Environmental Health Office, Micheweni, Pemba.**

Use of CHVs as change agents for health and hygiene promotion increased potential for sustaining SBCC activities at community level. However, withdrawal of incentives, as mentioned earlier, was demotivating them. The CHVs were inadequately prepared for the exit of the project. The recent strategy adopted by government to recognize and to integrate CHVs as part of Community Health Workers (CHWs) will go a long way in ensuring the sustainability of their work.

“Our main challenge is that of field allowances to cover our transport and lunch costs as so as to motivate us in doing our work. There is also shortage of protective clothing such as gloves, rain boots, masks and raincoats for our field activities.” **Community Health Volunteer, Kisimbani, Wete, Pemba.**

“We were not given clear plans or arrangements on how we were going to continue with our work when the project ended. Also, the support we were receiving during the project in the form of allowances, rain coats, rain boots and SATO pans, are no longer available” **Community Health Volunteer, Kisimbani, Wete District, Pemba.**

Sustainability of the enabling environment: ZACCEP structures at national level, through the leadership of the 2nd Vice President's Office, will continue beyond the project. However, as noted earlier in the report, inadequate funding and human resources will hamper activities at all levels and functionality at district and community levels.

“The structures are no longer as effective as there were during the project. One of the main reasons for this is the reallocation of trained staff. For example, one of my staff member trained and equipped with a motorcycle through the project was recently reallocated to Micheweni Hospital, and the other one who was based at national level was reallocated to the district level at WETE, and then later on moved to a private hospital called Saifee Hospital. So, if we are to have a cholera outbreak, it will be very hard to get his expertise as he has now moved away from government. As RRT, we also need some additional motorcycles and vehicles for us to be able to efficiently coordinate cholera response activities.” **Rapid Response Team (RRT) Member, Wete, Pemba.**

5 Conclusion, Lessons Learned and Recommendations

5.1 Conclusion

Main conclusion: The endline evaluation has established that the Zanzibar ‘Towards a Cholera-Free Nation’ Project is relevant and has proved to be feasible, flexible, acceptable, and implementable in the evolving context of Zanzibar. The project, through its integration into the government systems and the different MDAs and, with an expanded coordination mechanism that accommodates civil society organisations, and the private sector can be replicated by the 2ndVPO, with technical support from the MOH, within and beyond Zanzibar. The project’s model has demonstrated the robustness and effectiveness of the Revolutionary Government of Zanzibar’s Comprehensive Cholera Elimination Plan (ZACCEP) 2018-2027 in effectively providing coordination mechanisms for cholera interventions, guiding development partners in designing and implementing cholera preventive activities and providing an enabling environment for the elimination of cholera in Zanzibar through its three (3) pillars. However, opportunities for more equity-focused and human rights-based approaches for engaging special groups e.g., those with disabilities, the elderly, the chronically ill, child headed households and minority groups need to be strengthened.

Relevance: The project’s interventions were largely appropriate and relevant for the elimination of cholera in Zanzibar. Its design and theory of change (ToC) were also valid for the context in Zanzibar. The causal linkages were relevant, targeting critical interventions such as coordination, water quality, sanitation infrastructure, and hygiene education across multiple settings (rural and urban communities, schools, health centres, food vendor markets and local authorities). This multifaceted strategy ensured that each component contributed to the overall effectiveness of the project.

Coherence: The ‘Towards a Cholera-Free Nation’ project was strongly aligned with Zanzibar’s national priorities and policies, and with UNICEF’s national and global priorities, including the ZACCEP Ten Year Plan (2018-2027), the Water Policy and Act of 2006, the Zanzibar Development Plan (2021–2026) and the Zanzibar Development Vision 2050. It also aligned well with the UNICEF’s Strategic Plan, the Sustainable Development Goals (SDGs), the UNICEF’s Eastern and Southern African Region’s Strategic Framework for Cholera (2018 – 2022) and both the 2016–2021 and the 2022-2027 UNICEF Tanzania Country Programmes. The project was effectively coordinated, particularly at national levels, through the strengthening of an already existing government-led ZACCEP multi-sectoral coordination mechanism which involved a wide range of stakeholders including MDAs and development partners, and chaired by the 2nd Vice President’s Office.

Coverage: The project was able to cover comprehensively, the targeted population of 1,056,203 people in the five districts and the 182 hot spot shehias (which represented 48 per cent of the 387 shehias in Zanzibar). An additional population of over 660,000 people in the remaining six districts in Zanzibar indirectly benefitted from the national cholera awareness and sensitization campaigns. The selection criteria for the ZACCEP project was designed to ensure the prioritization of the most vulnerable and needy districts, shehias and population groups, based on previous cholera data and situational analyses indicating higher susceptibility to cholera outbreaks.

Effectiveness: The project made significant achievements meeting or exceeding at least 77 per cent of its targets. Out of the total 31 targets, the project was able to meet 24 (77.4 per cent) and only 3 targets (9.7 per cent) were not met. Performance on 4 (12.9%) out of the 31 targets could not be ascertained as there was no data available to verify them during this evaluation.

Over the five-year period of project implementation, there was a demonstrated improvement in performance among the three (3) main outcomes of the project, notably i) capacities among government and community systems for continuity, ownership, and sustainability of the program, including coordination and funding at national and subnational levels; ii) equitable access to safe WASH, and health services; and iii) communities' adoption of improved WASH behaviours and practices.

There was improvement in the quality of drinking water due to increased mean FRC levels and lower samples with faecal coliforms. However, the absence of any water samples with the required standard of FRC of 0.5mg/l at both baseline and endline is still a cause for concern.

To a very large extent, the outputs of the project contributed to the achievement of observed outcomes. However, the project could have further addressed the challenges faced by the poorest and most vulnerable groups to achieve more comprehensive and inclusive results.

A range of factors facilitated the attainment of results: collaborative partnerships and effective coordination among the different stakeholders; district and shehia competitions; strengthening and enforcement of public health regulations and community laws; and sound social and behaviour change communication (SBCC) initiatives. Inhibiting factors included: Covid-19 pandemic and general elections, poor and resistant communities, coupled with interference from politicians, reshuffling of government staff and inexperienced workers, myths and misconceptions about cholera in general, and about the cholera vaccine in particular, outdated WASH Policy and inefficiencies within MDAs, low revenue collection and shortage of electricity to pump water and the long recruitment and contracting process within both government and the UN.

Efficiency: Most of the project's interventions were delivered within the intended or reasonably adjusted timeframes which met the demands of the evolving context in Zanzibar. Nonetheless, this could have been improved by inclusion of an inception phase to allow for preparatory activities to pave way for the actual implementation.

Impact: There were no cholera outbreaks or cases, and the case fatality rate (CFR) remained at zero percent throughout the course of the project largely because of the contributions of the interventions implemented. Stakeholders noted that this was mainly because the project not only targeted the main cholera districts, shehias, schools and other hotspots, but it also identified key stakeholders for cholera management, implemented a range of preparedness and response actions to address the identified root causes of previous outbreaks. The evaluation established that the actions implemented by the project directly contributed to improving WASH service levels for the targeted populations in Zanzibar.

Monitoring: The project established monitoring systems at all levels. This included using existing systems. The capacity and use of monitoring tools varied across different stakeholder groups or components of the project. Monitoring was used in various structures of the ZACCEP and packaged into various knowledge products. Although data collection and monitoring tools were available at community level, these mostly focused on water supply and sanitation coverages, and used by CHVs. Indicators were also only available at outcome level and not output and impact levels. There were also missing indicators for some results. The indicators could also have been aligned to the Joint Monitoring Programme (JMP) as this would not only have made the standardisation of the indicators easier, but also made the project to contribute to JMP and SDG reporting.

Sustainability: The project took into account sustainability issues at design and during its implementation. However, these were inadequate and could have been strengthened by the

development and implementation of a sustainability or exit strategy, framework or plan. Sustainability related indicators would have also enhanced the ability of the project monitor the progress on interventions to sustain the project benefits.

5.2 Lessons Learned

The evaluation has identified the following lessons learned by the project:

Lesson Learnt 1: The multi-sectoral coordination and implementation nature of cholera prevention and response actions is an effective approach, but attention needs to be paid to areas that can undermine efficiency and effectiveness. This happens where performance of the project is strongly interlinked with the performance of individual sectors and MDAs. The inefficiencies in one sector or MDA may not only jeopardise project results related to their sector or agency, but also of the entire project.

Lessons Learnt 2: Introducing new and different vaccines at the same time to the same targeted populations without proper sensitization and planning may result in low vaccination coverage of both vaccines especially if there are strong objections for one of the vaccines. The second round cholera vaccine was introduced at a time when the covid-19 vaccine was also introduced. Even with the wider vaccination campaigns, this led to the low vaccination coverages of the cholera vaccine. Ensuring time lag between promotions of the two vaccines could have enhanced coverage.

Lesson Learnt 3: Elimination of WASH-related diseases such as cholera and covid-19 need to be sustained by continued risk communication and community engagement beyond the project within the relief, recovery, and development continuum. Some communities had reverted back to poor WASH behaviours due to lower risk perception as the cholera and COVID-19 pandemics had subsided. Lower risk perception can also lead to the relaxation of enforcing public health regulations by authorities.

Lesson Learnt 4: A cholera elimination project premised on a strong gender analysis at design will enhance systematic mainstreaming of gender and with it, deeper WASH and Health outcomes. No gender analysis was undertaken for the project and therefore there was no systematic strategy or plan to incorporate into project activities. Although, during implementation, some initiatives were undertaken, these were after thoughts and could have benefited from a systematic approach. There is therefore a need to enhance gender by undertaking gender analyses to identify entry points for a similar project to enhance its gender responsiveness.

5.3 Recommendations

The recommendations in Table 15 are proposed to enhance designing, implementation, coordination, monitoring, evaluation, and reporting of ZACCEP and similar future projects by government and other stakeholders. They are based on a critical analysis of both the evaluation participants' perspectives and indeed the evaluation team's understanding of results against the project's theory of change and similar projects. They were also presented to, and endorsed at an all-stakeholders workshop attended by UNICEF, WHO, UNDP, CDC, 2ndVPO, MoH, ZAWA, MDAs and implementing Partners (IPs), among others. They have been prioritised according to short-term and long-term (in terms of response period) and level of priority (impact on project outcomes).

Table 15: Summary of recommendations

Finding	Recommendation	Responsibility	Priority
<p>Low human resources capacity, insufficient financial and material resources, reallocation of staff, reshuffling of government ministries and inefficiencies within MDAs affected the effective coordination and delivery of the project's results, particularly in Pemba and at district levels. This was exacerbated by complex procurement procedures and delays in fund disbursements from the Ministry of Finance to the implementing MDAs</p>	<p>Recommendation 1: There is need for the 2nd VPO to take significant steps to address the challenges and inefficiencies within the MDAs that are affecting the effective coordination and delivery of the ZACCEP. The following actions need to be considered:</p> <ul style="list-style-type: none"> • Conduct stakeholder mapping of and incorporate potential partners with a stake in cholera elimination in the ZACCEP coordination structures at all levels and develop ToRs that clearly define the roles and responsibilities of the different members • Advocate for a budget line for multi-sectoral coordination and continuously track the contribution of the various MDAs towards the ZACCEP to ensure that the required resources are mobilized to implement the plan. • Establish a technical working group for resource mobilization which will develop and oversee implementation of a Resource Mobilization Strategy. • Enhance coordination at district and shehia levels by building human resource capacity anchored on a sector-wide human resource capacity assessment for cholera elimination amongst the MDAs; and support and closely monitor the coordination activities of the ZACCEP structures at district and shehia levels, ensuring the structures are active and performing their expected roles. 	<p>Primary: 2nd VPO</p> <p>Secondary: ZACCEP Steering Committee, Disaster Management Commission</p>	<p>High Priority</p> <p>Immediate to long-term (0-5 years) response</p>
<p>Although there was a training on 'Accountability to Affected Populations' at the beginning of the project targeted at all stakeholders, the project seems to have missed the opportunity to integrate or mainstream protection interventions in its design and throughout its monitoring and</p>	<p>Recommendation 2: There is need to further integrate the project's interventions into the sectoral plans of other sectors such as protection and nutrition as this will result in greater synergies and ultimately impact. Evidence from the WASH in Schools interventions can be used to influence the Ministry of Education at national level to adopt the group hand washing and</p>	<p>Primary: 2nd VPO, UNICEF</p> <p>Secondary:</p>	<p>Medium Priority</p> <p>Short to medium term (0-2 years) response</p>

Finding	Recommendation	Responsibility	Priority
implementation. There is also little evidence of the integration with the nutrition sector.	SWASH Clubs model into all its primary schools, and to also incorporate WASH topics in the curriculum for the training of teachers and teaching of students. Linkages between nutrition and WASH coordination structures and outputs can be enhanced to facilitate integration of WASH in nutrition plans and actions.	ZACCEP Steering Committee, ZACCEP Task Force	
Although efforts were made to ensure the collection, analysis and reporting of sex-disaggregated data during assessment, monitoring and implementation, other disaggregated data in the form of locations was largely missing.	Recommendation 3: In addition to sex disaggregated data, there is need to ensure the collection of disaggregated data in the form of locations (by Island, By District, Urban vs Rural) or diversity at project design, implementation, monitoring and reporting. This includes the inclusion of disaggregated targets and achievements in the results framework. This enables the continuous analysis of equity from project design, during implementation and also at reporting.	Primary: UNICEF, MoH Secondary: WHO, Development Partners	Medium Priority Short-term to long-term (0-2 years) response actions
Shortage of electricity to power water to residents remains a major challenge for ZAWA, contributing to less treated water being availed to residents. ZAWA also faces significant challenges to effectively collect revenues, as evidenced by the decline in water sales and service charges.	Recommendation 4: Interventions should go beyond the distribution of water purifiers (HTH powder and water treatment products), but to also addressing some of the underlying challenges facing the overall water supply and sanitation service delivery. This can include the rehabilitation of the ZAWA piping system, strengthening ZAWA's revenue collection system, installing alternative electricity or solar generators, extending water pipeline to unserved areas, sourcing additional water source that are resilient to climate shocks, ZAWA's operations including financial and human resource capacity for sustained water treatment and quality assurance, and other O&M issues. This will improve ZAWA's water production capacity so that it meets the demands of users.	Primary: UNICEF, ZAWA, MoH Secondary: MDAs,	High Priority Medium to long-term (1-5years) response actions
Poor and resistant communities, coupled with interference from politicians who distribute free latrine construction materials significantly contributed to the low attainment of ODF among targeted villages.	Recommendation 5: There is need to advocate for the development and adoption of a 'Zanzibar Open Defaecation-Free Strategy' that will clearly outline the policy directives and key strategies to be used to promote ODF, and also the criteria for the declaration and certification for ODF villages.	Primary: UNICEF, MoH Secondary: Development Partners	High Priority Long-term (3-5years)
The project had put in place systems to track implementation progress. However, availability	Recommendation 6: Monitoring needs to be strengthened through the following:	Primary:	Medium Priority

Finding	Recommendation	Responsibility	Priority
<p>and use of tools varied across interventions and beneficiary groups. At community level, monitoring tools were mainly used by CHVs, leaving out other key stakeholders. There also seemed to be no routine end use monitoring of both WASH and medical supplies distributed to MDAs, communities and health care facilities</p>	<ul style="list-style-type: none"> • Continuous updating of tools based on the feedback from the users, and to also make the tools more relevant and aligned with the indicators as the project got amended • Development of tools for end use monitoring of WASH and medical supplies. The monitoring tools could have been integrated into existing tools, through for example, the health care workers and the CHVs. • Digitizing the record-keeping system at community level to enable more efficient data management, analysis, and reporting. • Increasing community involvement beyond the CHVs in the monitoring process can enhance data accuracy and local ownership of the interventions. • Integrating more advanced data analytics to provide real-time insights and predictive analytics for better resource allocation. <p>Integrating the monitoring data with other project management systems to facilitate holistic tracking and decision-making.</p>	<p>UNICEF, Implementing partners</p> <p>Secondary: MDAs, MoH</p>	<p>Immediate to medium term (0-2years) response actions</p>

6 Annexes

6.1 Annex 1: Terms of Reference

Summary	Type of contract	<i>Institutional</i>
	Title	<i>Final Evaluation of the “Toward a cholera Free Nation Project” (2019 - 2023).</i>
	Purpose	To engage institutional consultancy services to undertake a final evaluation of the “Towards a Cholera Free Project” in Zanzibar - 2019 – 2023 (as part of the ten-year government Plan for Cholera Elimination termed Zanzibar Comprehensive Cholera Elimination Plan (ZACCEP 2018-2027)).
	Start/End Date	15 th September 2023 – 15 th January 2024
	Duration	4 Months
	Reporting to Research and Evaluation Manager (Social Policy) in close consultation with the Chief of WASH, UNICEF Tanzania.	
	Expected budget	

Background

Cholera has been a major public health problem in Zanzibar with a significant number of cases and deaths as well as causing economic and social disruption to families. Zanzibar has experienced repeated outbreaks of cholera, since 1978 when the first major epidemic was recorded. So far, over 17 outbreaks of cholera are recorded with a total of 14,364 cases and 210 deaths. This figure is presumably underestimated due to lack of reliable data for some outbreaks and under-reporting of cases and deaths of previous epidemics. The recent major outbreak of cholera which spanned ten months between September 2015 and July 2016 recorded a total of 4,330 cases and 68 deaths with a Case Fatality Rate of 1.6%. The main causes of recurrent outbreaks in Zanzibar include poor sanitation infrastructures, inadequate access to a safe drinking water supply, poor food hygiene, and unfavourable WASH behaviours and practices.

In recognition of the above, in 2018 the MOH in collaboration with the Office of the Second Vice President developed a ten-year multi-sectoral plan to eliminate cholera, named '**Zanzibar Comprehensive Cholera Elimination Plan (ZACCEP 2018 – 2027)**'. The ZACCEP concept was highly appreciated by the Global Task Force on Cholera Control (GTFCC) at its international meeting in October 2017 and quoted as a model for the region.

UNICEF firmly intended to support the Government of Zanzibar achieve its vision to eliminate cholera in ten years, with the understanding that cholera elimination interventions are developmental and transformational. With this view, UNICEF developed a project titled "*Towards a cholera Free Nation*" aiming for lasting changes in terms not only of eliminating cholera, but also of improving quality of life. A second focus was on improving infrastructure, enhancing community hygiene and sanitation behaviours and practices, and strengthening advocacy cplatforms for better health outcomes for the entire population, particularly children. The duration of the "Towards a cholera Free Nation Project was five years spanning from 2019 – 2023, targeting five cholera hotspot districts out of 11 districts of Zanzibar. The project covered 182 cholera hotspot Shehias (wards), representing 48 per cent of the 387 Shehias in Zanzibar, with a population of 1,056,203 people as direct beneficiaries, while the rest of the population (over 660,000) indirectly benefited from the national cholera awareness and sensitization campaigns including SBCC, and from interventions at national level to improve effectiveness of the health system and emergency preparedness and response.

The overall goal of the project was to contribute to cholera elimination efforts in Zanzibar.

The project had 5 objectives:

1. **Objective 1:** To strengthen coordination of cholera prevention and control through effective, evidence-based, multi-sectoral planning.
2. **Objective 2:** To improve public advocacy and strengthen partnerships for cholera prevention and control.
3. **Objective 3:** To contribute to improved access to safe water and sanitation.
4. **Objective 4:** To strengthen the capacity of the health sector for early detection and response to contain Cholera.
5. **Objective 5:** To increase community knowledge and transform social norms about appropriate practices for the prevention and control of cholera.

The above objectives were articulated to address three main areas of ZACCEP defined as: **Enabling environment; prevention; and response.** The focus of the project was to produce tangible and sustainable results, generating learning and evidence for replicating the model in Tanzania mainland and more widely in the region. However, this is not included as one of the aspects to be evaluated under this contract, because the project didn't implement any dissemination activities to ensure the replication or scaling up to mainland.

Major partners: The major partners were MOH, Ministry of Education and Vocational Training, 2nd Vice President's Office, Ministry of Water, Zanzibar Water Authority (ZAWA), State University of Zanzibar (SUZA), Zanzibar Local Government Authorities, WHO.

D-Tree International, Mufti office and Tanzania Episcopal Conference (TEC). Towards a Cholera Free Nation Project was mainly financed by KOICA with co-funding from CDC and UNICEF/UNDP through the Green Shark Challenge funds. A total budget of USD 4,500,000 was from KOICA, 750,000 from CDC, and 100,000 from UNICEF/UNDP GreenShark challenge, making a total of USD 5,350,000. The CDC funds covered routine water quality monitoring and promotion of using safe water activities, GreenShark fund covered Solid Waste Management activities, and the rest of the activities over 85% were covered by KOICA.

<p>Purpose, Objectives & Expected results</p>	<p>The purpose of this institutional contract is to conduct a summative evaluation, document project achievement in terms of outputs, outcome, impact, and lessons learnt. The evaluation will combine qualitative and quantitative methodologies aligned to the objectives, results and indicators outlined in the project logical framework. Eventually, mobilize the various stakeholders to act based on the evaluation report.</p> <p>The objectives of this contract are to:</p> <ol style="list-style-type: none"> 1. To evaluate the project performance over five years covering three main outcomes notably <ul style="list-style-type: none"> o Capacities among government and community systems for continuity, ownership, and sustainability of the program, including coordination and funding at national and subnational levels o Equitable access to safe WASH, and health services; and o Communities' adoption of improved WASH behaviors and practices. 2. To document key findings, success, best practices, challenges, lessons learnt and recommendations for sustainability of the ZACCEP in Zanzibar. 3. Produce final soundly written evaluation report which will be submitted to head of WASH Programme in UNICEF for donor and UNICEF use. <p>Envisaged Use of the Evaluation:</p> <p>Intended users of the evaluation report included but not limited to: RGOZ through the Ministry of Health, Second Vice President's Office, Ministry of Education and Vocational Training, Ministry of Water Energy and Mineral, Zanzibar Water Utilities, Local Government Authorities, Zanzibar Water Authority (ZAWA), UN agencies (UNICEF, WHO, UNDP), Global Task Force on Cholera Control, MOH – Mainland, State University of Zanzibar, and Public Health Laboratory – Pemba.</p>
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<p>Description of the assignment</p>	<p>Scope of the Evaluation:</p> <ul style="list-style-type: none"> a. Programmatic Scope: The evaluation should be summative, it will be undertaken as an independent examination of the background, assessment, activities and means deployed by UNICEF and key implementing partners including the MOH, WHO, MOWEM, ZAWA and LGAs. It will examine the standard and quality of facilities and services provided by the project covering all the three project outcomes (Enabling Environment, Preparedness / Response, and Demand creation for Prevention / Resilience). Opinions should be gathered from direct and indirect beneficiaries, technical ministries, departments, and other key stakeholders. The evaluation report will outline the main findings and recommendations for future interventions and decision making. b. Chronological Scope : The evaluation will cover assessment of the project achievements for a project “Towards a cholera Free Nation Project that had a duration of five years spanning from May 2019 – December 2023. c. Geographical Scope : Evaluate the direct activities covered in 5 districts, namely Urban, West A, West B, Wete and Micheweni. Also evaluate general campaign through SBCC which covered all 11 districts of Zanzibar d. Gender, Equity, Disability and Human/child rights considerations: The evaluation team should include an analysis of the integration and participation of men, women, adolescents, and children in schools as well as people with disabilities in the project report. <p>Evaluation Criteria and Questions:</p> <p>Impact: The impact can be short or long-term, intended, or unintended, positive, or negative, macro (sector) or micro (household).</p> <ul style="list-style-type: none"> 1. What evidence is available that the action taken contributed directly or indirectly to reduce, prevent the spread of cholera? 2. What is the additional value of approach on the impact of the project? Does it, as aimed, increase the access and acceptance of the ZACCEP? Is the outcome satisfying? <p>Coverage</p> <ul style="list-style-type: none"> 3. Was the targeted population properly covered? • Were the population, community structures, shehia committees and stakeholders made aware of the ZACCEP and were they able to access services and participate in programme activities <p>Coherence</p> <ul style="list-style-type: none"> • What steps were taken by key implementing agents e.g. MOH, Disaster Management Commission in the 2nd Vice President Office to ensure the integration of the different project components or ministry departments and agencies (MDAs) to ensure maximum coverage? • How was the project coordinated to ensure effective participation and complementarity of all MDAs and international organisations? • What is the coherence of “Toward a Cholera Free Nation” project with national policy.
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- What could the DMC/2nd VPO as a coordination agency done better to ensure the coherence of the project while taking into consideration the specificity of the various partner (MDAs)

Effectiveness:

- Have the stated project goal, specific objectives, and indicators – as shown in the project logical framework – been achieved and if so, to what extent.

1. Explain to what extent the direct results of interventions (output) contributed to the sustainable achievement of policy objectives, in this reference the ZACCEP 20182027 which advocates for cholera elimination.

Sustainability:

Sustainability concerning whether the cholera elimination interventions are likely to continue after donor funding has ended and whether its longer-term impact on the wider development process can also be sustained at the level of the sector, district, and country at large.

2. Was the project designed and implemented to ensure sustainability of the activities implemented?
3. How successful were the activities to strengthen the capacity of local agencies, organizations, and individuals?
4. Did the project prepare an efficient exit strategy in which local implementing partners were identified appropriately? Is this exit strategy process ongoing effectively? How is it integrated into the ZACCEP plan?

Some evaluation criteria have not been included in this TOR such as relevance effective and efficiency, because in case on relevance – this aspect was predetermined during development of the proposal, hence UNICEF is not intended to discuss the relevance criteria at this stage considering that Cholera elimination is a global agenda under the GTFCC and is a RGOZ priority. Efficiency is also not included because public health emergency interventions are life service, the cost cannot easily be compared for cost-effective.

Other evaluation criteria Monitoring

5. Which tools have been developed to monitor the progress and impact of the project? Were they used effectively? How can they be improved?
6. Were appropriate and relevant indicators developed for the project, how were they linked with ZACCEP
7. How have lessons learned from various monitoring / evaluation sessions been incorporated into the program, and shared with partners?

The list of evaluation questions will be discussed and finalised with UNICEF Tanzania and key stakeholders during the inception phase.

Evaluation Approach and Methods:

The evaluation methodology will be guided by the 2016 Norms and Standards of the United Nations Evaluation Group (UNEG), the UNEG Ethical Guidelines for Evaluation (2020),

UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (2021), and by those developed by UNICEF at headquarters and country level. This section provides some initial thinking on the proposed methodology, which will be addressed by the evaluation team in the technical proposal and further developed in the inception report.

This summative performance evaluation will be non-experimental and utilization-focused, adopting theory-based and mixed methods approaches. The evaluation will focus on determining which aspects of the programme work well or not, and why. This will facilitate any necessary modifications and help refine complex intervention components. Evidence will be collected primarily through extensive desk review of program documents and data available, complemented by information gathered directly from key stakeholders at national and local levels through Key Informant Interviews (KII) and Focus Group Discussions

(FGDs). In addition, the evaluation team will collect random water samples from households and vendors to analyze the presence of Free Residual Chlorine, vibrio cholerae or the indicator pathogens in households and water collection points.

An evaluation matrix will be developed to demonstrate how the evaluation team plans to answer each evaluation question, including the indicators, data sources, methods, and products that will be developed for each. A Theory of Change (ToC) approach (including reconstructing a theory of change for the response) will be used in consultation with stakeholders, as appropriate. Discussions of the ToC will focus on mapping the assumptions behind the project's desired change(s) and the causal linkages between the intervention(s) and the intended outcomes.

Evaluability/Data Availability:

Baseline survey report, six monthly and annual implementation reports will be provided to the evaluation team before starting the work.

There are some limitations in available data that need to be considered in the evaluation's design, the report available eg the Baseline survey, may not have all the information to be evaluated. Therefore, the tools for the primary quantitative and qualitative data to be collected during this evaluation will be designed to generate the required data to answer the evaluation questions and to mitigate the gaps as much as possible.

Specific tasks to be undertaken include:

Document review:

The evaluation team will review the project documents such as project proposal, donor annual reports and Government reports for MoH and 2nd Vice president's office to get acquainted with the project details. Specific reports of sub-projects i.e. CDC water quality monitoring, community engagement and SBC as well as WASTEX reports on Community-based Solid Waste Management should be part of the project documents to be reviewed.

a) Briefing in Zanzibar with Chiefs of ZFO, WASH Program, and SBC teams.

1. From the desk review the evaluation team will produce and present an inception report containing a summarized version of the most important aspects of the evaluation, timeframe and methodology, and people/institutions to be consulted, communities to visit and if applicable questionnaire and checklist to be applied.
2. Prepare a power point presentation that will articulate the findings of the desk review and overview of the inception report that will be shared with key ZACCEP partners for inputs.

b) Conduct Field visit for consultation with various stakeholders and data collection

1. Meet with relevant project stakeholders notably: government ministries, departments and agencies, development organizations, both bi-lateral and multi-lateral, local and international NGOs, health facilities, media houses, and private sector actors. The field visit will involve specific shehia and institutions in Pemba and Unguja.
2. Hold meetings with various beneficiaries of the project, including affected population, children (in schools and out of school), women, men,

adolescents, food vendors, and community influencers, to get feedback on the project and benefits perceived from its implementation.

3. Undertake random water samples from households and vendors and to analyze for the presence of Free Residual Chlorine, vibrio cholerae or the indicator pathogens in households and water collection points.
4. Analyze different WASH sector reports to understand the impact at Household, schools and healthcare facilities.

c) **Organize a stakeholder (validation workshop)** to present to sector stakeholder's key findings, and jointly discuss key successes, best practices, lessons learnt, challenges and recommendations.

	<p>d) Finalize the evaluation report with a maximum length of 50 pages including the Executive Summary at the beginning of the document, background, methodology, findings, conclusions, and recommendations.</p> <p>Ethical Considerations: The evaluation team should adhere to the following UN and UNICEF norms and standards and is expected to clearly identify any potential ethical issues and approaches, as well as the processes for ethical review and oversight of the evaluation process in their proposal. Copies of all these documents will be provided upon request:</p> <ol style="list-style-type: none"> 1. United Nations Evaluation Group (UNEG) Standards for Evaluation in the UN System; 2. United Nations Evaluation Group (UNEG) Norms for Evaluation in the UN System, including impartiality, independence, quality, transparency, consultative process; 3. Ethical Guidelines for UN Evaluations and the UNICEF procedure for ethical standards in research, evaluation, data collection and analysis will guide the overall process; 4. UNICEF adapted evaluation report standards and GEROs; 5. The evaluation should incorporate the human rights-based and gender perspective and be based on results-based management principles and logical framework analysis. <p>Owing to the envisaged participation of human subjects, especially children involved in the evaluation, the evaluation team is required to adhere to any national ethical review board requirements and seek clearance if needed .</p>
<p>Deliverables</p>	<ol style="list-style-type: none"> 1. Inception report: Concise report on how the evaluation team will carry out the work within a time-bound work plan and timelines for each deliverable, methodology and assessment tools for all stakeholders that will be approved by the MoH, 2nd VPO and UNICEF (all assessment tools to be used in the field visit must be in English and translated into Kiswahili for easy application at community level). 2. Stakeholder meeting: The evaluation team will convene a stakeholder meeting to discuss the inception report and accommodate their recommendations. Stakeholder’s inputs will be incorporated to come up with Final Inception Report. 3. Draft evaluation report, incorporating lessons learnt and recommendations. The draft report should be shared to key stakeholders notably UNICEF and WHO as well as key ministries. 4. Validation workshop: Convene and facilitate a wider stakeholders validation workshop to share the draft report for comments to be incorporated into the report for finalization 5. Final report incorporating lessons learnt and recommendations, and summary brief:

	<p>Evaluation Report. A complete report that considers stakeholders’ consultations and recommendations should be submitted timely as indicated in the reporting requirement table below. The report format should be proposed by the evaluation team and agreed during the inception meeting but should have the following basic chapters. Executive Summary, Main body (<i>i. Background, ii. methodology, iii. findings and discussion, iv. conclusion, v. Lessons learnt, vi. recommendations</i>), Annexes</p>	
<p>Reporting requirements</p>	<p>Reporting</p>	<p>Dates/by when</p>
	<p>An inception report indicating how the hired institution will carry out the work within a time-bound work plan and timelines, methodology and assessment tools, and ethical clearance approval</p>	<p>15th Sept. 2023</p>
	<p>Stakeholder meeting report with recommendations made to the inception report</p>	<p>21st Sept. 2023</p>
	<p>Draft evaluation report depicting lessons learnt and recommendations for discussion with stakeholders in a validation workshop</p>	<p>15th Nov. 2023</p>
	<p>Report on validation workshop with recommendations made</p>	<p>15th Dec. 2023</p>
	<p>to draft report</p>	
	<p>Final Draft Evaluation report depicting lessons learnt and recommendations + summary brief</p>	<p>15th Jan. 2024</p>
	<p>Note:</p> <ol style="list-style-type: none"> 1. The assessment/study tools used for the evaluation will be in English and translated into Kiswahili for usage at the community level. 2. All the reports and materials prepared will be submitted in soft copy All reports and documents will be in English 	
<p>Location and Duration</p>	<p>The assignment will mainly be carried out in Zanzibar, covering both Unguja and Pemba Islan start date is 15th September 2023 and the end date 15th January 2024 (4 Months-)</p>	

<p>Qualification requirements</p>	<p>Academic qualification: The evaluation team leader will hold an advanced university degree from a recognized academic institution in one or more of the following disciplines - public health, social sciences, development studies, or a related discipline. OR first university degree combined with relevant professional work experience especially in the field of WASH, Social and Behaviour Change (SBCC) may be considered in lieu of advanced university degree.</p> <p>Technical skills and knowledge: The evaluation team leader should have strong knowledge of Water, Sanitation, and Hygiene (WASH), combined with knowledge of Social Behaviour Change, and community engagement, emergency preparedness and response systems; the team should have members with at least 8 years' experience in conducting qualitative summative evaluation in a leading role using participatory approaches and human centred design. Others are excellent analytical skills, excellent report writing skills and computer skills including use of data analysis software packages.</p> <p>Similar Past experiences: Minimum eight years progressively professional work experience in humanitarian/development programme evaluation, working with governments, work with recognized civil society and/or NGOs, community engagement and assessments of accountability to affected populations. Experience in evaluation of similar projects or other related areas is required. Relevant experience in a UN system agency or organization and experience working within Zanzibar and understanding of local systems will be considered as added assets.</p> <p>Other requirements: Results driven; able to work effectively in a multi-cultural environment and with minimum supervision. Ability to work under tight schedules, respond to multiple demands including within a changing environment. Have an innovative and resourceful mindset to make solutions work in adverse conditions. Willingness to travel within Zanzibar (Unguja and Pemba)</p> <p>Languages:</p> <ol style="list-style-type: none"> 1. Strong communication in English, including the ability to clearly and concisely express concepts and ideas in both oral and written form, and the ability to speak Kiswahili is an added advantage. 2. Ability to write clear and useful reports (may be required to produce examples of previous work) 3. Ability to manage time and resources and to work to tight deadlines <p>Experience in leading participatory community dialogues including CLTS processes, working</p>
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	<p>with children, adolescents and community members and capacity development processes with a wide variety of national and local stakeholders.</p>
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Competencies	Builds and maintains partnerships; demonstrates self-awareness and ethical awareness; innovates, and embraces change; drive to achieve results for impact; manages ambiguity and complexity; thinks, and acts strategically; work collaboratively with others. To view our competency framework, please click the link below: https://www.unicef.org/careers/media/1041/file/UNICEF%27s_Competency_Framework.pdf																																													
Evaluation process and methods	<p>1. The evaluation approach is weighted on technical and financial proposals at a ratio of 70/30 respectively.</p> <p>2. The technical proposal will be evaluated on the following criteria:</p> <table border="1" data-bbox="448 520 1364 1633"> <thead> <tr> <th data-bbox="448 520 634 625">Technical Criteria</th> <th data-bbox="634 520 1235 625">Technical Sub-criteria</th> <th data-bbox="1235 520 1364 625">Maximum Points</th> </tr> </thead> <tbody> <tr> <td data-bbox="448 625 634 699">Overall Response</td> <td data-bbox="634 625 1235 699">Completeness of response + Overall concord between RFP requirements and proposal.</td> <td data-bbox="1235 625 1364 699">5</td> </tr> <tr> <td colspan="2" data-bbox="448 699 1235 751">Maximum Points for overall response</td> <td data-bbox="1235 699 1364 751">5</td> </tr> <tr> <td data-bbox="448 751 634 863"></td> <td data-bbox="634 751 1235 863">Reputation of the Institution and personnel (Competence / Reliability) + General organizational capability which is likely to affect implementation</td> <td data-bbox="1235 751 1364 863">10</td> </tr> <tr> <td data-bbox="448 863 634 936">Institution and Key Personnel</td> <td data-bbox="634 863 1235 936">Range and depth of experience with similar projects/evaluations</td> <td data-bbox="1235 863 1364 936">10</td> </tr> <tr> <td data-bbox="448 936 634 1073"></td> <td data-bbox="634 936 1235 1073">Key personnel: - Proposed team structure - Relevant experience and qualifications of teamleader/team-member(s)</td> <td data-bbox="1235 936 1364 1073">10</td> </tr> <tr> <td colspan="2" data-bbox="448 1073 1235 1125">Maximum Points for Institution and Key Personnel</td> <td data-bbox="1235 1073 1364 1125">30</td> </tr> <tr> <td data-bbox="448 1125 634 1272">Overall quality of the technical proposal</td> <td data-bbox="634 1125 1235 1272">Relevance and rigor of the technical approach/ methodology, including consideration of the context + quality assurance process</td> <td data-bbox="1235 1125 1364 1272">30</td> </tr> <tr> <td colspan="2" data-bbox="448 1272 1235 1314">Maximum Points for Overall quality of the technical proposal</td> <td data-bbox="1235 1272 1364 1314">30</td> </tr> <tr> <td data-bbox="448 1314 634 1440">References</td> <td data-bbox="634 1314 1235 1440">3 references for similar assignments (price and scope) carried out within 5 years from the moment of the tender submission need to be submitted for the consortium/company to qualify</td> <td data-bbox="1235 1314 1364 1440">5</td> </tr> <tr> <td colspan="2" data-bbox="448 1440 1235 1482">Maximum Points for references</td> <td data-bbox="1235 1440 1364 1482">5</td> </tr> <tr> <td colspan="2" data-bbox="448 1482 1235 1524">Total maximum attainable score for technical proposal</td> <td data-bbox="1235 1482 1364 1524">70</td> </tr> <tr> <td colspan="2" data-bbox="448 1524 1235 1566">Minimum acceptable score for technical proposal</td> <td data-bbox="1235 1524 1364 1566">49</td> </tr> <tr> <td colspan="2" data-bbox="448 1566 1235 1608">Financial proposal</td> <td data-bbox="1235 1566 1364 1608">30</td> </tr> <tr> <td colspan="2" data-bbox="448 1608 1235 1650">Total</td> <td data-bbox="1235 1608 1364 1650">100</td> </tr> </tbody> </table> <p>3. The financial proposal must include costs for all services to be provided, including travel in Pemba and Unguja, meals, accommodation, community meetings, enumerators, and two stakeholders meetings.</p> <p>4. All air travel costs should be in economy class.</p>	Technical Criteria	Technical Sub-criteria	Maximum Points	Overall Response	Completeness of response + Overall concord between RFP requirements and proposal.	5	Maximum Points for overall response		5		Reputation of the Institution and personnel (Competence / Reliability) + General organizational capability which is likely to affect implementation	10	Institution and Key Personnel	Range and depth of experience with similar projects/evaluations	10		Key personnel: - Proposed team structure - Relevant experience and qualifications of teamleader/team-member(s)	10	Maximum Points for Institution and Key Personnel		30	Overall quality of the technical proposal	Relevance and rigor of the technical approach/ methodology, including consideration of the context + quality assurance process	30	Maximum Points for Overall quality of the technical proposal		30	References	3 references for similar assignments (price and scope) carried out within 5 years from the moment of the tender submission need to be submitted for the consortium/company to qualify	5	Maximum Points for references		5	Total maximum attainable score for technical proposal		70	Minimum acceptable score for technical proposal		49	Financial proposal		30	Total		100
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<p>Management oversight of the evaluation and quality assurance</p>	<p>The evaluation will be managed by the Research and Evaluation Manager at UNICEF Tanzania, in close collaboration with Chief of WASH and in close consultation with MoH.</p> <p>An Evaluation Reference Group (ERG) will be established specifically for this evaluation, to guide the evaluation process and ensure adequate participation of key stakeholders. The R&E Manager will chair the ERG with members including the Chief of WASH, Chief of Zanzibar Field Office, two WASH officers from Zanzibar, a representative of PMFC as well as</p>
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	<p>Government and other key partners. The MOH will facilitate stakeholders' inception meeting and final validation meeting, and review of drafts. For quality assurance of this evaluation, the TORs, draft inception and final evaluation reports will be shared with the R&E Manager and ESARO Evaluation, to obtain their technical input and quality assurance. All evaluative products need to be Quality Assured by ESARO Evaluation Section, as per QA Regional Guidelines. Receiving at least a satisfactory review from ESARO Evaluation Section is a precondition for moving from one evaluation phase to the next.</p> <p>The main roles of the ERG are:</p> <ul style="list-style-type: none"> - To contribute to the design and execution of the evaluation - To monitor and facilitate implementation of the evaluation - To share available information (data, documentation, etc.) - To provide feedback/comments on key evaluation deliverables - To assist with the interpretation of findings and co-creation of recommendations - To disseminate the results of the evaluation to key stakeholders - To support the development of the management response plan <p>At a minimum, the ERG will meet / provide comments in three stages: the inception report, the draft report, and the final report for validation.</p> <p>The Evaluation team should adhere to Revised Evaluation Policy of UNICEF; UNEG Ethical Guidelines for Evaluation; to UNEG Code of Conduct for Evaluation, to UNICEF Reporting Standards and UNICEF's Global Evaluation Reports Oversight System (GEROS) quality standards.</p>
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6.2 Annex 2: Evaluation Framework

Evaluation Criteria	Key Questions	Sub-Evaluation Questions	Indicators	Data Collection Methods	Data Sources
Impact Long or short-term, intended or unintended, positive or negative	What evidence is available that the action taken contributed directly or indirectly to reduce or prevent the spread of cholera in the short, medium and long-term?	<ul style="list-style-type: none"> Has there been any cholera outbreaks or cases during the 5-year project period? How fatal were the outbreaks? What were the barriers or enabling factors facilitating or inhibiting the timely response and reporting of cholera cases? 	1. Magnitude of cholera outbreaks during the project lifecycle. 2. Number of cholera cases 3. Case Fatality Rates. 4. Sanitation Coverage, Water Coverage, ODF rates.	- Desk Review - Secondary Data Analysis	DHS-MIS, Annual Reports, Situational Analysis Reports, Weekly Epidemiological Reports
			5. Average time taken by MoH to detect, respond and report on cholera outbreaks. 6. Extent of barriers and/or enabling factors for enhancing timely response actions	- Desk Review - Secondary Data Analysis - KII	Annual Reports, Weekly Epidemiological Reports, Ministry of Health Records, Ministry of Health Officials, WHO Officials
	What is the additional value of approach on the impact of the project? Does it, as aimed, increase the access and acceptance of the ZACCEP? Is the outcome satisfying? Has the project helped to change deep-rooted social, cultural and gendered norms that negatively impact fulfilment and protection of everyone's right to water and sanitation?	<ul style="list-style-type: none"> Were there any value-added effects of the project in addressing cholera outbreaks? Were there any positive or negative unanticipated direct or indirect impacts of the project on communities? How were these dealt with? What's the extent to which the project helped address negative social, cultural and gendered norms? 	1. Scope of value-added effects of the project in addressing cholera outbreaks	- Desk review - KII	Annual Reports, Implementing Partners, ZACCEP Task Force members, UNICEF Programme Officers
2. Range of unanticipated positive or negative impacts of the project.	- Desk Review - Secondary Data Analysis - KII - FGDs		Project Reports, UNICEF POs, Implementing Partners, Environmental Health Officers, Health Workers, Weekly Epidemiological Reports		
3. Extent of the changes in social, cultural and gender norms on WASH	- Desk Review - KII - FGDs		Annual Reports, NGOs, Community Representatives, Shehia Committees, Women's Groups, Community Health Workers, Disabled Person's Organisations		
Coverage	Was the targeted population properly covered? Were the population, community structures, shehia committees and stakeholders made aware of the ZACCEP and were they able to access services and	<ul style="list-style-type: none"> How did the selection criteria for districts, schools, shehias and beneficiaries adopted by the project ensure the inclusion of the most vulnerable groups and communities? 	1. Stakeholders' and communities' perceptions on the adopted selection criteria for districts, schools, shehias and beneficiaries (inclusion and exclusion errors)	- Desk Review - KII - FGDs	Annual Reports, UNICEF POs, Implementing Partners, Environmental Health Officers, Community Health Volunteers, Shehia Leaders, Solid Waste Management Groups, food vendors, adolescents (girls and boys)

Evaluation Criteria	Key Questions	Sub-Evaluation Questions	Indicators	Data Collection Methods	Data Sources
	<p>participate in programme activities?</p> <p>Were the needs, roles and involvement men, women, boys, girls and those of vulnerable groups (children, older persons, PLHIV and persons living with disabilities) identified to ensure that a culturally appropriate programme was designed and implemented?</p>	<ul style="list-style-type: none"> What actions were used to raise awareness of the ZACCEP among stakeholders and communities? Were the actions effective? What were the gaps? 	<p>2. Range of actions used to raise awareness of ZACCEP among stakeholders.</p> <p>3. Level of awareness of ZACCEP among population, community structures, shehia committees and stakeholders</p>		
		<ul style="list-style-type: none"> To what extent were the needs of and priorities of the different vulnerable groups (children, older persons, PLHIV and persons living with disabilities) effectively covered by the project? Which needs and priorities were not adequately covered and why? 	<p>4. Perceptions of vulnerable groups on the level of coverage of their needs and priorities</p>	<ul style="list-style-type: none"> - Desk review - KII - FGDs 	<p>Annual Reports, UNICEF POs, Implementing Partners, Health Workers, School Heads, Environmental Health Officers, Community Health Volunteers, Shehia Leaders, Women's Groups, Disabled Persons Organisations</p>
			<p>5. Sanitation and water coverages; Handwashing rates; student to drop hole ratios</p>	<ul style="list-style-type: none"> - Desk review - KII - FGDs 	<p>Annual Reports, Implementing Partners, Environmental Health Officers, Community Health Volunteers, Shehia Leaders, Religious Leaders, Solid Waste Management Groups</p>
	<p>How adequate was the oral cholera vaccine coverage</p>	<ul style="list-style-type: none"> Was the oral cholera vaccine adequate to cover the populations at risk of cholera? What factors facilitated or undermined its full coverage? 	<p>1.1. Coverage of the Oral Cholera Vaccine (OCV) versus population in need</p>	<ul style="list-style-type: none"> - Desk review - Secondary Data Analysis - KII - FGDs 	<p>Project Reports, DHS-MIS, WHO reports, Health Workers, Community Health Volunteers, Shehia Leaders, Religious Leaders</p>
Coherence	<p>What steps were taken by key implementing agents e.g. MOH, Disaster Management Commission in the 2nd Vice President Office to ensure the integration of the different project components or ministry departments and agencies (MDAs) to ensure maximum coverage?</p>	<ul style="list-style-type: none"> Is there any evidence of any cholera elimination interventions that have been integrated into other sectoral plans eg health, education? What were the hindrances? 	<p>1. Level and type of integrated cholera elimination interventions in other sectoral plans</p>	<ul style="list-style-type: none"> - Desk Review - KII 	<p>Annual Reports, Implementing Partners, 2nd VPO, ZACCEP Task Force Reports, Disaster Management Commission Focal Persons</p>
		<ul style="list-style-type: none"> What initiatives were taken to ensure integration of the different project components in other sectors to ensure maximum coverage? How effective were they? 	<p>2. Steps/ Initiatives taken to integrate cholera elimination interventions in other sectors eg Setting up of Multi-Sectoral Rapid Response Teams, conducting joint assessments, development of multi-sectoral plans (contingency plans, preparedness and response plans, multi-sectoral cholera elimination plan etc.)</p>	<ul style="list-style-type: none"> - Desk Review - KII 	<p>Annual Reports, 2nd VPO, ZACCEP Task Force Reports, Disaster Management Commission Focal Persons</p>

Evaluation Criteria	Key Questions	Sub-Evaluation Questions	Indicators	Data Collection Methods	Data Sources
	How was the project effectively coordinated to ensure effective participation and complementarity of all MDAs and international organisations?	<ul style="list-style-type: none"> What coordination mechanisms were set up or strengthened by the project? Are these fully functional and adequately funded at all levels (national and district)? Are the members of the structures clear of their roles and responsibilities? Is there no duplication of roles among members? What challenges do the coordination structures face which is hindering their effectiveness? 	1. Form of coordination mechanisms established/ reactivated/ strengthened.	- Desk Review - KII	Annual Reports, ZACCEP Task Force Reports, Disaster Management Commission Focal Persons
			2. Funding levels for the coordination structures, and existence of budget lines for multi-sectoral coordination.	- Desk Review - Secondary Data Analysis - KII	Annual Reports, 2 nd VPO, ZACCEP Task Force Records
			3. Extent of clarity and gaps in membership roles	- Desk Review - KII	Annual Reports, ZACCEP Task Force Records, Disaster Management Commission Focal Persons
			4. Level of functionality and effectiveness of national and subnational coordination platforms (ZACCEP structures).	- Desk Review - Secondary Data Analysis - KII	Annual Reports, ZACCEP Task Force Records, Disaster Management Commission Focal Persons
	What is the coherence of "Toward a Cholera Free Nation" project with national policy?	<ul style="list-style-type: none"> Are there any synergies and interlinkages between the project and UNICEF's goals and priorities (internal coherence)? To what extent is the project compatible with Zanzibar's national priorities and policies? Is it consistent and complementary to other cholera and WASH interventions in Zanzibar (external coherence)? 	1. Project alignment and synergies with UNICEF's goals and priorities, and international standards (GTFCC, SDGs, etc)	- Desk Review - KII	Annual Reports, Zanzibar Water Policy, UNICEF Strategy Documents, ZACCEP Task Force Records, Disaster Management Commission Focal Persons
			2. Project alignment with Zanzibar's national policies (Water Policy, ZACCEP, etc)	- Desk Review - KII	Annual Reports, Zanzibar Water Policy, UNICEF Strategy Documents, ZACCEP Task Force Records, Disaster Management Commission Focal Persons
			3. Degree of complementarity or duplication of activities with other projects	- Desk Review - KII	Annual Reports, Zanzibar Water Policy, UNICEF Strategy Documents, ZACCEP Task Force Records, Disaster Management Commission Focal Persons
	What could the DMC/2nd VPO as a coordination agency done better to ensure the coherence of the project while taking into consideration the specificity of the various partners (MDAs)	<ul style="list-style-type: none"> What facilitated or inhibited the ZACCEP structures in effectively coordinating cholera and project activities? What could have been done differently? 	1. Range of factors which facilitated or inhibited effective coordinating of project activities.	- Desk Review - KII	Annual reports, ZACCEP Steering Committee and Task Force Minutes, Disaster Management Commission Reports
Effectiveness	Have the stated project goal, specific objectives, and indicators – as shown in the project logical framework –	<ul style="list-style-type: none"> What is the extent to which the project achieved its objectives, and its results, including any differential 	1. Level of achievements versus planned objectives and targets.	- Desk review - Secondary Data Analysis	Annual reports, DHS-MIS, WASH-MIS, HIMS, Sanitation Registers, KOBO database, GIS data, Weekly Epidemiological Reports

Evaluation Criteria	Key Questions	Sub-Evaluation Questions	Indicators	Data Collection Methods	Data Sources
	been achieved and if so, to what extent.	<ul style="list-style-type: none"> • results across districts and beneficiary groups? • What were the key drivers or barriers which facilitated or inhibited the achievement of the project's results? • Were there any interventions which significantly contributed to the results more than others? 	2. Range of factors and barriers which facilitated or inhibited the achievement of the project's results.	<ul style="list-style-type: none"> - Desk review - KIIs - FGDs - Case Studies - Human Interest Stories 	Annual Reports, various secondary data sources (see Section 3.2.2.1) MOHZ officials, Health Care Workers, ZAWA Officials, MOE Officials, UNICEF, Implementing Partners, Community Health Volunteers, Religious & Shehias Leaders, SWM groups, Women's Groups
			3. Extent of interventions' contribution to the results.	<ul style="list-style-type: none"> - Desk review - Secondary Data Analysis - KIIs - FGDs - Case Studies 	Annual Reports, various secondary data sources (see Section 3.2.2.1) MOHZ officials, Health Care Workers, ZAWA Officials, MOE Officials, UNICEF, Implementing Partners, Community Health Volunteers, Religious & Shehias Leaders, SWM groups, Women's Groups
			4. Beneficiaries' perceptions on the quality of WASH and health services availed, including on issues of equity.	<ul style="list-style-type: none"> - Desk review - KIIs - FGDs 	Annual Reports, various secondary data sources (see Section 3.2.2.1) MOHZ officials, Health Care Workers, MOE Officials, Implementing Partners, Community Health Volunteers, Religious & Shehias Leaders, SWM groups, Women's Groups
			5.1. Level of improvements in hygienic behavioral changes (HWWS at critical times, water and food handling, use of improved latrines and early care seeking). 5.2. Range of low-cost liquid and solid waste management systems put in place in urban areas.	<ul style="list-style-type: none"> - Desk review - Secondary data analysis - KIIs - FGDs - Case Studies 	Annual Reports, various secondary data sources (see Section 3.2.2.1) MOHZ officials, Health Care Workers, MOE Officials, Implementing Partners, Community Health Volunteers, Religious & Shehias Leaders, SWM groups, Women's Groups
			6. Level of improvements in water quality meeting national standards (microbiological and free chlorine residual (FCR) levels)	<ul style="list-style-type: none"> - Desk review - Secondary Data Analysis - Water quality assessment results 	Annual Reports, Kobo database, CDC reports, Field testing results
			1. Extent of government, schools, health facilities and communities' capacities to self-manage, operate,	<ul style="list-style-type: none"> - Desk review - KIIs - FGDs 	Annual reports, MoE reports, MoH reports, Sheiha committees, CHVs, School Authorities, Healthcare Workers
			• To what extent has the project improved the capacities among		
Has the project increased the capacities among government, schools, health facilities, local					

Evaluation Criteria	Key Questions	Sub-Evaluation Questions	Indicators	Data Collection Methods	Data Sources
	authorities, water vendors and communities to manage and prevent cholera?	<p>government, schools, health facilities and communities to self-manage, operate, and maintain their WASH/Health services and infrastructure? What mechanisms have been put in place to raise funds for the maintenance, repair and replacement of the infrastructure?</p> <ul style="list-style-type: none"> To what extent has the capacity of local authorities and water vendors in safe water provision and waste management been improved? What are the gaps? Did the project improve the capacity of health facilities and workers to manage cholera cases? What are the gaps? 	<p>and maintain (and raise funds) for their WASH facilities.</p> <p>2. Extent of local authorities and water vendors' capacities to properly manage water services ie treatment/ chlorination and waste management (collection, transportation, disposal, cycling)</p> <p>3. Extent of health facilities and health care workers' knowledge and capacity on cholera case management.</p>	<p>- Desk review</p> <p>- KIIs</p> <p>- Desk review</p> <p>- KIIs</p>	<p>Annual reports, LGAs reports, ZAWA reports, ZAWA focal persons, Water Vendors</p> <p>MoH reports, Healthcare Workers, WHO Officials</p>
	How, and to what extent can the direct results be attributed to the project interventions? Explain to what extent the direct results of the interventions (output) contributed to the sustainable achievement of policy objectives, in this reference the ZACCEP 2018-2027 which advocates for cholera elimination.	<ul style="list-style-type: none"> Are the results achieved directly attributable to the interventions implemented by the project ? To what extent is the project producing worthwhile results (outputs, outcomes) and/or meeting each of its objectives? 	1. Level of contribution of project interventions to the project results, and to the three pillars of the ZACCEP i.e. enabling environment, prevention and response.	<p>- Desk review</p> <p>- Secondary Data Analysis</p> <p>- KIIs</p>	Annual Reports, UNICEF Officials, WHO Officials, ZACCEP Task Force members, Disaster Management Commission Officials, Environmental Management Authority Officials, Implementing Partners, Publications
	To what extent did the project integrate human rights and the participation of men, women, adolescents, and children in schools as well as people with disabilities?	<ul style="list-style-type: none"> Did the selection criteria adopted by the project ensure the inclusion of the most vulnerable groups, districts, schools and shehias? 	1. Steps or actions taken to ensure the inclusion of the most vulnerable groups, districts, schools and shehias (inclusion and exclusion errors).	<p>- Desk Review</p> <p>- KII</p> <p>- FGDs</p>	Annual Reports, UNICEF POs, Implementing Partners, Environmental Health Officers, Community Health Volunteers, Shehia Leaders, Shehia Committees, Solid Waste Management Groups, School Children

Evaluation Criteria	Key Questions	Sub-Evaluation Questions	Indicators	Data Collection Methods	Data Sources
		<ul style="list-style-type: none"> To what extent did the services and infrastructure availed by the project meet the diverse needs of the most vulnerable groups, including children? Were there any rights of women and children which were violated? To what extent did the project engage and ensure the participation of adolescents? Were there any grievance redress or feedback mechanisms/ channels which supported rights-holders in holding duty bearers accountable for their actions and obligations? How effective were these? 	2. Extent of the presence of dignifying, private, gender, child and disability-friendly WASH and Health facilities and services	<ul style="list-style-type: none"> - Desk Review - KII - FGDs 	Annual Reports, UNICEF POs, Implementing Partners, Environmental Health Officers, Community Health Volunteers, Sheiha Committees, Shehia Leaders, Solid Waste Management Groups
			3.1. Extent of the use of adolescents/ young people's engagement platforms (online and offline)	<ul style="list-style-type: none"> - Desk Review - KII - FGDs 	Annual Reports, UNICEF POs, Implementing Partners, Environmental Health Officers, Community Health Volunteers, Religious Leaders, Shehia Committees, Adolescents, Solid Waste Management Groups, Community Groups
			3.2. Scope of grievances redress and feedback mechanisms/ channels instituted by the project		
			3.3. Range of unintended negative effects of the project on rights-holders' human rights		
	What is the level of quality and standards of the constructed WASH infrastructure and availed services? Are the WASH and Health facilities and services availed easily accessible to the most vulnerable, ie women, girls, pregnant women, the elderly and the disabled?	<ul style="list-style-type: none"> Did the installed WASH infrastructure/ facilities meet the minimum national standards as set out in relevant national policies? What constraints and/or barriers are still faced by women, girls, boys, men as well as other vulnerable groups in using and accessing the WASH/Health facilities and services? 	1. Quality and standards for installed/ constructed infrastructure	<ul style="list-style-type: none"> - KII - FGDs - Observations 	Field Observations, UNICEF staff, Implementing Partners, Environmental Health Officers, ZAWA staff
			2. Extent of appropriateness of activities, materials, infrastructure and services provided.	<ul style="list-style-type: none"> - Desk review - KII - FGDs - Observations 	Field Observations, UNICEF staff, WHO staff, Implementing Partners, Environmental Health Officers, ZAWA staff, Healthcare Workers, CHWs

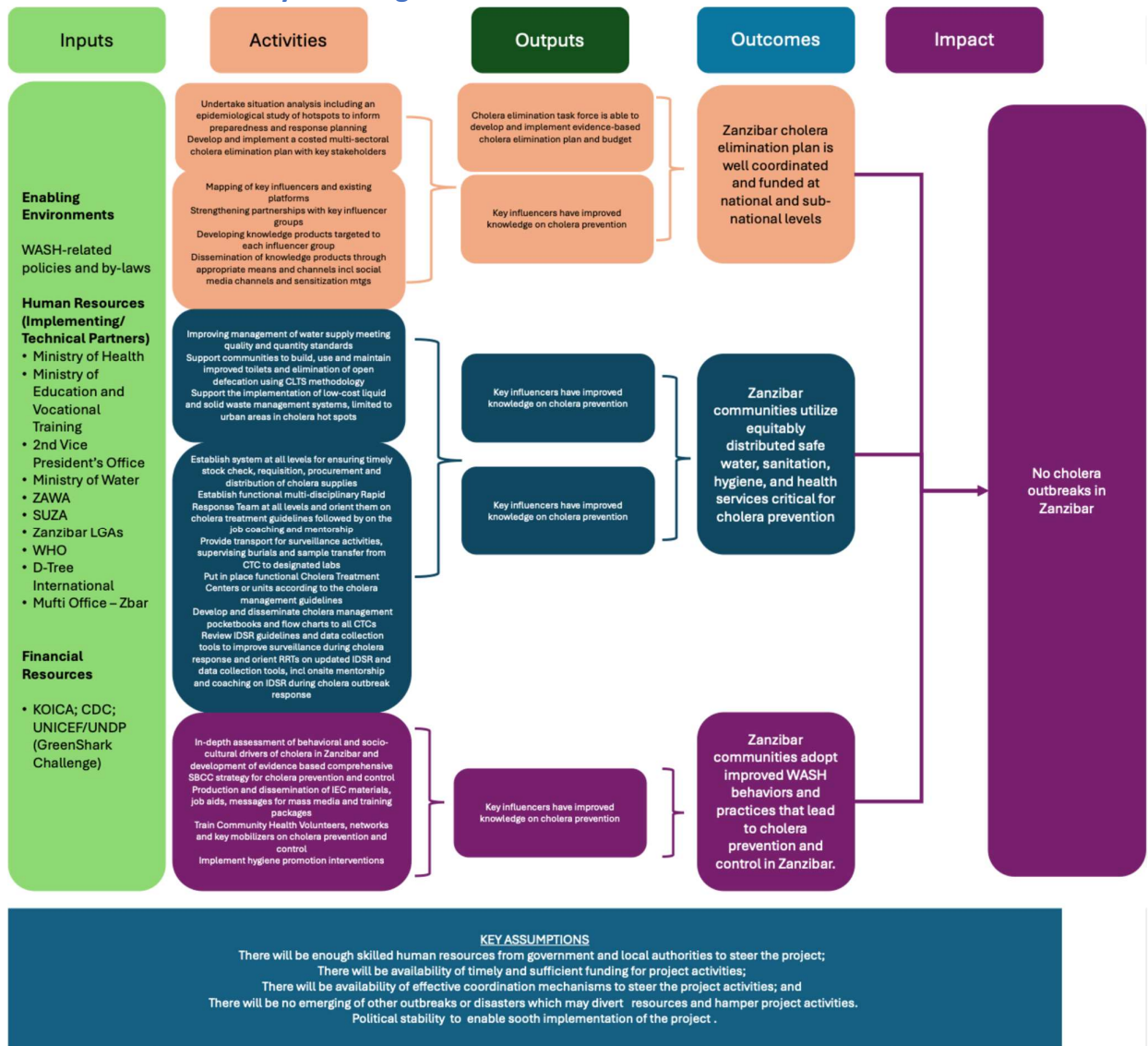
Evaluation Criteria	Key Questions	Sub-Evaluation Questions	Indicators	Data Collection Methods	Data Sources
Relevance	Was the project's design, causal linkages and assumptions valid for the context of Zanzibar? How responsive was the design of the project to the rights, needs and priorities of rights-holders, and to changing circumstances?	<ul style="list-style-type: none"> To what extent was the project designed to address the rights, needs and priorities of rights-holders? (i.e. its objectives, theory of change, assumptions, interventions, risk analysis, context analysis, etc.) 	1.1. Degree of the strength of causal linkages in addressing the rights, needs and priorities of rights holders 1.2. Extent of the validity of assumptions to the operating context and to the ToC 1.3. Range of factors facilitating or undermining the causal linkages	- Desk review - KII - FGDs	UNICEF staff, Implementing Partners, ZACCEP Task Force, Environmental Health Officers, ZAWA staff, Healthcare Workers, CHWs Community Health Volunteers, Adolescents, Solid Waste Management Groups
Efficiency	Did the timeliness and adequacy of interventions facilitate the realization of the envisioned causality chain?	<ul style="list-style-type: none"> Were interventions delivered within the intended or reasonably adjusted timeframes which met the demands of the evolving context in Zanzibar? 	1.1. Perceptions of beneficiaries and stakeholders on the timeliness of interventions 2. Perceptions on adequacy of interventions	- Desk review - KII - FGDs	UNICEF staff, Implementing Partners, ZACCEP Task Force, Environmental Health Officers, ZAWA staff, Healthcare Workers, CHWs, Community Health Volunteers, Adolescents, Solid Waste Management Groups
Monitoring	Which tools have been developed to monitor the progress and impact of the project? Were they used effectively? How can they be improved?	<ul style="list-style-type: none"> To what extent were the M&E tools aligned with the project's ToC and results framework? What were the gaps? 	1.1. Alignment of tools to ToC 1.2. Adequacy of tools to measure the performance of the ToC 1.3. Capacity of implementers to use the tools 1.4. Extent of the use of data from M&E in planning and informing decision-making 2.1. Range of gaps in the development and use of the tools 2.2. Appropriateness of data collection methods	- Desk review - KII	UNICEF staff, Implementing Partners, ZACCEP Task Force, Environmental Health Officers, ZAWA staff, Healthcare Workers, CHWs
		<ul style="list-style-type: none"> Did the tools developed ensure the monitoring, collection, analysis and use of disaggregated data (sex, age, geographical location, urban versus rural, disability, etc)? 	3. Extent of monitoring, collection, analysis and use of disaggregated data (sex, age, diversity)	- Desk Review - KII - FGDs	Annual Reports, UNICEF POs, CDC reports, WHO reports, Implementing Partners, Environmental Health Officers, Community Health Volunteers, Shehia Leaders, Solid Waste Management Groups

Evaluation Criteria	Key Questions	Sub-Evaluation Questions	Indicators	Data Collection Methods	Data Sources
	Were appropriate and relevant indicators developed for the project? How were they linked with ZACCEP?	<ul style="list-style-type: none"> Were the indicators aligned with the project's ToC and results framework? What is the extent of alignment of the indicators with the ZACCEP M&E framework? 	<ol style="list-style-type: none"> Extent of alignment of indicators for the project with ZACCEP M&E framework Extent of alignment of indicators with the ToC and results framework 	<ul style="list-style-type: none"> Desk review KII 	Project Reports, UNICEF staff, Implementing Partners, ZACCEP Task Force,
	How have lessons learned from various monitoring / evaluation sessions been incorporated into the program, and shared with partners?	<ul style="list-style-type: none"> Were there any mechanisms to facilitate the use of, and sharing of lessons generated from project implementation? How did the lessons learnt inform ongoing programming? What were the gaps? 	<ol style="list-style-type: none"> Extent of the use of mechanisms to facilitate use of lessons learned from monitoring Extent of the use of lessons learned obtained from monitoring Levels of changes made to the project design and implementation based on lessons learned from monitoring Extent of the use of mechanisms for sharing findings with partners and stakeholders 	<ul style="list-style-type: none"> Desk review KII 	Project Reports, UNICEF staff, CDC Officials, Implementing Partners, ZACCEP Task Force, Environmental Health Officers, ZAWA staff, Healthcare Workers, CHWs
Sustainability	Was the project designed and implemented to ensure continuity, ownership and sustainability of the activities implemented and results achieved? To what extent did the project contribute to building an enabling environment (social, political, economic) for the continual realisation of human rights, gender equality and the inclusion of vulnerable groups?	<ul style="list-style-type: none"> Did the project come up with a sustainability strategy whose implementation is already in place? What are the individual, organisational and institutional factors that supports or may constrain the continuity, ownership and sustainability of the project's results? 	<ol style="list-style-type: none"> Level of implementation of a sustainability strategy Range of individual, organisational and institutional factors that supports or may constrain the project's results. Reduction in harmful practices and attitudes 	<ul style="list-style-type: none"> Desk review KIIs 	Project documents, UNICEF Officials, ZACCEP Task Force, Implementing Partners
				<ul style="list-style-type: none"> Desk review KIIs FGDs 	Annual Reports, UNICEF Officials, ZAWA Officials, MoH Officials, MOE Officials, ZACCEP Task Force, Implementing Partners, Community Health Volunteers, Water/ Food Vendors, Religious/ Shehias Leaders, CBOs/ Women's Groups, SWM Groups
		How successful were the activities to strengthen the surveillance system (epidemiological & laboratory)	<ul style="list-style-type: none"> Was there a capacity assessment of stakeholders, followed by the development of a capacity-building plan? 	<ol style="list-style-type: none"> Degree of implementation of a capacity assessment and capacity building plan. 	<ul style="list-style-type: none"> Desk review KIIs

Evaluation Criteria	Key Questions	Sub-Evaluation Questions	Indicators	Data Collection Methods	Data Sources
	and capacity of local agencies, organizations, and individuals?	<ul style="list-style-type: none"> Is there a well functional early warning system and a surveillance system (epidemiological and laboratory) beyond the project timeline, that ensures the continuous early detection and timely response to cholera outbreaks in the future? Are the MDAs, schools, health facilities and communities sufficiently capacitated (financially, economically, socially, environmentally and institutionally) to continue implementing cholera prevention and response actions after the project ends? What are the gaps and challenges? 	2. Level of functionality of an early warning system and a surveillance system (epidemiological and laboratory) (beyond the project timeline) to ensure continuous early detection and timely response to cholera outbreaks in the future.	<ul style="list-style-type: none"> - Desk review - Secondary Data Analysis - KIIs 	Annual Reports, UNICEF Officials, WHO Officials, MoH Officials, Health Care Workers, ZACCEP Task Force, Implementing Partners, Disaster Management Commission, Community Health Volunteers
			3. Extent of government departments and agencies (MDAs), schools, health facilities and communities capacity to continue with the prevention and management of cholera after the project ends.	<ul style="list-style-type: none"> - Desk review - KIIs 	UNICEF, WHO, MoH, ZAWA, MOE, ZACCEP Task Force, Implementing Partners, Community Health Volunteers, Solid Waste Management Groups, Water / Food Vendors, Religious Leaders, Shehias Leaders, CBOs
	Did the project prepare an efficient exit strategy in which local implementing agencies were identified appropriately? Is this exit strategy process ongoing effectively? How is it integrated into the ZACCEP plan?	<ul style="list-style-type: none"> Did the project prepare an Exit Strategy which is being implemented at all levels? What are the gaps and challenges? Is the strategy and its implementation aligned to the ZACCEP 10-year plan? 	1. Level of implementation of an Exit Strategy (if available)	<ul style="list-style-type: none"> - Desk review - KIIs 	Annual Reports, UNICEF Officials, Implementing Partners, ZACCEP Task Force Officials
			2. Extent of integration of the Exit Strategy (if available) into the ZACCEP 10-year plan.	<ul style="list-style-type: none"> - Desk review - KIIs 	Annual Reports, UNICEF Officials, Implementing Partners, ZACCEP Task Force Officials
	What are the good practices, innovations and key conditions for national scaling up of the project? What could or should be done differently in future replication and scaling up of the project?	<ul style="list-style-type: none"> Is there evidence of any innovations and good practices which emanated from the project? How did these inform ongoing programming? What are the factors or conditions that may support or undermine replication and 	1. Scope of good practices and innovations which emanated from the project.	<ul style="list-style-type: none"> - Desk review - KIIs - FGDs 	Project Reports, UNICEF Officials, MoH Officials, MOE Officials, ZAWA Officials, Implementing Partners, Health Care workers, SWM groups, CBOs, Community Health volunteers, Water/ Food Vendors, Religious & Shehias Leaders
			2. Extent to which existing conditions and factors supports or undermines	<ul style="list-style-type: none"> - Desk review - KIIs 	UNICEF, MoH, MOE, ZAWA, Implementing Partners, SWM groups,

Evaluation Criteria	Key Questions	Sub-Evaluation Questions	Indicators	Data Collection Methods	Data Sources
		national scale-up of the project?	national scale up and replication of the project	- FGDs	CBOs, Water Vendors, Community Health volunteers, Religious Leaders, Shehia Committees

6.3 Annex 2a: Theory of Change



6.4 Annex 3: Project Performance, Targets vs Actual

Colour codes: **Red**: targets with no corresponding data for verification (red). **Green**: verified targets that were met; **Yellow**: Verified targets that were not met.

Outcome 1	Indicator	Baseline	Target	Cumulative progress as at 31 Dec 2023 (Reported by UNICEF – EoP)	Cummulative progress at endline evaluation (Dec 2023)	Progress assessment	Data sources/ MoV
Zanzibar cholera elimination plan is well coordinated and funded at national and sub-national levels	1.1 Time taken by MoH to detect, respond and report on cholera outbreak	(a) Detection: two weeks (b) Response: one month (c) Report: one month	(a) Detection: 72 hours (b) Response: 72 hours (c) Report: within 24 hours	(a) Detection: 72 hours (b) Response: 72 hours (c) Report: within 24 hours	This could not be verified as no outbreak was reported during the implementation period.		Project reports' MoH records.
	1.2 Number of cholera outbreaks during the project lifecycle	Once per year	0	0	0	Target met	Project reports' MoH records.
	1.3 Per cent of national budgets allocated to emergency preparedness and response, per cent	0<1 per cent	2 per cent	1.53 per cent	Data was unavailable.		Disaster Management Commission records
	1.4 Number of key influencers taking action on cholera prevention, #	0	5 groups	100 per cent 100 per cent 4 groups of key influencers sensitized including tourism, youth, faith groups and media	6 groups of people engaged on various issues (disaggregated data missing) Adolescents (??); Faith leaders(487); Women's Madrassa groups (287); Madrassa teachers (563); Media organisations(10);	Target met	UNICEF Project documents; Religious leaders, Adolescent groups.

						Tourism organisations (2), parliamentarians		
Output 1.1	Activity	Indicator	Baseline	Target	Cumulative progress as at 31 Dec 2023 (Reported by UNICEF – EoP)	Cummulative progress at endline evaluation (Dec 2023)	Progress assessment	Data sources/ MoV
By 2021, Zanzibar cholera elimination task force is able to develop and implement evidence-based cholera elimination plan and budget	1.1.1 Undertake situation analysis, including an epidemiological study of hotspots to inform preparedness and response planning 1.1.2 Develop and implement a costed multi-sectoral cholera elimination plan with key 'stakeholder's role	Elimination plan developed	0	Elimination plan with budget in place	100 per cent ZACCEP was launched in 2019. Epidemiological study done in 2020	100% ZACCEP was launched in 2019. Epidemiological study done in 2020	Target met	ZACCEP document; Situaational analysis study
	1.1.3 Establish/strengthen coordination mechanisms at national levels with clear terms of reference	Number of coordination mechanisms established/ reactivated/ strengthened, #	Multisectoral Disaster Management Technical Working Group (2)	National (1) All districts (5)	100% At least 4 taskforce meetings, and 2 ZACCEP Steering committee meetings were held annually.	100% (a) National level-ZACCEP taskforce established and strengthened (b) ZACCEP Steering Committee established and strengthened (c) Shehia Health Custodian Committees (SHCC) strengthened	Target met	ZACCEP Steering Committee and Task Force minutes of meetings; Shehia Committee minutes
Output 1.2	Activity	Indicator	Baseline	Target	Cumulative progress as at 31 Dec 2023 (Reported by UNICEF – EoP)	Cummulative progress at endline evaluation(Dec 2023)	Progress assessment	Data sources and MoV

By 2021, key influencers have improved knowledge on cholera prevention in Zanzibar	1.2.1 Mapping of key influencers and existing platforms	Number of Key influencers identified	0	At least 3 key influencing groups mapped and maintained	100% KPs continued to be disseminated to various groups including key influencers.	100% Key influencers re-sensitized (religious leaders women madrassa groups, youth groups)	Targets met	MoH Bulletin; Sample of knowledge products
	1.2.2 Strengthening partnerships with key influencer groups				Sensitization on EVD, Covid-19, Polio and Measles was conducted through radio and TV.			
	1.2.3 Developing knowledge products targeted to each influencer group	Number of knowledge products developed and disseminated to influencers	0	5 knowledge products developed and disseminated to influencers		KPs with key messages were developed and distributed (policy briefs, 280 handbags, 200 diaries, 100 T-shirts) to CHVs, religious leaders and government officials		
	1.2.4 Dissemination of knowledge products through appropriate means and channels including social media channels and sensitization meetings	Number of issues-based quality media reports on cholera elimination	0	At least 4 issue-based media reports.	100% Hygiene and sanitation messages continued to be aired through T.V. (ZBC, Cable T.V.) and radios as well social media (through the MOH-HPU website)	100% Cholera, Covid-19, EVD and Measles messages aired through mass and social media.	Target met	MoH bulletin; UNICEF Project reports; KIIs
		Number of parliamentary discussions on cholera	0	At least one annual meeting organized	100% 4 meetings held with Parliamentarians; House of Representatives (HoRs); Principal Secretaries; Planning Officers;	100 per cent 4 meetings held with Parliamentarians and HoRs on emergency preparedness; Principal Secretaries on WASH budget monitoring; Planning Officers on WASH Planning and WASH Policy.	Target was met. However, one meeting could not be held in 2019 due to covid-19 restrictions.	UNICEF Project Reports; Meeting reports; KIIs

		Number of tourism industry actors sensitized on cholera elimination	0	At least 3 dissemination workshops organized	100% 2 sensitization workshops conducted with representatives from the tourism sector since 2019. Hotels are contributing to promoting innovations on waste management	67% 2 out of the 3 planned workshops were held. However, evaluation noted that hotels have been promoting recycling of solid waste and wastewater, and also procuring of upcycled products and compost made from waste by SWM groups.	Target partially met	Documentary review; KIIs
		Number of faith leaders sensitized on cholera elimination, #	0	At least 3 dissemination workshops/ meetings	100 per cent More than 3 meetings held	100% A total of 8 meetings were held with faith leaders and the 5 with women in madrassas and their leaders	Target met	Documents review; KIIs; FGDs
		Number of young people engaged through off-line and online platforms on cholera elimination	0	Partnership with youth organization forged	100 per cent Partnership with youth groups was forged and maintained through U-report.	100% Youth groups were engaged through the U-Report	Target met	Documentary review; FGDs
Outcome 2	Indicator	Baseline	Target	Cumulative progress as at 31 Dec 2023 (Reported by UNICEF – EoP)	Cummulative progress at endline evaluation(Dec 2023)	Progress assessment	Data sources and MoV	
Zanzibar communities utilize equitably distributed safe water, sanitation, hygiene and health services critical for cholera prevention and control	Number of cholera cases during cholera outbreaks, #	344 (2017)	60	100% No cholera outbreaks have been reported since July 2019.	100% No cholera cases were recorded during the project period	Target met	Documentary review; KIIs	

		Number of cholera deaths, #	4 (2017)	0	100% Maintained no cholera deaths	100% No cholera deaths were recorded during the project period	Target met	Documentary review; KIIs; FGDS
		Case Fatality Rate (CFR)	1.2 (2017)	0	100% No cholera cases were reported	100% CFR maintained at 0 throughout the project period	Target met	Documentary review
Output 2.1	Activity	Indicator	Baseline	Target	Cumulative progress as at 31 Dec 2023 (Reported by UNICEF – EoP)	Cummulative progress at endline evaluation(Dec 2023)	Progress assessment	Data sources and MoV
By 2021 Households are able to access safe water supply and sanitation	2.1.1 Improved the management of water supply meeting quality and quantity standards	Per cent of households having access to basic water supply supported by the Project	0	95%	97%	97% (Figure extrapolated from the 2022 TDHS)	Target met	TDHS 2022
	2.1.2 Support the communities to build, adequately use and maintain improved toilets and elimination of open defecation using CLTS methodology	Per cent of households having access to basic sanitation services supported by the Project,	0	60%	80%	80% (Figure extrapolated from the 2022 TDHS)	Target met	TDHS 2022
	2.1.3 Support the implementation of low-cost liquid and solid waste management systems, limited to urban areas in cholera hot spots	No. of communities/ Shehias with functioning SWM groups.	24	38 (7 in Magaribhi A, 7 in Magaribhi B, 24 existing committees)	47 Shehia with 40 functional SWM groups	40 functional SWM groups established, with 1070 members (438males, 632females)	Target met	Project reports
		No. of low-cost technologies piloted	0	1	3 technologies piloted	3 technologies piloted: - charcoal production - compost - PVC-sand paving bricks	Target met	Project reports; KIIs; FGDS

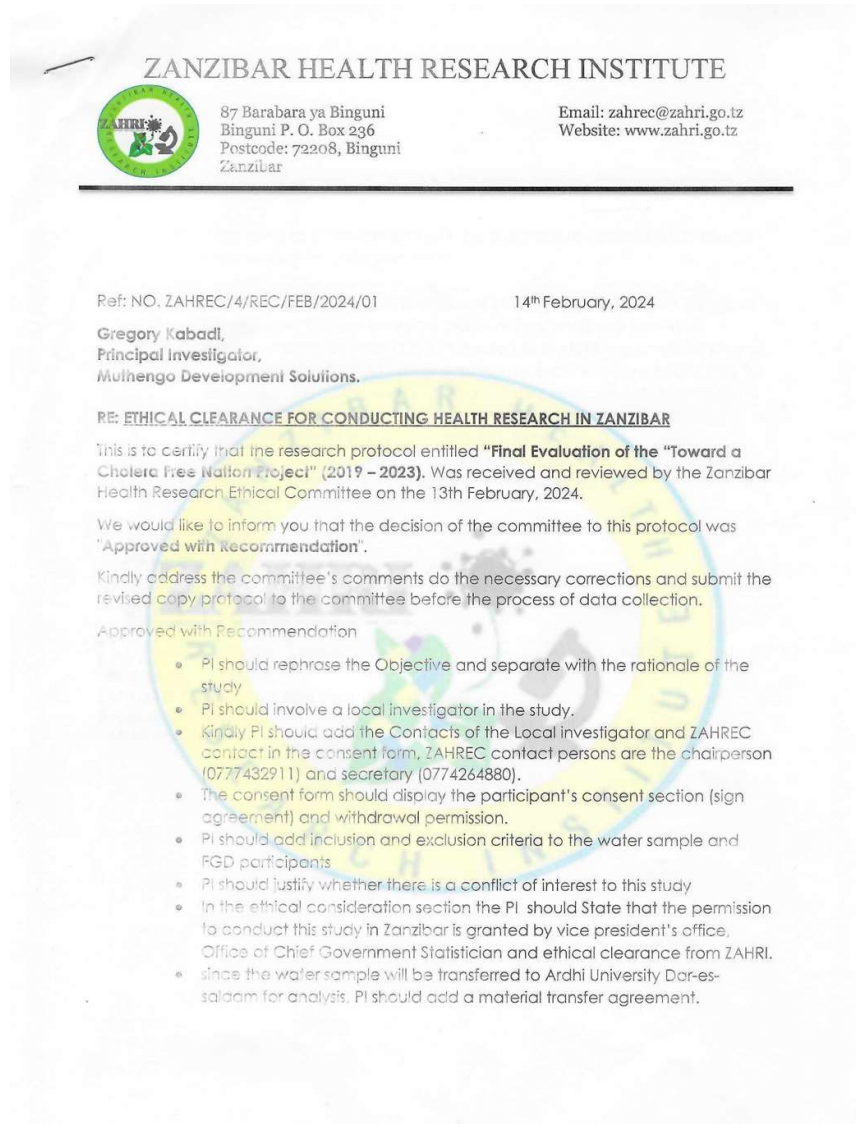
Output 2.2	Activity	Indicator	Baseline	Target	Cumulative progress as at 31 Dec 2023 (Reported by UNICEF – EoP)	Cummulative progress at endline evaluation(Dec 2023)	Progress assessment	Data sources and MoV
		No. of schools with group handwashing stations supported by projects	0	121 schools	122 schools	122 schools have functional group hand washing facilities benefiting 171,968 students (85,273 boys and 86,695 girls) and 2,933 teachers (327males, 2,606females)	Target met	Project reports; KIIs
By 2021 capacity of health workers at institutional and community levels strengthened in case management and surveillance	2.2.1 Establish system at all levels for ensuring timely stock check, requisition, procurement and distribution of cholera supplies	Availability of essential medicines and supplies for cholera response at CTC during cholera outbreak, per cent	40 per cent (2017)	At least 95 per cent	100% of the required supplies were procured in 2023 for prepositioning and replenishing of the 2022 stocks. A total of 2,400 Rapid Diagnostic Kits were received in 2023 and distributed in HCFs with some to Central Medical Stores and in CTCs.	The percentage could not really be ascertained, as there was no outbreak during the project period. However, prepositioning and replenishment of supplies meant that these were available in case of any outbreak.	Target met	Documentary review; KIIs
	2.2.2 Establish functional multi-disciplinary Rapid Response Team (RRTs) at all levels and orient RRTs to cholera treatment guidelines followed by on the job coaching and mentorship	No. of RRTs at National and district levels	National RRT -1 District RRT = 0	1 National RRT 11 District RRT	All the RRTs (1 National and 11 Districts) were trained the IDSR and other international standards.	1 National RRT and 11 district RRT were established and are fully functional. However, project focused more on the RRTs in the 5 operational districts.	Targets met	Documentary reviews; KIIs
	2.2.3 Provide reliable transport for surveillance activities, supervising burials and for	Availability of transport for surveillance and supervision	50 per cent (Government transport)	100 per cent	MOH transport strengthened following Covid-19 pandemic. Approx 90 per cent, (MOH	Project supported MoH with the maintenance of ambulances and procurement of 13	Target partially achieved	Project documents; KIIs

	sample transfer from CTC to designated laboratory				ambulances 80 per cent; 13 UNICEF Motorcycles covers	motorcycles, covering approx. 90% of the needs.		
	2.2.4 Put in place functional Cholera Treatment Centers or units (CTC/CTU) according to the cholera management guidelines	Number of CTC established according to guidelines, #	Less than 5 (2017)	11 CTCs	100 per cent achieved The programme has maintained the 20 CTC established in 2020; 10 are active and 10 kept as backup.	20 CTCs have been established and equipped, and 68 health workers trained on case management and IPC. 10 are currently active concentrating on the treatment of acute watery diarrhea (AWD), and the other 10 are standby facilities.	Target met	Project documents; KIIs
	2.2.5 Develop and disseminate cholera management pocketbooks and flow charts to all CTCs	Number of pocketbooks distributed per CTC. Number of flow charts distributed per CTC	0	At least 3 pocketbooks per CTC At least 1 flow chart for CTC	100 per cent achieved and maintained through capacity building and refresher training to RRTs.	500 pocket books and flow charts on cholera management guidelines were produced and distributed to more than 100 health facilities and CTCs.	Target met	Project documents; KIIs
	2.2.6 Review IDSR guidelines and data collection tools to improve surveillance during cholera response and orient RRTs on updated IDSR and data collection tools, including onsite mentorship and coaching on IDSR during cholera outbreak response	Per cent of cholera cases managed according to standard guidelines, per cent	50 per cent (2017)	100 per cent	There has been no cholera outbreak since 2019 however, programme conducted training and equipped 50 Rapid Response Team members with knowledge on early detection, reporting, prevention.	No cholera cases were reported during the project period. However, districts were strengthened on prevention and rapid response, in case of any new outbreak.	Target met	Project reports; KIIs
	Outcome 3	Indicator	Baseline	Target	Cumulative progress as at 31 Dec 2023 (Reported by UNICEF – EoP)	Cummulative progress at endline evaluation(Dec 2023)	Progress assessment	Data sources and MoV
	Zanzibar communities adopt improved WASH behaviors and	3.1 Per cent of people who	37%	90%	Estimated at 60% because there has	Data on HWWS could not be		2022 TDHS-MIS

practices that lead to cholera prevention and control in Zanzibar		wash their hands with soap at critical time, per cent			been no outbreak and community tend to neglect preventive measures once there isn't a threat.	ascertained from the sources available		
		3.2 Per cent of H.H. that treat water, per cent	24 per cent	85 per cent	Estimated at 72 per cent. 72 per cent of the water samples taken from water vendors had recommended FRC 0.5-1m/l. This is a proxy indicator.	23.7% Proxy indicator for percentage population using an appropriate water treatment method	Target not met	2022 TDHS - MIS
Output 3.1	Activity	Indicator	Baseline	Target	Cumulative progress as at 31 Dec 2023 (Reported by UNICEF – EoP)	Cummulative progress at endline evaluation(Dec 2023)	Progress assessment	Data sources and MoV
By 2021 families and communities have comprehensive knowledge for prevention and control of Cholera in Zanzibar	3.1.1 In-depth assessment to understand behavioral and socio-cultural drivers of cholera in Zanzibar and development of evidence based comprehensive SBCC strategy for cholera prevention and control	Comprehensive SBCC strategy available	0	Comprehensive SBCC strategy in place in Zanzibar	Maintained 100 per cent SBCC strategy in place and continues to be used.	Comprehensive SBCC strategy developed and launched in Zanzibar	Target met	Documentary review
	3.1.2 Production and dissemination of IEC materials, job aids, messages for mass media and training packages	Number of Shehias with mobilized social networks and community leaders to prevent and control cholera	0	182 Shehias	Maintained 100 per cent. All shehia leaders (182) have been sensitized on cholera control, Covid-19 and EVD.	All the 182 targeted Shehias had social networks and community leaders who were engaged on cholera, covid-19 and EVD issues.	Target met	Project documents; KIIs, FGDs

	<p>3.1.3 Train Community Health Volunteers (CHVs), networks and key mobilizers on cholera prevention and control</p> <p>3.1.4 Implement hygiene promotion interventions</p>	<p>Percent of people who recall 4 key cholera prevention and control messages</p>	<p>No data</p>	<p>85 per cent</p>	<p>Data not available</p>	<p>Indicator could not be ascertained as no household survey was carried out during the evaluation</p>		
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6.5 Annex 4: Ethical Approval



Annex 5: Data collection Tools

Key Informant Guide: UNICEF Programme Officer

Section A: Coverage

1. How were the operational districts, shehias and beneficiaries for the project selected?

PROBE: How did you ensure that the most needy and vulnerable locations and beneficiaries were not left out?

2. Do you think the interventions for the project were adequate to cover the needs?

3. How were the stakeholders for the project selected? In your opinion, are there any stakeholders you think were left out, who would have added value to the project?

Section B: Coherence

1. What efforts, if any, were made to ensure that the project integrated cholera elimination into other sectoral plans/ interventions (Education, Health, Nutrition, Protection)? **PROBE:** Were there any multi-sectoral joint assessments, planning sessions, implementation, monitoring and preparedness and response plans?

2. What coordination mechanisms were put in place or supported by the project?

PROBE: How were they supported? Did the structures carry out their mandate as envisaged? What value did they bring? Do you think they will continue functioning after the project?

3. a). What challenges were faced by the ZACCEP/DMC coordination mechanisms and 2nd VPO which affected the project? **PROBE:** Clarity of roles, funding issues, inconsistent membership, attendance, irregularity of meetings, duplication of roles, etc.

b). What could the structures and the 2nd VPO have done better to steer the project?

Section C: Monitoring Issues

1. a). Which monitoring systems and tools have been developed to monitor and evaluate the progress and impact of the project?

b). In your opinion, were they adequately used in an effective manner?

c). How could these tools, and their use be improved?

2. a). Were there any mechanisms to capture and share knowledge, good practices and lessons learnt?

b). How did the new knowledge, good practices and lessons learnt inform ongoing programming?

Section D: Effectiveness

1. What interventions do you think had the most significant contributions to the project's results, and why?

2. What factors facilitated or inhibited the achievement of the project's results?

PROBE: Internal and external factors?

Section E: Impact of the Programme

1. In your opinion, do you think the project has resulted in the knowledge and wider acceptance of ZACCEP?

a) Has it influenced in the increase in budget allocations to the ZACCEP by government and donors?

PROBE: What else has it influenced?

b) Are there any unanticipated positive results from the project?

Section F: Sustainability Issues

1. Does the project have an Exit Strategy? If so, how was it developed?

PROBE: Did it involve wider consultations with key stakeholders, donors and beneficiaries? How has been its implementation so far?

2. a) Are there any extra-ordinary initiatives/ good practices/ innovations that emerged during implementation of the programme? **PROBE:** These could be activities, results, technologies, approaches, etc?

b). In your opinion, how can these be scaled up?

3. What were the lessons that were learnt, if any, during the course of the project?

Section G: Gender, Equity, Disability and Human Rights

1. a). In your opinion, how did the project cater for the different needs of the diverse groups: men, women, adolescents, boys, girls and people living with disabilities?

b). Did you think the results of the project benefited all these groups equally?

PROBE: Were WASH and Health facilities and services friendly to all gender groups and to people with disabilities? Did they offer privacy for girls, particularly those on their menstrual cycles?

c). Did it impact more on one gender than the other?

d). Did women also have influential positions in decision making bodies eg ZACCEP Steering Committee and Task Force, Religious Leaders, Shehias Leaders, SWM Groups, etc?

e). Did the burden of responsibilities fall more on one gender than the others?

d). What was the extent of monitoring, collection, analysis and use of disaggregated data. **PROBE:** sex, geographical location, urban versus rural?

Key Informant Guide: WHO Programme Officer

Section 1: Coverage

1. a). How were the operational districts, shehias and beneficiaries for the Oral Cholera Vaccine selected?
- b). How did you ensure that the most needy and vulnerable were not left out?
- c). Was the coverage for the OCV adequate for the needs?
- d). How acceptable was the vaccine?
- c). What were the key drivers or barriers which facilitated or inhibited the program?
- d). In your opinion, do you think it led to the contribution and wider acceptance of the ZACCEP?

Section 2: Coherence

1. What efforts were made to ensure that the OCV vaccination programme integrated cholera elimination into other sectoral plans/ interventions (Education, WASH, Nutrition, Protection)? **PROBE:** Were there any multi-sectoral joint assessments, planning sessions, implementation & monitoring activities, preparedness and response plans?

Section 3: Effectiveness

1. a). How, and to what extent has the OCV program contributed to eliminating cholera?
- b). How has it contributed to the three pillars of the ZACCEP ie enabling environment (strengthening surveillance; capacity building), prevention measures (SBCC), and response (case management, surveillance, logistics & supplies).

Section 4: Sustainability

- 1.a) How has the project improved the early warning and surveillance system (epidemiological and laboratory)?
- b). How will this ensure early detection and timely response to cholera outbreaks?

Key Informant Guide: Centers for Diseases Control (CDC)

Section 1: Coverage

1. How were the operational districts, shehias and water points for water quality monitoring selected?
PROBE: How did you ensure that the most vulnerable locations and water points were not left out?
2. Do you think the interventions for the project were adequate to cover the needs?
3. How were the stakeholders for the project selected? In your opinion, are there any stakeholders you think were left out, who would have added value to the project?

Section 2: Coherence

1. What efforts, if any, were made to ensure that the project integrated cholera elimination into other sectoral plans/ interventions (Education, Health, Nutrition, Protection)? **PROBE:** Were there any multi-sectoral joint assessments, planning sessions, implementation, monitoring and preparedness and response plans?
2. What coordination mechanisms were put in place or supported by the project?
PROBE: How were they supported? Did the structures carry out their mandate as envisaged? What value did they bring? Do you think they will they continue functioning after the project?
3. a). What challenges were faced by the ZACCEP/DMC coordination mechanisms and 2nd VPO which affected the project? **PROBE:** Clarity of roles, funding issues, inconsistent membership, attendance, irregularity of meetings, duplication of roles, etc.
b). What could the structures and the 2nd VPO have done better to steer the project?

Section 3: Effectiveness

1. a) How did your interventions contribute to the elimination of cholera? **PROBE:** mapping and registration of water vendors, routine water quality monitoring, community engagement, strengthening of shehia committees, media engagement, training of vendors
b). Have your interventions led to increased households, schools and vendors who now chlorinate their water? Which of your interventions do you think had the most significant contributions to the elimination of cholera, and why?
2. What factors facilitated or inhibited the achievement of your interventions?
PROBE: Internal and external factors? Availability of chlorine, skilled staff, transportation, etc
3. Were there mechanisms to share the results of water quality monitoring with users? How effective were these mechanisms?

Section 4: Sustainability Issues

1. Do you think the shehia committees, households, water vendors and local authorities (ZAWA) now have the capacity to chlorinate their water and effectively carry out water quality monitoring after the project comes to an end? What are the gaps?
2. a). What measures were put in place by the project to ensure continuation of chlorination and water quality monitoring activities after the project ends?
b). Are these measures so far working as planned?

Section A: Coverage

1. How were the operational districts, shehias and beneficiaries for the project selected? 2. Were the project interventions adequate to cover the needs?

PROBE: How did you ensure that the most needy and vulnerable locations and beneficiaries were not left out?

3. Do you think the interventions for the project were adequate to cover the needs?

3. a). What support (financial, technical, materials) did your department receive from the project?

b). Are you very satisfied with the level of support and quality of materials/ infrastructure?

4). a) What support did the communities/ beneficiaries receive?

b). Was the level of support adequate to cover the needs?

c). Did the services benefit one gender more than the other, and some locations than others?

5). a). How were the stakeholders for the project selected?

b). In your opinion, are there any stakeholders you think were left out, who would have added value to the project?

Section B: Coherence

1. What efforts, if any, were made to ensure that the project integrated cholera elimination into other sectoral plans/ interventions (Education, Health, Nutrition, Protection)? **PROBE:** Were there any joint assessments, planning sessions, implementation & monitoring activities, preparedness and response plans, with other sectors?

2. a). In your opinion, how effective were the ZACCEP/DMC structures in coordinating the project activities) **PROBE:** Did they facilitate effective participation and complementarity of all MDAs and international organisations?

3. a). What challenges were faced by the ZACCEP/DMC coordination mechanisms which affected the project? **PROBE:** Clarity of roles, funding issues, inconsistent membership, attendance, irregularity of meetings, duplication of roles, etc.

b). What could the structures and the 2nd VPO have done better to steer the project?

Section C: Effectiveness

1. In your opinion, which interventions had the most significant contribution to the elimination of cholera?

2. In your opinion, which factors (internal and external) facilitated or inhibited the achievement of the project's results? **PROBE:** What could have been done better?

3. a). Do you think all the WASH facilities (HW facilities, water vending points, taps, etc) and materials (buckets, chlorine tablets) that were constructed or given out through the project were easily accessible to the most vulnerable groups, eg people with disabilities, pregnant women, the elderly, children?

b). Did the facilities and materials benefit some locations more than others, eg urban than rural?

4. a) In your opinion, do you think the project interventions have led to the envisaged WASH practices and behavioural changes (with particular reference to HWWS at critical times, safe water and food handling, elimination of OD, regular and consistent use of improved latrines and early care seeking)?

PROBE: What have been the success or constraining factors? Which groups have been most difficult to change and why?

5. Has the formulation of environmental health and food hygiene regulations reduced cholera risk? **PROBE:** Is there compliance? What have been the challenges in enforcing them?

Section D: Impact

1. Has the project contributed to the reduction of the time taken by MoH to detect, respond and report on cholera cases? **PROBE:** How? Any figures to back this?
2. a). In your opinion, do you think the project has resulted in the knowledge and wider acceptance of ZACCEP?
b). Has it influenced in the increase in budget allocations to the ZACCEP?
PROBE: What else has it influenced?
- c). Are there any unanticipated positive results from the project?

Section E: Sustainability

1. In your opinion, do you think the gains achieved by this project (infrastructural, capacities, law enforcement, inspections, regulations, etc) will be sustained?
PROBE: Which gains will not be sustained? Which ones will be sustained in the short term, and long terms, and why?
2. a). How successful was the project in strengthening the capacity of the EH department and that of the respective beneficiary communities (shehias, schools, health facilities)? **PROBE:** Capacity in terms of knowledge & skills, mobility, funding, supplies, etc
b). Is this capacity sufficient to sustain the gains achieved under this project?
c). Will the ministry be able to sustain the WASH-MIS system beyond this project? What are the potential challenges?
3. In your opinion, what are the extra-ordinary initiatives/ good practices that emerged from implementing the programme (activities, results, technologies, approaches, etc? How can these be scaled up?

Key Informant Guide: Ministry of Health (Health Promotion Unit)

Section 1: Coverage

1. For the SBCC component, all the 11 districts of Zanzibar were chosen. So how did you make sure that the informational and educational messages reached out to everyone? **PROBE:** How did you ensure that the most at-risk and vulnerable locations and beneficiaries were not left out? I.e. High risk groups, those without access to TV, radio and newspapers? Were messages tailored to the different high risk groups?
2. Do you think the SBCC interventions for the project were adequate to cover the needs?
3. a). Apart from awareness raising, were there other interventions that were aimed at strengthening social norms at household, community and societal levels? Were there risk communication and community engagement (RCCE) initiatives? What were they?
b). What participatory tools were used to engage communities? **PROBE:** What innovative approaches and tools were used?
c). How, and what community networks, wider social platforms and key influencers were harnessed?
d). What channels were used and how effective were they?
c). How did you reach out to children and how did you ensure that the messages were child-friendly?

Section 2: Coherence

1. Were there any efforts made to ensure that SBCC interventions were integrated or collaborative with other sectoral programs (Health, Nutrition, Education, Protection)? **PROBE:** Was there any joint planning, programming, implementation & monitoring activities,?
2. a). In your opinion, how effective were the ZACCEP/DMC structures in coordinating the project, in particular SBCC activities) **PROBE:** Did they facilitate effective participation and complementarity of all MDAs and international organisations?
3. a). What challenges were faced by the ZACCEP/DMC coordination mechanisms which affected the project, in particular SBCC interventions? **PROBE:** Clarity of roles, funding issues, inconsistent membership, attendance, irregularity of meetings, duplication of roles, etc.
b). What could the structures and the 2nd VPO have done better to steer the project?

Section 3: Effectiveness

1. a) In your opinion, do you think the SBCC interventions led to the envisaged WASH practices and behavioural changes (with particular reference to HWWS at critical times, safe water and food handling, elimination of OD, regular and consistent use of improved latrines and early care seeking)? **PROBE:** Were there any mechanisms to measure the changes? At what level?
b). What have been the success or constraining factors? Which groups have been most difficult to change and why? What could have been done better?
c). In your opinion, which SBCC interventions had the most significant contribution to behaviour changes?
2. a). Do you think all the WASH facilities (HW facilities, water vending points, taps, etc) and materials (buckets, chlorine tablets) that were constructed or given out enabled/facilitated the required WASH behaviours? What were the gaps?

Section 4: Impact

1. 2. a). In your opinion, do you think the project has resulted in the knowledge and wider acceptance of ZACCEP?
PROBE: What else has it influenced?

c). Are there any unanticipated positive results from the project?

Section 5: Sustainability

1. In your opinion, do you think the behavioural changes achieved by this project will be sustained? Will SBCC activities continue, even when there is no cholera?

PROBE: Which activities and behaviours will be difficult to sustain, and why? Which ones do you think will be sustained in the short term, and long terms, and why?

2. a). How successful was the project in strengthening the capacity of community structures/ networks, such as Community Health Volunteers, to continue promoting the required WASH behavioural changes)? **PROBE:** Capacity in terms of skills, participatory materials, mobility, funding, supplies, etc

b). Is this capacity sufficient to sustain the knowledge gains and behavioural changes achieved under this project? What are the gaps?

3. a). In your opinion, what are the extra-ordinary initiatives/ good practices that emerged from implementing the programme (activities, results, technologies, approaches, etc?

b). How can these be scaled up?

Key Informant Guide: Ministry of Health (CTC/CTU Health Care Workers)

Section 1: Coverage

1. a). What criteria was used to choose the HCF to be a CTC/CTU?
- b). What is the maximum number of cholera patients catered for by this center (males and females)? Is this adequate for the needs, based on the last epidemic?
2. a). What support did you receive from the project? **PROBE:** Any documentary evidence, or availability of supplies? Was the support adequate?
- b). How many health care workers in this facility have been trained in cholera case management? **PROBE:** Who trained them and when? Is the number sufficient to run the CTU during an outbreak?
- 3). a). Are there separate toilets and HWF for patients and staff?
- b). Is soap always available at the facilities?

Section 2: Coherence

1. Were there any efforts made to ensure that surveillance and case management was integrated or collaborative with other sectoral programs (WASH, Nutrition, Education, Protection)?

Section 3: Effectiveness

2. a) In your opinion, how effective have been this CTC/CTU in managing cholera cases? **PROBE:** Average admission days, etc
- b) Have the units contributed to the elimination of cholera in Zanzibar? **PROBE:** Does the facility have treated water? Is there sound IPC practices? Have staff been trained in IPC, including hand hygiene? Find out if there are aware of the minimum IPC standards.

Section 4: Impact

1. In what ways do you think the project contributed to the reduction of the time taken by MoH to detect, respond and report on cholera cases? **PROBE:** Any documentary evidence?

Section 5: Sustainability

1. a). In your opinion, how do you think the CTC/CTUs will be affected when the project and support from UNICEF ends? why? How will the facilities cope?
- b). What challenges are the facilities still facing that may hinder the management of cholera patients in an emergency?

Key Informant Guide: ZACCEP Steering Committee (2nd VPO)

Section 1: Coverage

1. How were the operational districts, shehias and beneficiaries for the project selected? 2. Were the project interventions adequate to cover the needs?

PROBE: How did you ensure that the most needy and vulnerable locations and beneficiaries were not left out?

3. Do you think the interventions for the project were adequate to cover the needs?

4). a). How were the stakeholders for the project selected?

b). In your opinion, are there any stakeholders you think were left out, who would have added value to the project?

Section 2: Coherence

1. What efforts, if any, were made to ensure that the project integrated cholera elimination into other sectoral plans/ interventions (Education, Health, Nutrition, Protection)? **PROBE:** Were there any joint assessments, planning sessions, implementation & monitoring activities, preparedness and response plans, with other sectors?

2. a). In your opinion, how effective were the ZACCEP structures in coordinating the project activities)

PROBE: Did they facilitate effective participation and complementarity of all MDAs and international organisations?

3. a). What challenges were faced by the ZACCEP/DMC coordination mechanisms which affected the project? **PROBE:** Clarity/ duplication of roles, funding issues, inconsistent membership, attendance, irregularity of meetings, duplication of roles, etc.

b). What could the 2nd VPO have done better to steer the project?

Section 3: Effectiveness

1. How, and to what extent has the project contributed to eliminating cholera, and to effective multi-sectoral coordination and collaboration?

Section 4: Impact

1. a). Has the project resulted in the knowledge and wider acceptance of ZACCEP?

b). Has it influenced in the increase in budget allocations to the ZACCEP? **PROBE:** What else has it influenced?

c). Are there any unanticipated positive results from the project?

Section 5: Sustainability

1. a). In your opinion, do you think the ZACCEP coordination structures will be as effective as they are in coordinating cholera preparedness and response after the project ends? **PROBE:** Funding, participation and attendance, restructuring of government, etc

b). What measures were put in place to ensure the functionality of the after the project ends?

c). Are these measures so far working as planned?

2. a). To what extent did the project manage to address any capacity gaps within your office, and the ZACCEP coordination structures? **PROBE:** Training, funding, human resources, mobility, etc

b). What were the gaps, and how could these have been addressed?

3. a). What were the good practices and lessons that were learnt during the course of this project, if any?

- b). Were there any mechanisms to capture and share knowledge, good practices and lessons learnt?
What were these?
- c) How did the new knowledge, good practices and lessons learnt inform ongoing programming?
- d). How will this new knowledge, good practices and lessons learnt inform the future of ZACCEP?

Key Informant Guide: Zanzibar Water Authority (ZAWA)

Section 1: Coverage

1. a). How did the project assist your department in increasing its coverage?
- b). Is the current coverage enough to meet the current demand?

PROBE: What is the daily production vis a vis the daily demand? If there are gaps, how is it being filled? What are the constraining factors for meeting the daily demand, and why were these not addressed?

- c). In your opinion, do you think that there the most needy and vulnerable location and users are not being served?

Section 2: Effectiveness

1. In your opinion, what support did you receive from the project that had the most significant contribution to the elimination of cholera in Zanzibar?
2. Do you think all the all the support, materials and chemicals were the most appropriate to your needs? Was the support adequate? What could have been done better?
3. Were there mechanisms to share the results of water quality monitoring with users? How effective were these mechanisms? What were the gaps?
4. How has the project assisted you in improving solid and waste water management in your respective areas? What challenges persist that can predispose consumers to cholera?

Section 3: Sustainability

1. In your opinion, how do you think ZAWA will be affected from the time the project comes to an end in December? **PROBE:** Chlorination of water, mobility, staffing, leakages, refuse collection, etc. How will the gaps be filled?
2. What measures, if any, were put in place by the project to ensure that most of your services will continue in the short, medium and long term, when the project ends?
3. a). What were the good practices and lessons that were learnt during the course of this project, if any?
- b). Were there any mechanisms to capture and share knowledge, good practices and lessons learnt? What were these?
- c) How did the new knowledge, good practices and lessons learnt inform ongoing programming?
- d). How will this new knowledge, good practices and lessons learnt inform the future operations of ZAWA?

Section 1: Coverage

1. How did you get to know about the project and ZACCEP?
2. a). How was your school selected to be part of the program?
b). Do you think that there are other needy schools in your district that were left out?
3. a) What support did you receive from the project?
b). Was the support adequate to cover the WASH/ cholera needs?
c). How did you ensure that the support you received benefited both boys and girls, and that it did not leave out the most vulnerable?
4. Student to squat pan ratio, for girls and for boys? (observation).

Section 2: Effectiveness

1. a) How did your school promote hygienic practices amongst the students?
PROBE: hygiene clubs, IEC materials, edutainment, school curricula, etc
b) In your opinion, do you think the hygiene promotion interventions led to the envisaged WASH practices and behavioural changes (with particular reference to HWWS at critical times, safe water and food handling, regular and consistent use of improved latrines and early care seeking)? **PROBE:** Were there any mechanisms to measure the changes?
b). What have been the success or constraining factors? Is it boys, or girls who have been most difficult to change and why? What could have been done better?
c). In your opinion, which school hygiene promotion interventions had the most significant contribution to the behavioural changes?
2. a). Do you think all the WASH facilities (HW facilities, toilets) and materials that you received through the project were appropriate for their use? Are they easily accessible and used by the girls, boys and children with disabilities?

Section 5: Sustainability

1. In your opinion, do you think the SWASH Club activities and behavioural changes achieved so far through this project will be sustained?
PROBE: Which activities and behaviours will be difficult to sustain, and why? Which ones do you think will be sustained in the short term, and long term, and why?
2. a). Do you think your school will be able to maintain and repair the installed facilities on its own without any external support?
b). Where will the funds come from?
PROBE: Does the school have a separate budget for WASH? Where do the spares come from? Are they affordable? Are the skills for the repairs available locally?
3. a). In your opinion, what are the extra-ordinary initiatives/ good practices that emerged from your school under this project (activities, results, technologies, approaches, etc?)
b). How can these be scaled up in other schools?

Key Informant Guide: Disaster Management Commission (DMC)

Section 1: Coverage

1. How were the operational districts, shehias and beneficiaries for the project selected? 2. Were the project interventions adequate to cover the needs?

PROBE: How did you ensure that the most needy and vulnerable locations and beneficiaries were not left out?

3. Do you think the interventions for the project were adequate to cover the needs?

4). a). How were the stakeholders for the project selected?

b). In your opinion, are there any stakeholders you think were left out, who would have added value to the project?

Section 2: Coherence

1. What efforts, if any, were made to ensure that the project integrated cholera elimination into other sectoral plans/ interventions (Education, Health, Nutrition, Protection)? **PROBE:** Were there any joint assessments, planning sessions, implementation & monitoring activities, preparedness and response plans, with other sectors?

2. a). In your opinion, how effective were the DMC structures in coordinating the project activities)

PROBE: Did they facilitate effective participation and complementarity of all MDAs and international organisations?

3. a). What challenges were faced by the DMC structures which affected the project? **PROBE:** Clarity/ duplication of roles, funding issues, inconsistent membership, attendance, irregularity of meetings, duplication of roles, etc.

b). What could the 2nd VPO have done better to steer the project?

Section 3: Effectiveness

1. How, and to what extent has the project contributed to eliminating cholera, and to the three pillars of the ZACCEP?

2. What challenges did you face/are you still facing that may affect the prevention and management of cholera?

Section 4: Impact

1. a). Has the project resulted in the knowledge and wider acceptance of ZACCEP?

b). Has it influenced in the increase in budget allocations to the ZACCEP? **PROBE:** What else has it influenced?

c). Are there any unanticipated positive results from the project?

Section 5: Monitoring

1. Which monitoring systems and tools have been developed to monitor and evaluate the progress and impact of the project? Were they adequately used in an effective manner? How can they be improved?

2. Will the DMC continue using the tools after the project ends? **PROBE:** What could be the potential gaps and challenges?

3. What was the extent of monitoring, collection, analysis and use of disaggregated data (sex, geographical location, urban versus rural)?

Section 6: Sustainability

1. a). In your opinion, do you think the DMC structures will be as effective as they are in coordinating cholera preparedness and response after the project ends? **PROBE:** Funding, participation and attendance, restructuring of government, etc
- b). What measures were put in place to ensure the functionality of the after the project ends?
- c). Are these measures so far working as planned?
2. a). To what extent did the project manage to address any capacity gaps within your office, and the DMC structures? **PROBE:** Training, funding, human resources, mobility, etc
- b). What were the gaps, and how could these have been addressed?
3. a). What were the good practices and lessons that were learnt during the course of this project, if any?
- b). Were there any mechanisms to capture and share knowledge, good practices and lessons learnt? What were these?
- c). How did the new knowledge, good practices and lessons learnt inform ongoing programming?
- d). How will this new knowledge, good practices and lessons learnt inform the future of DMC?

Key Informant Guide: Implementing Partners

Section 1: Coverage

1. How were the operational districts, shehias and beneficiaries for the project selected?

PROBE: How did you ensure that the most needy and vulnerable locations and beneficiaries were not left out?

2. Do you think the interventions for the project were adequate to cover the needs?

3. How were the stakeholders for the project selected? In your opinion, are there any stakeholders you think were left out, who would have added value to the project?

Section 2: Coherence

1. What efforts, if any, were made to ensure that the project integrated cholera elimination into other sectoral plans/ interventions (Education, Health, Nutrition, Protection)? **PROBE:** Were there any multi-sectoral joint assessments, planning sessions, implementation, monitoring and preparedness and response plans?

2. What coordination mechanisms were put in place or supported by the project?

PROBE: How were they supported? Did the structures carry out their mandate as envisaged? What value did they bring? Do you think they will they continue functioning after the project?

3. a). What challenges were faced by the ZACCEP/DMC coordination mechanisms and 2nd VPO which affected the project? **PROBE:** Clarity of roles, funding issues, inconsistent membership, attendance, irregularity of meetings, duplication of roles, etc.

b). What could the structures and the 2nd VPO have done better to steer the project?

Section 3: Effectiveness

1. What interventions do you think had the most significant contributions to the elimination of cholera, and why?

2. What factors facilitated or inhibited the achievement of the project's results?

PROBE: Internal and external factors?

Section 4: Monitoring Issues

1. a). Which monitoring systems and tools have been developed to monitor and evaluate the progress and impact of the project?

b). In your opinion, were they adequately used in an effective manner?

c). How could these tools, and their use be improved?

2. a). Were there any mechanisms to capture and share knowledge, good practices and lessons learnt?

b). How did the new knowledge, good practices and lessons learnt inform ongoing programming?

Section 5: Gender, Equity, Disability and Human Rights

1. a). In your opinion, how did the project cater for the different needs of the diverse groups: men, women, boys, girls and people living with disabilities?

b). Did you think the results of the project benefit all these groups equally?

PROBE: Were WASH and Health facilities and services friendly to all gender groups and to people with disabilities?

c). Did it impact more on one gender than the other?

d). Did women also have influential positions in decision making bodies eg ZACCEP Steering Committee and Task Force, Religious Leaders, Shehias Leaders, SWM Groups, etc?

e). Did the burden of responsibilities fall more on one gender than the others?

d). What was the extent of monitoring, collection, analysis and use of disaggregated data. **PROBE:** sex, geographical location, urban versus rural?

Section 6: Sustainability Issues

1. Does the project have an Exit Strategy? If so, how was it developed?

PROBE: Did it involve wider consultations with key stakeholders, donors and beneficiaries? How has been its implementation so far?

2. a). What other measures were put in place to ensure continuation of activities after the project ends?

b). Are these measures so far working as planned?

3. a). Are there any extra-ordinary initiatives/ good practices/ innovations that emerged during implementation of the programme? **PROBE:** These could be activities, results, technologies, approaches, etc?

b). In your opinion, how can these be scaled up?

4. What were the lessons that were learnt, if any, during the course of the project?

Key Informant Interview Guide: Water Vendors

Section 1: Coverage

1. How were you selected to participate in this project?
2. Are your services enough to cover the daily demands? PROBE: Daily demand versus supply
3. a). What is the cost of your water?
b). Is the cost enough to cover your recurrent costs?
c) Is the cost not prohibitive enough that the most vulnerable people do not afford it? Those who do not afford, where do they get their water?
3. How did you get to know about the project and ZACCEP?

Section 2: Effectiveness

1. a). What support/ interventions did you receive through the project (training, supplies, infrastructure)?
b). In your opinion, did this support lead to the elimination of cholera? If so how?
c). Was the support adequate; what was missing?
d). What challenges did you face/are you still facing that may affect to prevent and manage cholera? How will these be resolved?
2. How has the formulation of environmental health and food hygiene regulations affected your work? PROBE: What are these regulations? Do you comply or you evade them? What's the bearing on the water users, and on elimination of cholera?

Section 3: Sustainability

1. In your opinion, how do you think your services will be affected from the time the project comes to an end in December? PROBE: Chlorination of water, training, etc. How will the gaps be filled?
2. What measures, if any, were put in place by the project to ensure that most of your services will continue in the short, medium and long term, when the project ends?
3. What were the good practices and lessons that you learnt during the course of this project, if any?
4. a). What capacity gaps did you have that have been addressed by the project?
b). How were these capacity gaps strengthened?
c). Do you think this will result in sustaining the activities after the project ends?

Section 4: Monitoring

1. a). Were there any tools you used for monitoring your activities during the course of the project ? PROBE: Tools to monitor water quantity and quality, number of users, etc
b). How can they be improved?

Key Informant Interview Guide: Religious Leaders

Section 1: Coverage

1. How did you get to know about the project and ZACCEP?
2. a). Are you aware of how the operational shehias and beneficiaries for the project were selected? Do you think that there were the most needy and vulnerable shehias and beneficiaries who were left out?
- b). How were you selected to become part of this programme?

Section 2: Effectiveness

1. a). What support/ interventions did you receive through the project (training, supplies, infrastructure)?
- b). Do you think the support was adequate? What was missing?
- c). How effective did you use this support to reach out to your wider audiences/ members? **PROBE:** What strategies did you use to get the messages across? And to influence your members towards cholera prevention and control? Did you have work plans, or any participatory tools and IEC materials? How effective were the strategies? What didn't work, and why?
2. a) In your opinion, do you think your activities led to the envisaged WASH practices and behavioural changes (with particular reference to HWWS at critical times, safe water and food handling, elimination of OD, regular and consistent use of improved latrines and early care seeking)? **PROBE:** Were there any mechanisms to measure the changes? At what level?
- b). Were there any efforts made by public and government officials to dispel any rumours and community concerns about cholera? What channels were used? Were these effective? What concerns, rumours and religious beliefs still exist?
- c). What have been the success or constraining factors to change your congregation's behavioural practices? Which groups have been most difficult to change and why? What could have been done better?
- d). In your opinion, which of the religious activities had the most significant contribution to the behavioural changes, and to the elimination of cholera?
3. What challenges did you face/are you still facing that may affect your role as Leaders in your respective religious groups? How will these be resolved?

Section 3: Monitoring

1. a). Were there any tools you used for monitoring your activities during the course of the project ? **PROBE:** Tools to monitor number of promotional materials distributed, audiences, attendees, etc
- b). How can these tools be improved?

Section 4: Sustainability

1. In your opinion, how do you think your activities will be affected from the time the project comes to an end in December? **PROBE:** Availability of promotional materials, transportation, incentives, etc. How will the gaps be filled?
2. What measures, if any, were put in place by the project to ensure that most of your activities will continue in the short, medium and long term, when the project ends?
3. What were the good practices and lessons that you learnt during the course of this project, if any?
- 4). Do you think you are well equipped and have enough capacity to sustain your activities after the project ends?

Key Informant Interview Guide: Shehias Leaders

Section 1: Coverage

1. How did you get to know about the project and ZACCEP?
2. a). Are you aware of how the operational shehias and beneficiaries for the project were selected? Do you think that there were the most needy and vulnerable shehias and beneficiaries who were left out?
- b). How were you selected to become part of this programme?

Section 2: Effectiveness

1. a). What support/ interventions did you receive through the project (training, supplies, infrastructure)?
- b). Do you think the support was adequate? What was missing?
- c). How effective did you use this support to reach out to your community members? **PROBE:** What strategies did you use to influence your members towards cholera prevention and control? Did you have work plans, or any participatory tools and IEC materials? How effective were the strategies? What didn't work, and why?
2. a) In your opinion, do you think your activities led to the envisaged WASH practices and behavioural changes in your respective communities (with particular reference to HWWS at critical times, safe water and food handling, elimination of OD, regular and consistent use of improved latrines and early care seeking)? **PROBE:** Were there any mechanisms to measure the changes? At what level?
- b). What have been the success or constraining factors? Which groups have been most difficult to change and why? What could have been done better?
- c). In your opinion, which of the community activities had the most significant contribution to the behavioural changes, and to the elimination of cholera?
3. What challenges did you face/are you still facing that may affect your role as Leaders in your respective communities? How will these be resolved?

Section 3: Monitoring

1. a). Were there any tools you used for monitoring your activities during the course of the project ? **PROBE:** Tools to monitor number of promotional materials distributed, audiences, attendees, etc
- b). How can these tools be improved?

Section 4: Sustainability

1. In your opinion, how do you think your activities and your roles in cholera prevention will be affected from the time the project comes to an end in December? **PROBE:** Availability of promotional materials, transportation, incentives, etc. How will the gaps be filled?
2. What measures, if any, were put in place by the project to ensure that most of your activities/ roles in cholera prevention will continue in the short, medium and long term, when the project ends?
3. What were the good practices and lessons that you learnt during the course of this project, if any?
- 4). Do you think you are well equipped and have enough capacity to sustain your activities/roles after the project ends?

Key Informant Interview Guide: Community Health Volunteers

Section 1: Coverage

1. How did you get to know about the project and ZACCEP?
2. a). Are you aware of how the operational shehias and beneficiaries for the project were selected? Do you think that there were the most needy and vulnerable shehias and beneficiaries who were left out?
b). How were you selected to become part of this programme?

Section 2: Effectiveness

1. a). What support/ interventions did you receive through the project (training, supplies, materials)?
b). Do you think the support was adequate? What was missing?
c). How effective did you use this support to reach out to your wider audiences, including individual households? **PROBE:** What strategies did you use to get information across (door-to-door, health clubs, demonstrations)? And to influence and rally your respective communities towards cholera prevention and control? Did you have work plans, or any participatory tools and IEC materials? How effective were the strategies? What didn't work, and why?
2. a) In your opinion, do you think your activities led to the envisaged WASH practices and behavioural changes (with particular reference to HWWS at critical times, safe water and food handling, elimination of OD, regular and consistent use of improved latrines and early care seeking)? **PROBE:** Were there any mechanisms to measure the changes? At what level? Are chlorine tablets available, where, and at what price?
b) Were there any efforts made by public and government officials to dispel any rumours and community concerns about cholera? What channels were used? Were these effective? What concerns, rumours and beliefs still exist?
c). What have been the success or constraining factors to change the community's behavioural practices? Which groups have been most difficult to change and why? What could have been done better?
d). In your opinion, which of the community activities had the most significant contribution to the behavioural changes, and to the elimination of cholera?
3. a). Do you think all the WASH facilities (HW facilities, water vending points, taps, etc) and materials (buckets, chlorine tablets) that were constructed or given out enabled the required WASH behaviours? What were the gaps?
4. What challenges did you face/are you still facing that may affect your role as CHVs in your respective communities? How will these be resolved?

Section 3: Monitoring

1. a). Were there any tools you used for monitoring your activities during the course of the project ? **PROBE:** Tools to monitor behavioural changes, HH WASH facilities, HH visits, construction of latrines, promotional materials distributed, audiences reached, attendees, etc. Did the tools collect disaggregated data?
b). How can these tools be improved?

Section 4: Sustainability

1. To what extent do you think yourselves and the affected communities were engaged in the cholera control response throughout the process, from planning and surveillance to implementation and

monitoring? **PROBE:** What processes were you engaged in? Which ones were you not? How could you have been better engaged? Were there any feedback mechanisms)

2. In your opinion, how do you think your activities/ roles will be affected from the time the project comes to an end in December? **PROBE:** Availability of promotional materials, transportation, incentives, etc. How will the gaps be filled?

3. What measures, if any, were put in place by the project to ensure that most of your activities will continue in the short, medium and long term, when the project ends?

4. Do you think you are well equipped and have enough capacity to sustain your roles after the project ends? What is missing?

FGD Guide: Solid Waste Management Groups

Section 1: Coverage

1. How did you get to know about the project and ZACCEP?
2. How were you selected to become part of this project?

Section 2: Effectiveness

1. a). What support/ interventions did you receive through the project (training, supplies, materials)? What WASH services were availed? Were the services accessible to the most vulnerable groups?
b). Do you think the support was adequate? What was missing?
c). How effective did you use this support to the management of solid waste in your respective communities? **PROBE:** What pilots are you implementing? Who is benefiting from your pilots, and how?
d). To what extent do you think all your pilots are leading to the elimination of cholera?
2. What challenges did you face/are you still facing that may affect your pilot activities? How will these be resolved?

Section 3: Sustainability

1. In your opinion, how do you think your pilot activities on SWM will be affected from the time the project comes to an end in December? **PROBE:** Technical support, funding, materials, transportation, incentives, etc. How will the gaps be filled?
2. What measures, if any, were put in place by the project to ensure that your pilot projects will continue when the project ends?
3. What were the good practices and lessons that you learnt during the course of implementing your pilot projects, if any?
- 4). Do you think you are well equipped and have enough capacity to sustain your pilots after the project ends? What is missing?

Section 4: Monitoring

1. a). Were there any tools you used for monitoring your pilot activities during the course of the project? **PROBE:** Tools to monitor amount of refuse collected, number of HHs, , etc.
b). How can these tools be improved?

Section 1: Coverage

1. How did you get to know about the project and ZACCEP?
2. a). Are you aware of how the operational shehias and beneficiaries for the project were selected? Do you think that there were the most needy and vulnerable shehias and beneficiaries who were left out?
b). How were you selected to become part of this programme?
c). What were your roles in this project?

Section 2: Effectiveness

1. a). What support/ interventions did you receive through the project (training, supplies, infrastructure)? **PROBE:** What communication materials were received? Were these relevant? Which WASH and Health services were availed, and were they accessible to the most vulnerable groups?
b). Do you think the support was adequate? What was missing?
c). How effective did you use this support to reach out to your community members? **PROBE:** What strategies did you use to influence your members towards cholera prevention and control? Did you have work plans, or any participatory tools and IEC materials? How effective were the strategies? What didn't work, and why?
2. a) How has the project activities improved your knowledge and WASH practices?
PROBE: Ask what key cholera prevention and control messages they can recall (what is cholera, how it can be prevented, why, when and where to seek help, and how to care for family members with diarrhoea). Let them mention the 5 critical times for hand washing. Ask a volunteer to demonstrate how to wash hands. Ask about how food and water is properly handled, including how water is treated. Are chlorine tablets available, where, and at what price?
PROBE: Were there any mechanisms to measure the changes? At what level?
b) Were there any efforts made by public and government officials to dispel any rumours and community concerns about cholera? What channels were used? Were these effective? What concerns and rumours still exist?
c). What have been the success or constraining factors? Which groups have been most difficult to change and why? What could have been done better?
d). In your opinion, which of the community activities had the most significant contribution to the behavioural changes, and to the elimination of cholera?
3. What challenges did you face/are you still facing that may affect your roles in your respective communities? How will these be resolved?

Section 3: Sustainability

1. To what extent do you think your committee and affected communities were engaged in the cholera control response throughout the process, from planning and surveillance to implementation and monitoring? **PROBE:** What processes were you engaged in? Which ones were you not? How could you have been better engaged? Were there any feedback mechanisms?
2. In your opinion, how do you think your activities and your roles in cholera prevention will be affected from the time the project comes to an end in December? **PROBE:** Availability of promotional materials, transportation, incentives, etc. How will the gaps be filled?
3. What measures, if any, were put in place by the project to ensure that most of your activities/ roles in cholera prevention will continue in the short, medium and long term, when the project ends?
4. What were the good practices and lessons that you learnt during the course of this project, if any?
- 5). Do you think you are well equipped and have enough capacity to sustain your activities/roles after the project ends?

Section 4: Monitoring

1. a). Were there any tools you used for monitoring your activities during the course of the project ?
PROBE: Tools to monitor number of promotional materials distributed, audiences, attendees, etc
- b). How can these tools be improved?

FGD Guide: School Children/ SWASH Clubs (Girls)

UNICEF Tanzania has commissioned Muthengo Development Solutions to conduct an evaluation regarding your perceptions on how the 'Zanzibar Towards a Cholera-Free Nation' project is performing in preventing cholera, particularly at your school. We want to ask questions about your school experiences, with regards to water, sanitation and hygiene. Any response that you provide to my questions will be kept confidential. No specific information about you will be shared with third parties. We will conduct our analysis based on an anonymized dataset. Your participation in the survey is entirely voluntary. If at any point there are any questions you do not feel comfortable answering, you can choose not to answer them. You can also choose to stop the discussion at any point if the issues make you uncomfortable. The discussions will take 45 minutes at most.

Section 1: Coverage

1. Have you heard about the ZACCEP? From who, and what is it about?
2. a). How and why do you think your school was selected to be part of the program?
3. a) What support did you receive from the project?
b). Do you think the support was adequate to cover the school's WASH/ cholera needs? What was missing?
c) Did the support benefit all the students? Or boys more than girls?

Section 2: Effectiveness

1. a) How do students in your school get to learn about water, sanitation and hygiene issues? **PROBE:** SWASH Club, school curriculum, School Health Teachers, IEC materials. How many members, what activities are involved in the SWASH Clubs, and how do they disseminate information to other students?
b). How does one become a member of the SWASH club?
c) How has your school hygiene promotion activities improved your knowledge and WASH practices?
PROBE: Ask what key cholera prevention and control messages they can recall (what is cholera, how it can be prevented, why, when and where to seek help, and how to care for family members with diarrhoea). Let them mention the 5 critical times for hand washing. Ask a volunteer to demonstrate how to wash hands. Ask about how food (5 keys to safe food) and water is properly handled (transportation, storage, withdrawal), including how water is treated.
2. Are there any materials that the school or club received to assist in educating students on issues of hygiene? Have these been effective? What are the gaps?

Section 3: Gender, Equity, Disability and Human Rights

1. a). Are there separate toilets and hand washing facilities for girls, boys and teaching staff?
b) How many toilets/ drop holes and hand washing stations are there for girls? Do you think these are enough? Why?
c) Is soap and water always available at the HW stations? If not, what do you use?
d) Do the toilets have lockable doors and do you feel comfortable in using them, even when you are on your menses? Is your security guaranteed when using the toilets? Why? What don't you like about the toilets? What is missing?
e) Are the toilets and HW stations accessible to wheelchair bound students?
f) Are the toilets always clean? Who cleans them and how often are they cleaned?
2. a) Where do students get water for drinking while at school?
c) How far is the water source and is water always available? Is the water treated?
3. Does the school provide sanitary pads for girls who are on their menses? What challenges are girls on their menses facing?

Section 5: Sustainability

1. In your opinion, do you think the hygiene promotion activities, including those of your club, will continue even when the project comes to an end?

PROBE: Which activities will be sustained or not sustained in the short term, and long term, and why?

2. a). Do you think your school will be able to maintain and repair the installed facilities on its own without any external support? Are students involved in the maintenance of the facilities? Did you receive any training on the use and maintenance of the facilities?

b). Where will the funds come from?

3. a). In your opinion, what are the extra-ordinary initiatives regarding water, sanitation and hygiene that your club or school did?

b). How do you think these be scaled up in other schools?

FGD Guide: School Children/ SWASH Clubs (Boys)

UNICEF Tanzania has commissioned Muthengo Development Solutions to conduct an evaluation regarding your perceptions on how the 'Zanzibar Towards a Cholera-Free Nation' project performed in preventing cholera, particularly at your school. We want to ask questions about your school experience, with regards to water, sanitation and hygiene. Any response that you provide to my questions will be kept confidential. No specific information about you will be shared with third parties. We will conduct our analysis based on an anonymized dataset. Your participation in the survey is entirely voluntary. If at any point there are any questions you do not feel comfortable answering, you can choose not to answer them. You can also choose to stop the discussion at any point if the issues make you uncomfortable. The discussions will take 45 minutes at most.

Section 1: Coverage

1. Have you heard about the ZACCEP? From who, and what is it about?
2. a). How and why do you think your school was selected to be part of the program?
3. a) What support did you receive from the project?
b). Do you think the support was adequate to cover the school's WASH/ cholera needs? What was missing?
c) Did the support benefit all the students? Or boys more than girls?

Section 2: Effectiveness

1. a) How do students in your school get to learn about water, sanitation and hygiene issues? **PROBE:** SWASH Club, school curriculum, School Health Teachers, IEC materials. How many members, what activities are involved in the SWASH Clubs, and how do they disseminate information to other students?
b). How does one become a member of the SWASH club?
c) How has your school hygiene promotion activities improved your knowledge and WASH practices?
PROBE: Ask what key cholera prevention and control messages they can recall (what is cholera, how it can be prevented, why, when and where to seek help, and how to care for family members with diarrhoea). Let them mention the 5 critical times for hand washing. Ask a volunteer to demonstrate how to wash hands. Ask about how food and water is properly handled, including how water is treated.
2. Are there any materials that the school or club received to assist in educating students on issues of hygiene? Have these been effective? What are the gaps?

Section 3: Gender, Equity, Disability and Human Rights

1. a). Are there separate toilets and hand washing facilities for girls, boys and teaching staff?
b) How many toilets/ drop holes and hand washing stations are there for boys? Do you think these are enough? Why?
c) Is soap and water always available at the HW stations? If not, what do you use?
d) What don't you like about the toilets? What is missing?
e) Are the toilets and HW stations accessible to wheelchair bound students?
f) Are the toilets always clean? Who cleans them and how often are they cleaned?
2. a) Where do students get water for drinking while at school?
c) How far is the water source and is water always available? Is the water treated?

Section 5: Sustainability

1. In your opinion, do you think the hygiene promotion activities, including those of your club, will continue even when the project comes to an end?

- PROBE:** Which activities will be sustained or not sustained in the short term, and long term, and why?
2. a). Do you think your school will be able to maintain and repair the installed facilities on its own without any external support? Are students involved in the maintenance of the facilities? Did you receive any training on the use and maintenance of the facilities?
 - b). Where will the funds come from?
 3. a). In your opinion, what are the extra-ordinary initiatives regarding water, sanitation and hygiene that your club or school did?
 - b). How do you think these be scaled up in other schools?

Observation Guide: Households

Water Supply

- Source of drinking water used by the household, if available on the premise
 - Improved
 - Unimproved
 - Type: Tap (Piped water), borehole, artesian well, dam, deep well, rainwater harvesting, sand abstraction, shallow well, spring
- Potential sources of contamination around the water source
 - Pit latrine, refuse pits, septic tank with 30m (if underground water source is used)
 - Check for presence of concrete apron and unblocked drainage channels
 - Pipe/ sewage leakages
 - Clogged soak away pits

Sanitation

- Type of toilet facility used
 - No facility
 - Improved
 - Unimproved
 - Type: Flush, pour flush, ventilated improved pit latrine, pit latrine without a slab, pit latrine a slab
- Is the toilet clean ("Clean" means that the floor, drop hole and walls of the toilet are visibly clean, and there are no faeces or urine on the floors or walls)?
 - Yes
 - No
- Does the household have a refuse pit?
 - Yes
 - No
- Are there signs of animal faeces around the yard?
 - Yes
 - No
- Are there signs of human faeces around the yard?
 - Yes
 - No

Water and food handling practices

- How is water transported from the source to the household (if applicable)?
 - Covered barrel, open barrel, covered bucket, pen bucket (narrow mouthed containers?)
- How is drinking water stored within the household?
 - Covered barrel, open barrel, covered bucket, pen bucket
- What is the condition of the stored water, if available? (Clean means absence of clay, mud, turbidity in water, things like dust, animal hair, insects and any visible residue, color objects in or on the surface of the water)
 - Visibly clean
 - Visibly dirty
- Where is the drinking water storage container placed within the household, if available?
 - Inside the house on a raised place
 - Inside the house on the floor
 - Outside the house on a raised place
 - Outside the house on the ground
 - Others (specify)
- How is the water drawn from the storage container (if applicable)?

- Using a ladle
- Using a single cup
- Using different cups for each user
- Other
- If cooked or left over food is available in the kitchen,
 - Is it separated from raw food?
 - Is it properly covered?
- Is there a dish rack at the household?
 - Yes
 - No
- Can domestic animals access utensils from the dish rack?
 - Yes
 - No

Handwashing practices

- Is there a specific hand washing station/area close to the toilet facility?
 - Yes
 - No
- Are soap and water available in the hand washing station/area?
 - Only Soap
 - Only Water
 - Both Soap and Water available
 - Both Soap and Water unavailable
 - Ash and water
 - Other(Specify).....

Observation Guide: Schools

Water Supply

- Source of drinking water for the school
 - Improved
 - Unimproved
 - Type: Tap (Piped water), borehole, artesian well, dam, deep well, rainwater harvesting, sand abstraction, shallow well, spring
- Is the source within the school yard?
 - Yes
 - No
- Potential sources of contamination around the water source
 - Pit latrine, refuse pits, septic tank with 30m (if underground water source is used)
 - For taps, check for presence of concrete apron
 - Pipe leakages
 - Clogged soak away pits

Sanitation

- Type of toilet facilities used
 - No facilities
 - Improved
 - Unimproved
 - Type: Flush, pour flush, ventilated improved pit latrine, pit latrine without a slab, pit latrine a slab
- Are the toilet facilities separate for girls, boys and teachers?
 - Yes
 - No
- Are the toilets adequate (students to drop hole ratio)?
 - Girls
 - Boys
- Are the toilets clean ("Clean" means that the floor, drop hole and walls of the toilet are visibly clean, and there are no faeces or urine on the floors)?
 - Yes
 - No
- Does the school have an incinerator?
 - Yes
 - No
- Are there signs of animal faeces around the school yard?
 - Yes
 - No
- Are there signs of human faeces around the school yard?
 - Yes
 - No

Handwashing practices

- Are there specific hand washing stations/areas close to the toilet facilities?
 - Yes
 - No
- Are soap and water available in the hand washing station/area?
 - Only Soap
 - Only Water
 - Both Soap and Water available
 - Both Soap and Water unavailable

- Ash and water
- Other(Specify).....

Observation Guide: Healthcare Facilities (CTC/CTU)

NB: If the CTU/CTC facilities are not present at the time of the evaluation, the team will rely on the KII interviews with healthcare workers

- Number of cholera beds available
 - Females.....
 - Males.....
- Presence of hand washing facilities at entry and exit points, at all the toilets?
 - For patients (indicate number)
 - For staff (indicate number)
- Is treated water available at the HW facilities at the time of the visit? (standard: 60 litres per patient per day and 15 litres per person per day for caregivers)
 - Yes
 - No
- Is soap available at the HW facilities?
 - Yes
 - No
- Are disinfecting materials available?
 - Yes
 - No
- Are toilets available within the facility? (standard 1 toilet/20patients)
 - For patients (indicate number, males and females)
 - For staff
- Are the toilets and the facility visibly clean?
 - Yes
 - No
- Are bathing facilities present? (standard 1 facility/40patients)
 - Yes (how many for males, females)...
 - No
- Is personal protective equipment eg short-sleeved top, trousers, boots, work overalls, reusable rubber gloves, heat resistant gloves, reusable plastic aprons, reusable face shields, etc) available for staff?
 - Yes (indicate type of equipment)
 - No
- Is a working incinerator available at the facility?
 - Yes
 - No
- Are charts on cholera treatment, including on hand hygiene available to guide health staff?
 - Yes
 - No
- Indicate the type and number of cholera supplies available in the facility?
 - Item..... Number.....
- Is hospital waste segregated (eg sharps, soft waste, organic waste, waste-waters, pathologic waste)?
 - Yes
 - No
- Is a footbath with an appropriate treatment solution available at the entrance, or there is an alternative method for spraying shoes?
 - Yes
 - No

Observation Guide: Food Vendor Markets

Visit food vendor markets within the project operational areas and observe the following: (also take photos)

Water Supply

- Is there a water source at the markets? What is the type?
- Is water available at the source at the time of the visit?
- Is the water free or users pay a fee? How much do they pay?
- Is the source protected and is the water visibly clean?
- Is the area around the source muddy? Is it clean?
- Is there a hand washing facility? Is it functional and is there water and soap at the facility?

Sanitation

- Are there toilets at the market?
- Are the toilets disaggregated by gender?
- Are the toilets free or users pay a fee? How much?
- Are the toilets working/ open?
- Are the toilets visibly clean?
- Are there bins where solid waste is collected? Are these too full/ overflowing?
- Are there signs of dumped/ uncollected garbage around the markets?

Food hygiene

- Do vendors sell cooked food?
 - Do the vendors sell fruits?
 - Are there areas where buyers wash their fruits before eating them?
 - Is the cooked food kept and sold hot?
 - Are flies visible around the food preparation areas?
 - Are areas where the food is sold visibly clean?
 - Do food vendors have uniforms and have their heads covered?
-