THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

NATIONAL MULTI-SECTORAL CHOLERA PREVENTION AND CONTROL PLAN 2023 - 2027

@2022 Edition

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PREFACE

Cholera remains a significant public health threat of concern in Tanzania. The first outbreak of cholera was reported in 1974 and over the years major epidemic have been noted in 1977 (1671 cases and 135 deaths with a case fatality rate (CFR) of 8.7%), 1992 (18,526 cases and 2173 deaths, CFR of 11.7%), and 1997 (40,226 cases and 2,268 deaths, CFR of 5.6%). The longest Cholera outbreak which started in August 2015 until December 2018 had recorded a total of **33,319** cases and 550 deaths (CFR 1.7%). Cholera continues to cause devastations to the population. In January 22, 2019, a new wave of cholera outbreak started again and until June 30, a total of 408 cases and 7 deaths (CFR 1.7%) were recorded. While in some instances, cases seem to be decreasing, but the epidemic has not been well controlled. In the first half of 2022, three outbreaks of cholera have been reported from three regions with a total of 435 cases and 8 deaths (CFR 1.8%). Hotspots areas keep on changing and in areas where there is sustained control, the country continues to have sporadic cases.

In 2019, the Ministry of Health, President's Office- Regional administration and Local Government; Ministry of Water; Prime Minister's Office together with the development partners recognized the need to end cholera in the country and to achieve the global goal of ending cholera, and unanimously agreed and developed a Multisectoral plan for Prevention and Control of Cholera. However, the plan has not been well implemented due to various reason including the disruption caused by COVID-19 pandemic and inadequate multisectoral commitment to drive its implementation.

The revision of the plan provided opportunity to address factors that affected implementation of the previous plan, build on the lesson learned from the COVID-19 pandemic response and on the identified gaps from the cholera After Action Review (AAR) and lessons learned during the recent responses in various Regions and Districts. The plan considers the National and Subnational levels, with priority of implementation to be based on hotspot approach (high, moderate and low risks areas), as it represents a significant step also towards the achievement of the SDGs to which Tanzania is a signatory.

This plan focuses on strengthening the multisectoral coordination and on other evidence-based priority interventions which include Surveillance, Case Management and Infection prevention and control, Laboratory, Water, Sanitation and Hygiene (WASH) and Social Mobilization and Community Engagement and incorporate assessment plan that could strengthen integration of oral cholera vaccine alongside side other intervention. These interventions aim to minimize morbidity and mortality by 90% and to prevent and contain cholera transmissions.
This five-year plan (2023 -2027) implementation will lay and strengthen foundation and a roadmap towards elimination of cholera in Tanzania and the achievement of the global goal of ending cholera by 2030.

Kassim M. Majaliwa (MP.)
PRIME MINISTER
UNITED REPUBLIC OF TANZANIA

ACKNOWLEDGEMENT

The previous cholera response plan was developed in 2019 in response to the 2015 - 2018 cholera outbreaks in the country. The revised plan addresses the challenges of the previous plan taking into considerations the evidence-based interventions and recommendations from different sectors and from the global roadmap to end cholera by 2030, in order to contain the current cholera outbreak and prevent further transmissions in the country.

This revised National multi-sectorial Cholera Prevention and Control plan has been through workshop organized by MoH in collaboration with the Prime Minister's Office (PMO) involving various sectors including Ministry of Water (MoW), the President's Office – Regional Administration and Local Government (PO-RALG), Kigoma, Katavi and Rukwa Regions and other stakeholders where the first draft was developed then shared to bigger group of stakeholders for inputs and comments and the draft two plan was validated through stakeholders meeting.

The MoH is grateful to WHO for its financial and technical support. The Ministry would also like to thank the staff within the various subcommittees namely, Coordination and leadership, Surveillance, Laboratory, Case Management and Infection prevention and control (IPC), Water, Hygiene and Sanitation (WASH), Social mobilization and Community engagement, and Logistics, for their technical inputs and stewardship in ensuring that the plan conforms to the National context and needs. The Ministry is also grateful to partners for their valuable contributions in Cholera response. These include US CDC, USAID, UNICEF, CDC – Tanzania, Red Cross, Serve the Children. Lastly, but not least, the MOH would like to extend her appreciation to other not mentioned, who provided valuable contributions in the process.

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ABBREVIATIONS AND ACRONOMY

AAR	-	After Action Review
CBO	-	Community Based Organization
CDC	-	Centers for Disease Control and Prevention (of United States of America)
CFR	-	Case Fatality Rate
CHMT	-	Council Health Management Team
CHWs	-	Community Health Workers
CTC	-	Cholera Treatment Centre
DC	-	District Commissioner
DED	-	District Executive Director
DMD	-	Disaster Management Department
EAPHLN	-	East African Public Health Laboratory Network
e-LMIS	-	electronic Logistic Management Information System
FELTP	-	Field Epidemiology and Laboratory Training Program
FHI	-	Family Health International (an NGO)
FP	-	Focal Person
HR	-	Human Resource
HWTS	-	Household water treatment and safe storage
IDSR	-	Integrated Disease Surveillance and Response
IEC	-	Information Education and Communication
IHR (2005)	-	International Health Regulations (2005)
IMS	-	Incident Management System
LGAs	-	Local Government Authorities
M&E	-	Monitoring and Evaluation
MC	-	Municipal Council
MOH	-	Ministry of Health
MOW	-	Ministry of Water
MSD	-	Medical Stores Department
MSF	-	Médicins Sans Frontières
NFP	-	National Focal Person
NGO	-	Non-Governmental Organization
NHLQATC	-	National Health Laboratory Quality Assurance Training Centre
NSC	-	National Sanitation Campaign (a monthly activity in Tanzania)
NSMIS	-	National Sanitation Management Information System
OCV	-	Oral Cholera Vaccine
ORS	-	Oral Rehydration Salt
PMO	-	Prime Minister's Office
PHEOC	-	Public Health Emergency Operations Centre
PORALG	-	President's Office, Regional Administration and Local Government
PPE	-	Personal Protective Equipment
RAS	-	Regional Administrative Secretary
RC	-	Regional Commissioner
RDT	-	Rapid Diagnostic Test
RHMT	-	Regional Health Management Team
RRT	-	Rapid Response Team
SCD	-	Standard Case Definition
SOPs	-	Standard Operating Procedures
TANDREC	-	Tanzania National Disaster Relief Committee
UNHCR	-	United Nations High Commissioner for Refugees
UNICEF	-	United Nation Children Fund
VEO	-	Village Executive Officer
VHW	-	Village Health Worker
VRAM	-	Vulnerability, Risk Assessment and Mapping
WASH	-	Water, Sanitation and Hygiene
WEO	-	Ward Executive Officer
WHO	-	World Health Organization

1. Introduction

1.1. Background

Tanzania lies on the East African coast between 1° and 11°45' south, and 29°20' and 40°35' east. It is bordered by Kenya and Uganda to the north, Rwanda, Burundi and the Democratic Republic of the Congo to the west, Zambia and Malawi to the southwest, and Mozambique to the south (Figure 1). The total population of Tanzania in the 2022 population census was 61,741,120. The total fertility rate according to the Tanzania Demographic health survey 2022 is 5.2. The infant mortality rate was reported to be 33 per 1000 live births and Under-Five Mortality rate was 43 per 1000 live births. The population is very young, with 55% under age 20 and only 4.7 percent 65 or older. (Tanzania Demographic and Heath Survey and Malaria Indictor Survey, 2022).

Map 1: Tanzania with its neighboring countries

Tanzania has two major rainfall regimes: one is uni-modal (October–April) and the other is bi-modal (October–December and March–May). The former is experienced in southern, central, and western parts of the country, and the latter is found in the north from Lake Victoria extending east to the coast.

In 2022, the real value of the National Income reached 141,872,730 million Tanzanian Shilling, compare to 135, 478189 million Tanzania Shilling in 2021, reflecting growth rate of 4.7. However, the growth rate decreased by 0.2 percent compare to 4.9 percent in 2021 due to the impact of conflict between Russia and Ukraine which lead to increase production costs in certain sectors, coupled with climatical change affecting agricultural production in some region of the country. The growth Domestic Product per capital (GDP per capita) for year 2022 averaged 2,844,641 Tanzania shillings, as opposed to 2,708,999 Tanzanian

shillings 2021, indicating an increase of 5.0%This amount is equivalent to 1,229.1 US dollar per person in 2022 compare to 1,173.3 US dollar 2021.

The WHO/UNICEF Joint Monitoring Program in 2017 indicated 50% accessibility to drinking water, 23.5% sanitation and 48% hygiene for the population of the United Republic of Tanzania.

According to the National Sanitation Management Information System (NSMIS) which is the routine monitoring system for sanitation and hygiene, the coverage of sanitation facilities (both improved and unimproved) is 98.8% and that only 1.2% of the household still practice open defecation. On the other hand, 77% of the households are reported to possess improved sanitation facilities and 43.8% has a designated functional facility provided with soap and water (NSMIS, June 2022).

1.2. Overview of Cholera outbreaks in the country

Tanzania has experienced cholera outbreaks over the past four (4) decades. Reports show cases ranging from 1,671 in 1977 to 40,226 in 1997. From the year 1970 to 2000, three major cholera epidemics occurred: 1977 (1671 cases and 135 deaths with a case fatality rate (CFR) of 8.1%), 1992 (18,526 cases and 2173 deaths, CFR of 11.7%), and 1997 (40,226 cases and 2,268 deaths, CFR of 5.6%). The 1992 outbreak case fatality rate is still the highest ever-recorded in East Africa. From August 2015 to December 2018, the country recorded the longest cholera outbreak with a total number of 33,319 cases and 550 deaths (CFR 1.7%). The epidemic affected all the 26 regions and 129 (out of 139) districts of Tanzania. The epidemic was first reported in Dar es Salaam, the busiest and populous city, stretching to other parts of the regions. All age groups and both males and females were affected including vulnerable populations in informal temporary settlements such as in mining, fish camps, and casual workers in small-scale and large-scale farms. Cholera cases occurred throughout the three-years with higher numbers reported during the rainy. In 2019, the country experienced the resurgence of Cholera cases affecting six regions (424 cases and 8 deaths, CFR of 1.9%). This information is summarized in table 1.

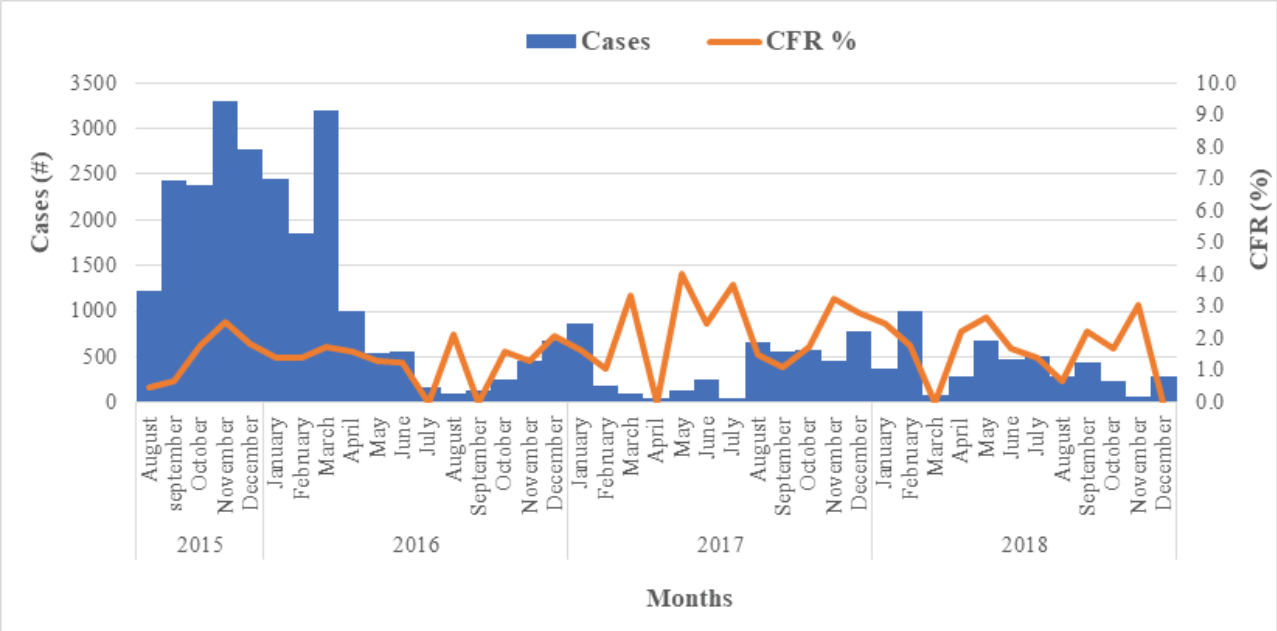


Figure 1: Trend of cholera cases and CFR by months, Tanzania, August 2015 – December 2018

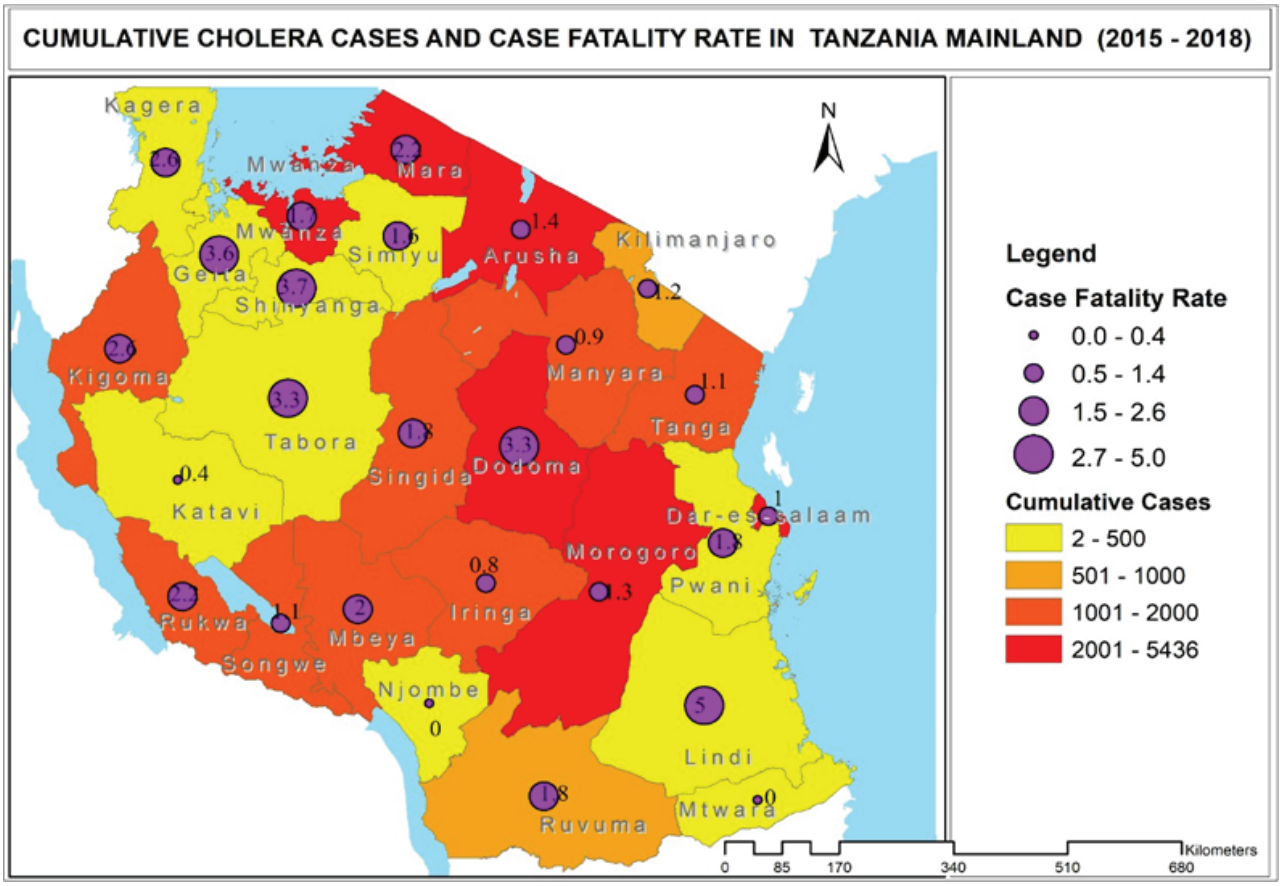


Table 1: Distribution of cases and deaths by regions, 1 January - 30 July 2019, Tanzania

Region	Cases	Deaths	CFR (%)
Dar es Salaam	153	4	2.6
Manyara	6	0	0.0
Arusha	25	1	4.0
Tanga	214	3	1.4
Kigoma	23	0	0.0
Songwe	3	0	0.0
Grand Total	**424**	**8**	**1.9**

From November 2021 to June 2022, the nation recorded 519 cases, including 11 deaths (CFR 2.1%) from four districts in three different regions. These results are summarized in table 2, figure 2 and figure 3 below.

Table 2: Distribution of cases and deaths by regions and Districts, November 2021-June 2022, Tanzania

Region	District	Cases	Deaths	CFR (%)
Rukwa	Nkasi DC	54	0	0
Kigoma	Kigoma MC	30	4	13.3
Rukwa	Nkasi DC	94	1	1.1
Kigoma	Uvinza DC	126	0	0.0
Katavi	Tanganyika DC	215	6	2.8
Grand Total		**519**	**11**	**2.1**

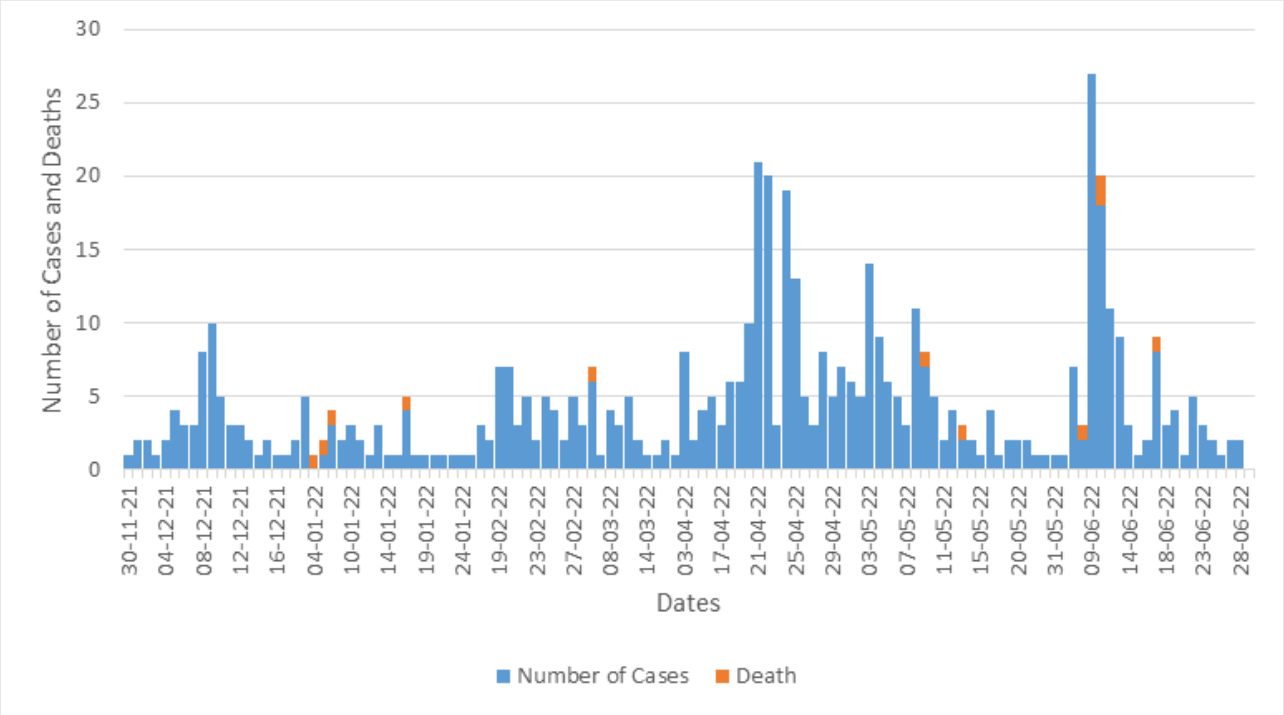
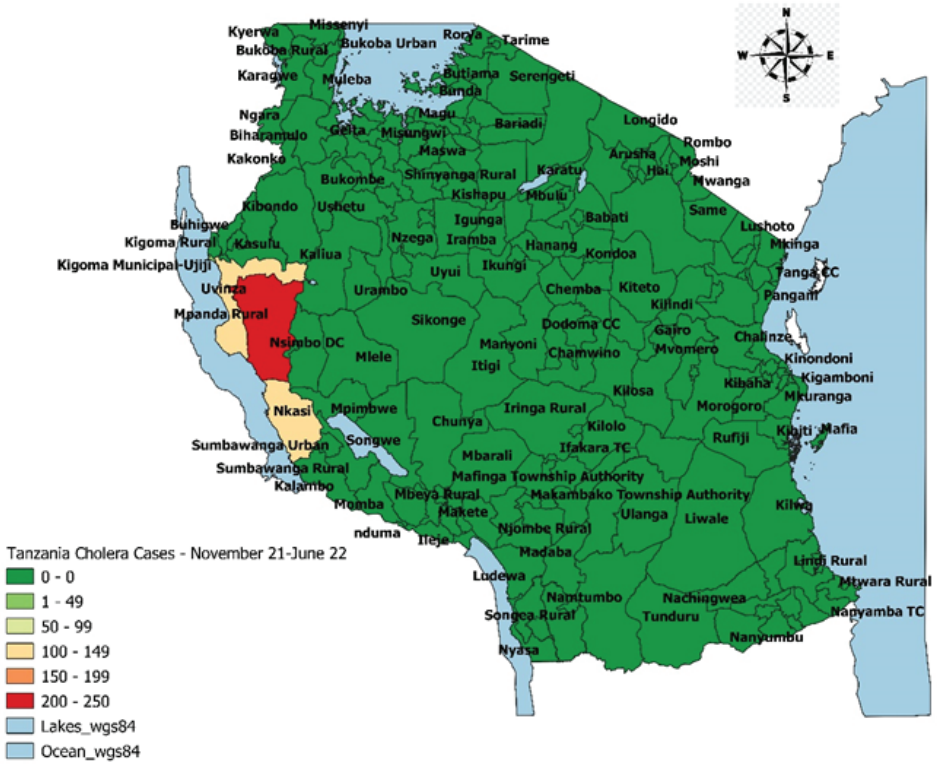


Figure 2: Trend of cholera cases and deaths in Tanzania from November 2021 to June 2022



Map 3: Distribution of cholera cases in Tanzania from November 2021 to June 2022

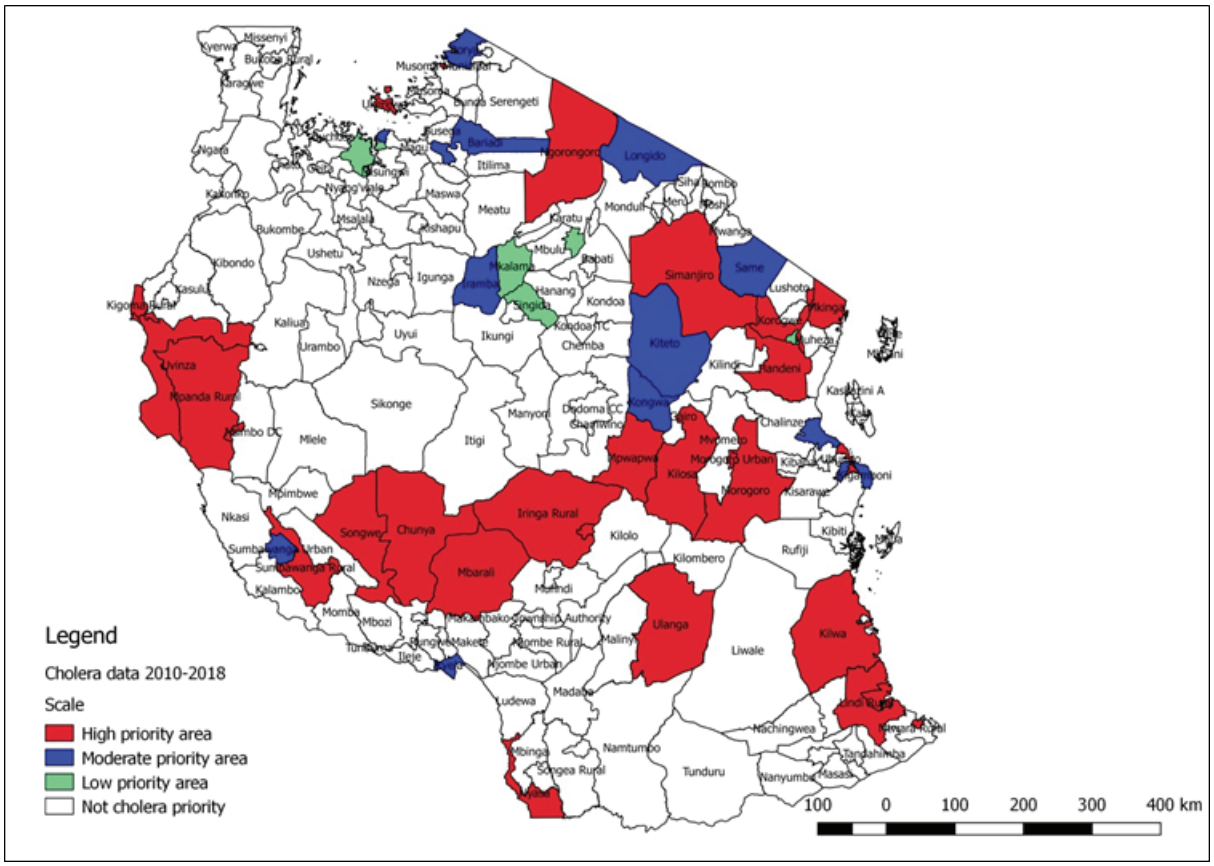
Major risk factors that contributed to the occurrences of cholera outbreaks in the country include poor personal hygiene, poor food hygiene, contaminated water sources and poor sanitation conditions. However, surveillance of the identified risk factors mainly environmental was not done, despite the existence of active and strong case surveillance and reporting mechanisms. There is no reported evidence on the improvement of the environmental risk factors in the affected areas or of systematic monitoring of the same. Concerns are high on the risk of recurrent outbreaks owing to the growing base of human and aquatic reservoirs for the infection where environmental factors are not effectively controlled

1.3. Vulnerability, Risk Assessment and Mapping

In February 2017, Tanzania conducted a Vulnerability Risk Assessment and Mapping (VRAM) for the cholera outbreak in five regions (Arusha, Dar es Salaam, Dodoma, Mara, and Morogoro) based on their history of cholera. VRAM aimed at assessing all factors that could contribute to the cholera outbreak, specifically, the capacity and vulnerability. VRAM was conducted by the Ministry of Health (MoH)) in collaboration with WHO and Ardhi University experts. Three (3) domains were respectively identified for measuring vulnerability and capacity. These domains included information on the Cholera hazard, the vulnerability, and the coping capacity. The capacity in this assessment included the status of human resources, financing, water quality monitoring, and management of the emergency; the subdomains assessed included social, economic, community health status, social determinants of health and community. A minimum set of variables and indicators were then identified for each domain. The findings for the four regions assessed showed generally that capacity was relatively low and the vulnerability was high. High vulnerability caused by inadequate personal hygiene, low accessibility to clean and safe water supplies and sanitation. Poor financing and low human resources contributed to lack of capacity to fight cholera.

1.4. Cholera Hot spot regions

Although the cholera epidemic has affected almost all the regions, some regions were most affected than the others. In an effort to control the cholera epidemic, mapping has been done to assist focusing the areas for intervention as the country plans for a wider elimination strategy. The figure below shows the 3 levels of categorization i.e., high priority, moderate and low priority. This plan will focus on 49 hot spots (44 as shown below and 5 identified in the cholera outbreak that occurred in Kigoma, Katavi and Rukwa in 2021 and 2022)



Map 4: Distribution of hotspot areas within the country, 2019, Tanzania

1.5. Situation analysis: Strength, Weaknesses, Opportunities and Threats

Tanzania Mainland conducted cholera After Action Review (AAR) in August 2017 to identify the strengths and gaps exhibited during the response to the on-going cholera outbreak. The joint exercise was conducted by a team of experts from the United Republic of Tanzania in collaboration with World Health Organization (WHO) and other partners using the WHO guidance. The AAR results show that Tanzania had been implementing several activities in responding to the cholera outbreak. While some activities were implemented as per plan and procedures, there were activities that did not follow the standard operating procedures (SOPs) or the response plan; it was contributed to a lack of some guidelines and SOPs especially at sub national level. In addition, in each of the thematic areas, some weaknesses and challenges were encountered that hindered efforts to stop the cholera outbreak in various areas. Given the challenges observed, the AAR team identified two priority actions for implementation for each functional area.

Table 3: Challenges and priority actions identified during Cholera AAR, 2017

Thematic area	Challenge	Priority action
Operational Response Coordination	- Lack of NTF for cholera prevention and control - Some cadres were not actively involved, e,g., laboratory, pharmacists) - National joint multi-sectoral plan not in place - Inadequate participation from other sectors at the national level to participate in the response - Coordination of partners and resources for response was ineffective and limited in some regions. - Lack of cholera Public health emergency committee in subnational level - Limited resource to support RRT in the field include fuel for fields movement - lack of IMS structures especially at subnational level	- Dissemination and harmonization of cholera plans, guidelines, SOPs at all levels as well as translation into simple swahili language - Establish, if absent, or strengthen, train and maintain Rapid Response Teams at national, regional and district levels. Regions and districts to capacitate more technical experts to be included in the RRT and not limit to fewmembers - Advocate for regions and district be allowed to establish special funds account during cholera (or emergencies) response to facilitaterapid response - Advocate to Prime Minister's Office (PMO) for the development of a multi-sectoral cholera response plan and consideration of cholera outbreak as an emergency that requires attention and substantial immediate support for rapid containment -orientation of subnational level on IMS -incorporate cholera outbreak communication strategy

Surveillance	- Risk assessment according to IHR was not integrated into the IDSR (surveillance) - Community Based Surveillance (CBS) not formally linked to health care - Underreporting and limited competencies in data analysis and outbreak investigation at regional and district level. - Low coverage of Event Based Surveillance (EBS) - Weak active search of Cholera cases - Inadequate resource and knowledge to conduct contact tracing -No cholera reports in IDSR	- Conduct supportive supervision and mentorship on IDSR at all levels - Formalize and scale up community-based surveillance (strengthening event-based surveillance) using existing structures - Mentorship to HCWs on data management and advocacy to higher level to improve reporting - To strengthen EBS in hot spot areas - Training and mentorship to improve active case search and contact tracing - Sensitization and advocacy to HCWs on the importance of recording Cholera cases in IDSR system
Public Laboratory		- Streamline procurement system for reagents, equipment, and supplies for laboratory testing - Scale up cholera and other enteric bacteria testing capacity to all regions and district laboratories
	- Improper decontamination of cholera beds, floors, surroundings, etc. at health facility - Cholera treatment plans were not followed at the cholera	- Facilitate early intervention with oral rehydration salts (ORS) right from the community level - Advocate for the identification of isolation area for infectious disease to be a prerequisite for all

Case management and IPC	treatment center (CTC) - Delay in transporting cases to the CTC - Patients' delay in seeking health care - Lack of pre-identified isolation area or CTC for managing suspected cholera cases in some districts - Severe dehydration of cholera patients on arrival at the CTC	health facilities (and especially at the district level)
Logistics	- Shortage of health commodities (case management, water treatment supplies, and essential supplies) at Council level - Shortage of health commodities at Medical Store Department (MSD)	- Responsible ministries, regions and councils should ensure proper planning and prioritization for emergencies (to cater for health commodities, fleet management, monitoring and evaluation (M&E)) - Ministry of health to ensure customization of electronic Logistics Management Information System (e-LMIS) to cater for emergency responses
	- Inadequate clean and safe water supply at community level - Inadequate sanitation (improved latrine access and disposal of excreta) especially in informal settlements - Improper disposal of waste water, fecal sludge management and unequal distribution of sanitation	1. Advocate to the Ministry of Water to (a) Increase access to clean and safe water supply to urban and rural population (b) Install water treatment infrastructure and facilities to all water projects in rural and urban areas (c) Increase access and availability

WASH	infrastructure - Unhygienic behavioral practices (poor hand hygiene, poor food handling practices and inadequate household water treatment and safe storage for drinking - Inadequate enforcement of laws and by-laws related to public health	of water treatment reagents 2. improve availability and utilization of improved sanitation facilities and proper fecal sludge management (a) Increase availability and utilization of improved toilets at household level, institutions and public places (b) Ensure proper waste water management through construction of waste water treatment plants and establishment of communal waste water treatment 3. Intensify community sensitization on implementation hygienic behavioral practices (practice hand hygiene, improve food handling practices and household water treatment and safe storage for drinking) 4. Improve safety monitoring of water, food and food premises 5. Improve enforcement of public health related laws and by-laws
Risk Communication & Social	- Incomplete communication strategy (yet to be finalized and disseminated to a larger groups of stakeholders) - Inadequate utilisation of multi-Sectoral mechanism for risk communication - Existing Rumours and negative perceptions in the community	- Finalize, print and disseminate risk communication guidelines and strategy which will provide a framework for systematic and effective risk communication - Train additional personnel on risk communication and social mobilization at sub-national levels on public health emergency.

mobilization	- Limited IEC/SBCC materials produced and disseminated in the affected areas, - Messages delivered not tailored to address the the socio-cultural factors. - Risk communication monitoring was not effective - Limited coverage for MHPSS services delivery	- Intensify media engagement and community influencers - Enhance production and dissemination of IEC/SBCC materials creation awareness and addressing relevant rumours - Enhance MHPSS services at subnational levels through media engagement and training of additional service providers - Enhance monitoring of RCCE interventions through development of tools and capacity building of personnel
	-	-

2. Goal and objective of the plan

This plan will focus on the high hotspot areas and it is expected the effects will be spilled over to the rest of the country. The main goals and objectives are as follows;

2.1. Goal

i. A healthy nation that is free from the economic and social disruptions caused by cholera

2.2. General objectives

Reduction in morbidity and mortality caused by cholera by 90% in Tanzania

2.3. Specific objectives:

i. To build capacity and readiness for response to cholera outbreaks
ii. To strengthen coordination of multi-sectors and partners for prevention and control of cholera at national, regional, and district levels
iii. To strengthen, support and build capacity for detection, reporting and case confirmation of cholera organism (Vibrio cholerae)
iv. To improve case management and Infection, Control and Prevention measures at CTC and health facilities
v. To improve access to improved water, sanitation and hygiene facilities in households, institutions and public places
vi. To enhance community engagement for adoption of appropriate and sustainable mechanisms and practices for protection and prevention against cholera
vii. To conduct needs assessment for justification of the use of the oral cholera vaccine (OCV)
viii. To promote operational research in order to document lessons learnt, best practices and challenges
ix. To ensure effective monitoring and evaluation of cholera preparedness and responses

3. Expected outputs and Targets

3.1. Expected outputs

a) Improved information sharing; effective multi-sectoral coordination of resources and technical support; and strengthened partnership for cholera control and prevention at all levels
b) Cholera Case Fatality rate reduced to < 1%
c) Improved accessibility to drinking water, sanitation and hygiene and communities' engagement to appropriate cholera preventive practices
d) Enhanced communities' engagement to appropriate cholera preventive practices
e) Cholera new cases prevented through enhanced accessibility to improved water, sanitation and hygiene services, intensive health promotion and education interventions and a well-established surveillance systems

3.2. Targets

a) By December 2026, at least 95% of the hotspot districts have functional multi-sectoral coordination structures and fully funded cholera multi-sectoral cholera prevention and control plans
b) By December 2026, 80% of hotspot districts timely detected cholera outbreaks and investigated
c) By December 2026, 80% of cholera suspected cases are laboratory confirmed and linked to surveillance data
d) By December 2026, reduce the case fatality rate for cholera to less than 1% in all CTC
e) By December 2026, all CTC in hotspots districts have proper IPC measures
f) By December 2026, at least 90% of all hotspots districts have established community ORS points with at least 90% coverage of communities
g) By December 2026, a comprehensive coordination structure for risk communication and community engagement has been developed
h) By December 2026, increase access to safe water supply to 80% and 95% of population living in hotspot areas in rural and urban settings respectively
i) By December 2026, increase coverage of improved latrines in cholera hotspot areas from 71.9% to 85%
j) By December 2026, quality monitoring of food and water safety at community level in hot spots regions is ensured.
k) By December 2026, increase WASH preparedness and response to cholera outbreaks

4. Priority Areas to be addressed in the plan multi-sectoral cholera prevention and control plan

Informed by the lessons learnt in the approach used to manage previous country cholera outbreaks, key pivotal technical areas to be addressed in this multi-sectorial cholera preventive and control plan will include;

a) Multi-sectorial coordination structures for cholera prevention and control
b) Enhanced epidemiological and laboratory surveillance in hot spot areas and detect, confirm and respond rapidly to cholera outbreaks
c) Promoting safe use of water, sanitation and hygiene practices
d) Improve risk communication and social mobilization to promote positive behavioural change; quick access to case management and IPC services
e) Stockpiling key essential logistical services to rapidly respond to the cholera threat

5. Multi-sectoral Coordination structure for Cholera Prevention and Control

5.1. Leadership and Coordination

Cholera results from factors which are attributed to sectors beyond traditional health sectors. Likewise, the measures needed to prevent and control cholera must be geared towards the collective efforts that are continuously implemented using the sector-wide approach in order to achieve cholera control in the mostly affected localities.

The Government, through the MoH and other key sectors including PO-RALG, MoW and other National agencies and departments as well as international development partners will join hands with local authorities to support both resources and technical expertise in scaling up an effective implementation of cholera preventive and preparedness measures, using existing established sector wide approach frameworks both present at national and subnational levels. These frameworks will also be used for control activities during a pro-active basis alignment within an embedded routine framework and not only reactive only such as during cholera emergency response.

These frameworks will also facilitate regular collaboration which will not only smoothen communication but also uplift the potential cooperation among key actors and sectors through a series of well-prepared MiUs, letter of agreements (LoA) and SOPs to enable adequate sectoral coordination. In doing so, clear roles and responsibilities will be aligned with the intended cholera preventive and control objective. The sensitization and engagement of leaders including influential peoples at all levels in the community will be done to ensure sustained intervention efforts with local ownership.

5.2. Institutional Framework

The overall coordination of this plan will be done by established National Cholera Prevention and Control Task Force (NCPTCF) under DMD in the Prime Minister's Office (PMO) where there is coordination of all relevant government sectors in close collaboration with National as well as International organizations through their associated sectors.

The MoH will be technical lead sector and will provide and oversee the technical areas as well as providing policy guidance in the implementation of this multi-sectoral cholera prevention and control plan as guided by the National Health Policy 2007 framework and the Disaster Management Policy of 2004 with regard to prevention, preparedness, response and recovery from emergencies of public health nature.

In order to bring an effective and efficient output as per the country expectation, tactical implementation of the plan will be done through a close collaboration with key sectors and agencies at the Region and District level which will need a local plan adaptation before execution and also owning the whole multi-sectoral strategies according to their context. The President's Office Regional Administration and Local Government (PO-RALG) will effectively work with sectoral key Ministries including MoH and MoW to implement this multi-sectoral plan with participation and engagement of all relevant Ministries and following the suggested time frame. The following is the institutional Framework:

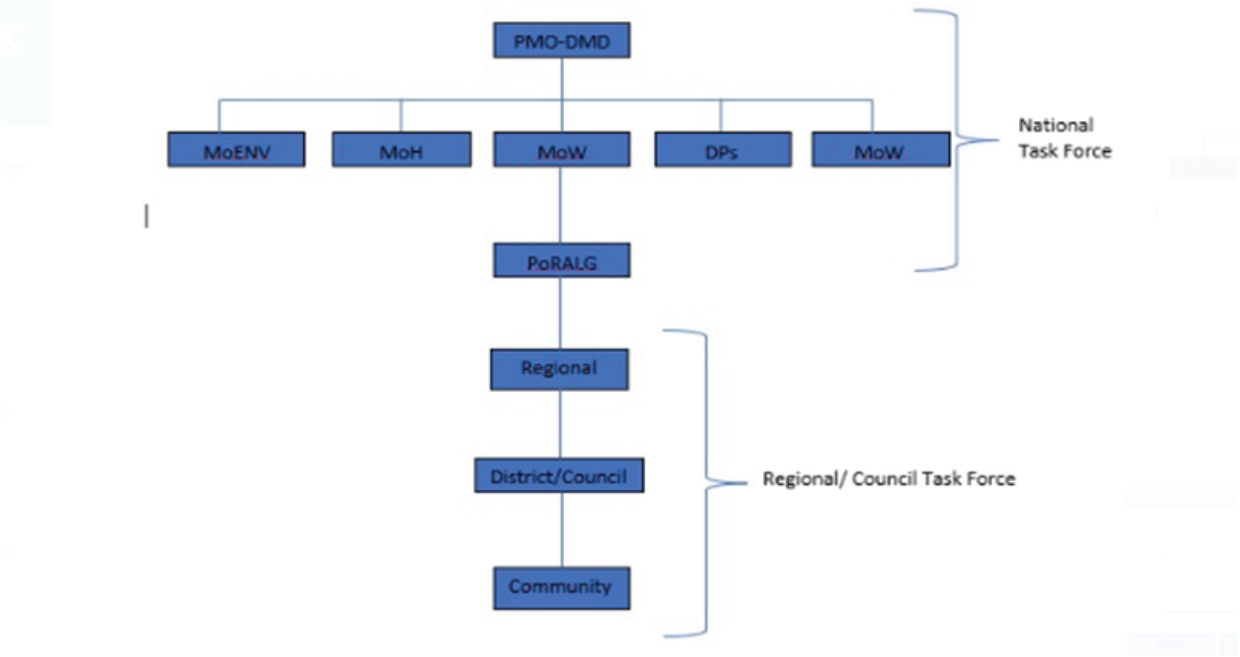
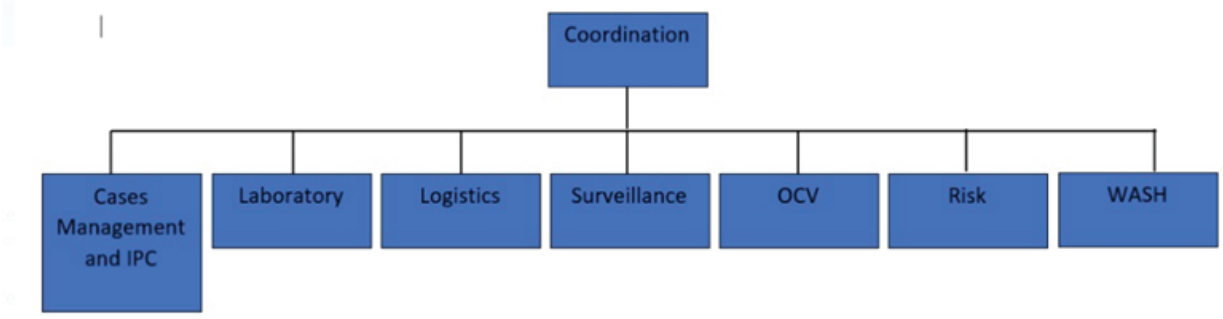


Figure 2: Overall leadership and coordination structure for the cholera prevention and control plan

Underneath both National levels, and Regional/District Level Task Force, there will be pillars as specified bellow



6. Priority Areas

6.1. Multi-sectoral Coordination for Cholera prevention and response

Strategic objectives

i. A Coordination structure and information sharing mechanism is strengthened between the Government and all multi-sectoral stakeholders in order to create common operational model and plan implementation
ii. Regional and council cholera multi-sectoral plans are implemented in line with the national multi- sectoral plan

Milestones

a) At least 30% of the hotspots districts have functional multi-sectoral coordination structures and fully funded cholera multi-sectoral cholera prevention and control plans, by 2023
b) At least 60% of the hotspots districts have functional multi-sectoral coordination structures and fully funded cholera multi-sectoral cholera prevention and control plans, by 2024
c) At least 80% of the hotspots districts have functional multi-sectoral coordination structures and fully funded cholera multi-sectoral cholera prevention and control plans, by 2025

Coordination					
S/N	**Activities**	**Indicators**	**Desires Targets(No, %)**	**National Responsible Person**	**Partners**
Objective 1: A Coordination structure and information sharing mechanism is strengthened between the Government and all multi-sectoral stakeholders in order to create common operational model and plan implementation by 2027					
National Level					
	Mapping and updating inventory of stakeholders for cholera control at Nationallevel	Proportion of existing stakeholders mapped	100%	PMO, MoH, MoW and PO-RALG	WHO,
	To conduct RRT training	Training report	At least 80%	MOH	Development partners(DPs) and implementation partners(Ips) IPs
	Printing 1000 NMCPCP for dissemination to the national (100), Regional 45 Hotspot district 600 partners and others stakeholders 50	Numbers of NMCPCP Printed	100%	MoH	Development Partners and IPs

	Develop TOR/LoA of key sectors in the cholera prevention and control and information sharing	Number of key sectors who signed the Mou/LoA	Stakeholders signed the MoU/LoA	PMO,MoH,	Development Partners and IPs
	Mobilize resources for implementation of the cholera plan at the National level	% of required resources secured	Resource mobilized	PMO, MoW, MoH and PO-RALG	Development Partners and IPs
	Support EOC Operations	% of budgeted funds secured out of allocated from partners and GoT	At least 80%	MoH	Development Partners and IPs
	Conduct at least two multi-sectoral coordination meeting at National level (Task Force)	Proportion of required meetings conducted	100%	MoH,PMO, MoW and PO-RALG	Development Partners and IPs
	To conduct bi annual Advocacy meeting for high level (policy and	Number of meetings conducted done on cholera issues at	100%	PMO,MoH	Development partners and IPs

	decision makers) coordination for cholera control at national level	National level			
	Hire a consultant to oversee the implementation of the plan	Consultant available	NA	MoH	Development partners and IPs
	Support launching of the National cholera control and Prevention plan	Signed Plan available	NA	MoH,PMO, MoW	Development partners and IPs
	To conduct supportive supervision on implementation of cholera multi-sectoral prevention and control plan	Number of reports submitted	At least 80%	MoH& PORALG	Development partners and IPs
	To disseminate of final national Multi-sectoral Cholera prevention and Control Plan	Proposition of district Plans disseminated	At least 80% of district supervised	MoH PO-RALG	Development partners and IPs
	To conduct Intra Action Review during	Report submitted	NA	MOH, PORALG	Development partners and IPs

	outbreak of cholera				
	To conduct After Action Review to identify the strengths and gaps exhibited during the response	Report submitted	NA	PO-RALG, MoH	Development partners and IPs
Objective 2: Strengthening multi-sectoral cholera prevention and response at subnational levels					
Subnational Level (Regional & LGAs)					
	Support regions and District toadapt the Cholera control and prevention plan	Proportion of hotspots regions and districts with Cholera control and prevention plan	100%	MoH and PO-RALG	Implementing Partners
	To conduct Advocacy meeting for high level (policy and decision makers) coordination for cholera control at Regional level	Proportion of hot spot regions who have conduced advocacy meeting on cholera issues	100%	PO-RALG	Implementing Partners

	To conduct Advocacy meeting for high level (policy and decision makers) coordination for cholera control at District level	Proportion of hot spot districts who have conduced advocacy meeting on cholera issues	100%	PO-RALG	Implementing Partners
	To conduct supportive supervision on cholera multi-sectoral prevention and control plan implementatio n	Number of report submitted	80%	PO-RALG	
	To conduct intra and after action review in the affected regions and districts	Number of reports submitted	At least 80%	PO-RALG	Implementing Partners

6.2. Surveillance and Laboratory

Effective surveillance and laboratory systems enable early detection of cholera outbreak, estimation of cholera morbidity and mortality and assessment of the size, extent and spread of the outbreak. The two-guide efficient resource allocation including personnel, equipment and supplies. Lastly, well-planned surveillance and laboratory systems allow effective assessment of the performance of control measures and planning for additional epidemiologic investigation.

The country has experienced the waves of cholera outbreaks regularly and currently the outbreak has been reported in three regions (Katavi, Rukwa and Kigoma). Most of the cases in all waves reported from the health facilities. One of the challenges observed in the current outbreak is under reporting of cases and deaths that occurred in the community and active case search and contact tracing limiting early containment of the outbreak. This calls for more focus on training of community event-based surveillance for community health care workers and key informants from the community and training of active case search and contact tracing to both community health care workers and heath facility heath care workers in the hotspot areas

In Tanzania cholera surveillance operates within the Integrated Disease Surveillance and Response (IDSR) framework. There are two arms and these include Indicator based surveillance and Event/Community based surveillance. At National level, there is a National Surveillance Coordinator, assisted by Surveillance Focal Persons who are present at subnational levels, supervised by PORALG. Partners supporting surveillance include WHO, CDC and other implementing partners

Laboratory confirmation and prompt reporting of cholera cases is critical in supporting control and prevention efforts. For effective control of cholera, timely mobilization of resources is required to reduce further spreading and possible deaths as a result of the outbreak.

Strategic Objectives:

1. Early detection and reporting, analysis and investigation of cholera outbreaks improved
2. Laboratory capacity for testing and confirming cholera cases increased
3. Data linkage between laboratory and surveillance improved

Milestones

1. At least 50 % of the hotspot districts timely detected cholera outbreaks and investigated by 2023
2. At least 60 % of the hotspot districts timely detected cholera outbreaks and investigated by 2024
3. At least 70 % of the hotspot districts timely detected cholera outbreaks and investigated by 2025
4. At least 95 % of the hotspot districts timely detected cholera outbreaks and investigated by 2026
5. At least 50% of cholera suspected cases are laboratory confirmed and linked to surveillance data by 2023
6. At least 60% of cholera suspected cases are laboratory confirmed and linked to surveillance data by 2024
7. At least 70% of cholera suspected cases are laboratory confirmed and linked to surveillance data by 2025
8. At least 80% of cholera suspected cases are laboratory confirmed and linked to surveillance data by 2026

Surveillance and laboratory activities				
Key activities	**Output indicators**	**Desired Indicator (%, No)**	**National responsible person**	**Responsible Partner**
Objective: 1. Early detection and reporting of cholera outbreaks improved				
National level				
Print and disseminate guideline for event-based surveillance to 27 hot districts	Proportions of hotspot districts with EBS guidelines	100%	MoH - EPID/PORALG	Development Partners and IPs
Conduct training to HCWs on event-based surveillance in hot spot districts	Proportion of HCWs Trained out of targeted	100%	MoH - EPID/PORALG	Development Partners and IPs
Conduct training to CHWs on event-based surveillance in hot spot districts	Proportion of CHWs trained out of targeted	100%	MoH - EPID/PO-RALG	Development Partners and IPs
Conduct training to surveillance officers and CHWs on Cholera active case search and contact tracing in hot spot districts	Proportion of surveillance officers and CHWs trained out of targeted	100%	MoH - EPID/PO-RALG	Development Partners and IPs
Print and distribute Swahili translated cholera standard case definitions posters for CHWs in hot spot districts	Proportion of Hotspot districts with Swahili translated cholera standard case definition posters for CHWs	100%	MoH - EPID/PO-RALG	Development Partners and IPs

Conduct quarterly (Virtually/Physical) supportive supervision to hot spot regions on IDSR focusing cholera	Proportion of hotspots regions supervised	100%	MoH /PORALG	Development Partners and IPs
Subnational Level (Regional & LGAs)				
Conduct quarterly (Virtually/Physical) supportive supervision to hot spot districts on IDSR focusing cholera	Proportion of districts and health facilities supervised	At least 80%	RMO/DMO	Implementing Partners
Develop and update an inventory of CHWs and influential people in the detection and reporting of cholera cases on yearly basis.	Updated inventory	N/A	RMO/DMO	Implementing Partners
Distribute Swahili translated cholera standard case definitions posters for CHWs in hot spot districts	Proportion of all facilities with Swahili translated standard cholera standard case definition posters for CHWs	100%	RMO/DMO	Implementing Partners
Conduct training on surveillance and outbreak investigation to clinicians from health facility in hot spot districts	Proportion of hotspots districts with trained clinicians	100%	RMO/DMO	Implementing partners
Objective 2: Analysis and utilization of cholera data by hotspot districts improved.				

National level				
To conduct training for IDSR FP, and Lab technician at district and regional level on data analysis and generation of information products including situation report preparation	Proportion of IDSR FP and Lab technician trained	100%	MoH-EPID/PO-RALG	Development Partners and IPs
Prepare and share Monthly national IDSR bulletin with stakeholders t national level	Proportion of monthly bulletins produced	100%	MOH-EPID/PORALG	Development Partners and IPs
Rollout of Electronic EBS in hotspot districts to enhance timely reporting and data quality	No hotspot districts with electronic EBS	100%	MOHC-EPID/PORALG	Development Partners and IPs
To conduct biannual data quality assessment	Proportion of quality assessments done	100%	MOH-EPID/PoRALG	Development Partners and IPs
Subnational Level (Regional & LGAs)				
Training of district surveillance officers on data management and generation of information products in hotspot districts	-Proportion of district surveillance officer trained – Proportion of information products report shared	100%	RMO/DMO	Implementing Partners

Objective 3: Laboratory capacity for testing and confirming cholera cases increased				
National level				
Procure cholera RDT	Proportion cholera RDT procured out of total		MoH- NPHL	Development Partners and IPs
Conduct cascade Orientation on the use of RDT, sample collection, packaging and transportation, to testing sites at all levels	Proportion of hotspots districts oriented	100%	MoH- NPHL	Implementing Partners
Conduct quality assurance monitoring for the Health facilities performing RDT cholera testing	Proportion of districts with health facilities which have been monitored Proportion of HF that have been monitored	100%	MoH (EPID& NPHL)	Implementing Partners
Subnational Level (Regional & LGAs)				
Prepare schedule of requirements for cholera reagents and essential supplies for diagnosis for the councils and HFs including cholera rapid diagnostic tests (RDT)	Proportion of hot spot districts with schedule of stockpiles for cholera laboratory diagnosis	100%	RHMTs and CHMTs	Implementing Partners

Objective 4: Data linkage between laboratory and epidemiological surveillance improved				
National level				
Conduct follow-up teleconference calls and mentorship on data linkage between surveillance and lab to hotspot districts	Proportion of districts/regions which had follow-up TC and mentorship done on data linkage	100%	MoH-EPID/NPHL/PORALG	Implementing Partners
Conduct biannual supportive supervision/mentorship of regions and districts Labs staffs on testing and reporting of all cholera suspected samples	Proportion of Regions and districts supervised/mentored on testing and reporting suspected samples	100%	MoH-EPID & NPHL)	Implementing Partners
Conduct mentorships to lab technicians and surveillance officers on harmonization and linking lab and surveillance data in the line list at the regions/district level	Proportion of Regions and districts supervised/mentored on testing and reporting suspected samples	100%	MoH-EPID & NPHL)	Implementing Partners
Subnational Level (Regional & LGAs)				
Conduct follow-up teleconference calls and mentorship on data linkage between surveillance and lab in the CTCs of the hotspot districts	Proportion of hotspot districts whose CTCs ad follow-up TCs and mentorship done on data		RHMTs and	Implementing Partners

	linkageProportion of CTCs which had follow-up TC and mentorship done on data linkage	100%	CHMTs	
Conduct mentorships to lab technicians and surveillance officers on harmonization and linking lab and surveillance data in the line list at the district/ health facilities levels	Proportion of districts/health facilities supervised/ment or ed on harmonization and linking lab and surveillance data in the line list	100%	RHMTs and CHMTs	Implementing Partners

6.3. Case Management

Case Management and IPC interventions for Cholera Epidemic focus on providing timely rehydration to cholera patients to save lives and on prevention and control of the infection spread including cleaning and decontamination procedures, use of disinfectants and decontamination facilities, use of PPE as well as the application of other universal precautions and providing patient's families with the relevant information on the preventive measures that should be taken within the household.

As a way to control the epidemic, there will be an assessment and estimation of essential medicines and emergency supplies based on the epidemiological situation to determine the critical requirement at a time and facilitate replacement of depleted stocks to prevent shortages. Furthermore, surveillance will be strengthened to ensure all cases that present in the community and in the health facilities are detected and being treated accordingly.

As established in the After Action Review in 2017, one of the reason attributed to cholera deaths was delay in health seeking including delay in initiating rehydration due to lack of access to ORS at the community. To address this, ORS points at the community have to be established.

Objectives

1. To reduce the case fatality rate for cholera to less than 1%
2. To improve cholera infection control measures during cholera outbreak at CTC and health facilities
3. To improve early management of cholera cases at the CTC and community level by establishing ORS points

Milestones

1. At least 90% of all CTC in hotspots districts have proper IPC measures by 2024
2. All CTC in hotspots districts have proper IPC measures by 2026
3. At least 60% of all hotspot's districts have established community ORS points with at least 90% coverage of communities by 2025
4. At least 90% of all hotspot's districts have established community ORS points with at least 90% coverage of communities by 2026
5. At least 90% of all hotspots districts healthcare workers trained on cholera management by 2026

Case management and IPC				
Activities	**Indicators**	**Desires Targets (No,%)**	**National Responsible Person**	**Responsible Partners**
Objective: cholera case management improved at all point of care				
National level				
Develop, review and disseminate protocol and guidelines for IPC at all point of care	Percentage ofcouncils with Reviewed IPC Protocols and guidelines	100%	MoHPORALG	Development Partners and IPs
Conduct supportive supervision for IPC component at all point ofcare	% of councils that have received supportive supervision visits on IPC	100%	MoH & PO-RALG	Development Partners and IPs
Develop, review, print and disseminate treatment protocols for cholera case management	Percentage of councils with reviewed cholera treatment protocols and guidelines	100%	MoH & PO-RALG	Development Partners and IPs

Conduct training for trainers (ToT)on case management	Proportion of TOT trained out of targeted	100%	MOH & PORALG	Development Partners and IPs
Conduct training for healthcare workers at hotspot districts on Cholera case management	Proportion of healthcare workers Trained out of targeted	100%	MOH & PORALG	Development Partners and IPs
Subnational Level (Regional & LGAs)				
Conduct supportive supervision for IPC component at all point of care	% of councils that have conducted supportive supervision visits on IPC	100%	RAS DED	Development Partners and IPs
Build capacity of health care workers at all levels	Proportion of councils which have conducted trainings for healthcare workers	100%	RAS DED	Development Partners and IPs
Capacity building to CHWs on community cholera control interventions	Proportion of councils which have conducted	100%	RAS DED	Development Partners and IPs

	trainings for CHWs			
Establish ORSPs at community level in all Hotspot Areas	% of cholera hotspots areas with established ORSP's	100%	RAS DED	Development Partners and IPs
Prepare schedule of requirements for health commodities in cholera Management	% of councils with health commodities for management of cholera stockpiles	100%	RAS DED	Development Partners and IPs
Improve Health care waste management infrastructure and practices to reduce secondary health care associated cholera infections	% of health facilities with required IPC equipment and supplies including functional incinerators and improved waste collection, segregation and disposal practices	100%	MoH & PO-RALG	Development Partners and IPs

6.4. Risk Communication and Community Engagement (RCCE) and Mental Health and Psychosocial Support (MHPSS)

Risk Communication and Community Engagement (RCCE) is one of the key pillars in the Cholera outbreak response and it is an essential part of any disease outbreak response. In the context of Cholera, RCCE refers to real time exchange of information, opinion and advice between frontline responders and people who are faced by the threat of Cholera to their survival, health, economic or wellbeing.

At national level, coordination of RCCE activities are through the Risk Communication Sub-committee. Key members of the sub-committee include WHO, MSF, CDC and Tanzania Red Cross Society (TRCS), PSI and other implementing partners whose participation and contribution has been key in the implementation of RCCE.

In order to share accurate information about Cholera and its symptoms along with what people can do protect themselves and their communities from contracting Cholera, communities will be reached in different ways such as through the use of electronic media (Radio, TV spots, social media messages, etc), print materials (posters, brochure, billboards, leaflets, banners, etc), face-to-face visits and community meetings, community gatherings and use of public address systems within the affected areas.

This community's support is crucial and it is going to be achieved through the engagement of community members themselves through their community entry gates. For ensuring that information is shared in a way that invites community members to become actively engaged in protecting their communities from Cholera and to facilitate Community Engagement, there will be engagement of religious leaders, community leaders, influential people, community volunteers, Community Health Workers, traditional and alternative healers, personnel in pharmacies (ADDO), dispensaries and mobile drug vendors and Cholera survivors

MHPSS

Mental Health and Psychosocial Support has been identified to be a critical and life-saving component during outbreak response in Tanzania. Cholera emergency like other emergencies cause psychological and social suffering to affected populations. The outbreak of cholera led to widespread fear and panic, stigmatization and social exclusion of people who are being treated for or recovering from the disease.

The psychological and social impacts of emergencies may be acute in the short term, but they can also undermine the long-term mental health and psychosocial well-being of the affected population. These impacts may threaten peace, human rights and development. One of the priorities in emergencies is thus to protect and improve people's mental health and psychosocial well-being. Achieving this priority requires coordinated action among all government and non-government humanitarian actors.

Objectives

1. Coordination of RCCE stakeholders at national, regional, district and community level are strengthened
2. Ensure that Community Engagement for adoption of appropriate and sustainable mechanism to support preventive behaviour change and practices are strengthened.
3. Enhance capacity for provision of psycho social care and support services for individuals, families and community affected by December 2027

4. Enhance capacity of community leaders and Health care/para social workers in provision of mental health and psycho social support services for self-care and psycho social first aid (PFA) by December 2027
5. To enhance evidence generation, community feedback and community mechanism to guide RCCE interventions on Cholera prevention and control

Milestones

1. Stakeholders' database established and updated frequently (with national and sub-national stakeholders) in place by March 2024
2. Quarterly stakeholders' coordination and review meetings to be held by December 2027
3. RCCE standard tool (checklist) for Cholera response and control developed from National to Regional levels by June 2024
4. 30% of all Risk Communication focal persons, community mobilizers, media personnel, CHWs, School Health Coordinators and Social Workers trained on RCCE and WASH in 2023, 40% by 2025 and at least 60% by 2027
5. At least 6 best practices exchange of community-led Cholera control initiative are conducted and documented by 2025. Annual publications on best practices/success stories from community-led initiatives for Cholera prevention disseminated by 2027
6. At least four studies on socio-cultural barriers related to Cholera control conducted and disseminated by December 2027.
7. 75% of frontline workers capacitated to enhance MHPSS services to affected communities by 2027
8. 60% of affected individuals are provided with MHPSS

Risk Communication and Community Engagement				
Key Activities	**Output Indicators**	**Desired Target (No, %)**	**National responsible person**	**Responsible Partner**
Objective 1: Coordination of RCCE stakeholders at national, regional, district and community level strengthened				
National level				
Mapping of stakeholders including **private sectors** (telecom companies, banks, FBOs etc.) and establish frameworks for collaboration and coordination at all levels.	Percentage of stakeholders mapped, engaged and coordinate at all levels	100%	Risk Communication committees at all levels (work with Coordination team)	Development Partners
Develop RCCE standard tool	standard tool in place	N/A	MoH &PO-RALG	Development Partners
Conduct annual advocacy meetings (political & religious leaders, Media Owners, Water authority bodies and Editors etc) on Cholera prevention and control	Number of advocacy meetings conducted on cholera within a reporting period	100%	MoH &PO-RALG	Development Partners

Subnational Level (LGAs)				
Mapping of stakeholders including **private sectors** (telecom companies, banks, FBOs etc.) and establish frameworks for collaboration and coordination at all levels.	Percentage of stakeholders mapped, engaged and coordinate at subnational level	100%	RHMTs & CHMTs (work with National Coordination team)	Partners
Conduct quarterly coordination and review meetings	Proportion of hotspots districts where meetings have been conducted	At least quarterly meetings done yearly	RHMTs & CHMTs (work with Coordination team)	Partners
Develop and implement Risk Communication and Community Engagement cholera prevention and control plan	Risk Communication and Community Engagement plan in place	RCCE plan developed and disseminated to all 49 hotspot districts	RHMT/CHMT.	Partners
Mapping of influential people and special groups (water vendors, fishermen, nomads, prisoners, miners, transporters, farm owners and farmers etc.)	Percentage of influential/special community gate keepers mapped	100%	RHMTs,CHMTs & HFs (work with WASH team)	Partners

Conduct advocacy meetings (political, religious and other influential people, Media Owners, CBWOs and Editors etc.)	Number of hotspot districts with high level advocacy meetings conducted within a reporting period	100%	RHMTs CHMTs	Partners
Conduct community outreach programs on Cholera prevention and control	Proportion of hotspots districts where community sessions conducted	100%	RHMT/CHMT/local leaders.	Partners
Revitalize Health, Education and Water committees (At district and village/street levels) to sustain	Proportion of Health, Education and Water committees revitalized	100%	RHMTs/CHMTs, Education section and CBWOs	Partners
promotion of positive sanitation and hygiene practices				

Objective 2: Ensure that Community Engagement for adoption of appropriate and sustainable mechanism to support preventive behaviour change and practices are strengthened				
National level				
Training of media personnel (including local media) on RCCE and WASH	Proportion of hotspot districts whereby media personnel have been trained on RCCE over a reporting period	Media reporting correctly on Cholera	MOH &PO-RALG	Partners
Conduct nationwide mass media campaign on Hygiene and Sanitation practices once a year (*especially during rainy season*)	Number of mass media campaign conducted Proportion of media channels reporting on Cholera prevention and control	At least 90% of media	MOH &PO-RALG	Partners
Orient Regional and District Education, Development & social welfare and Health section to promote WASH practices.	Percentage of hotspot districts/wards with school health coordinators	100%	MOH &PO-RALG	Partners

Production and dissemination of IEC/BCC materials.	Percentage of hotspot facilities or community mobilizers with updated cholera messages and materials	100%	MOH &PO-RALG	Partners
Develop a communication strategy for prevention of cholera to the community	Percentage of hotspot districts with community mobilizers with a communication strategy	At least 100%	MOH &PO-RALG	Partners
Subnational Level (Regional & LGAs)				
Disseminate findings and use the findings to inform strategic	Dissemination meetings report	Findings disseminated to all 49	RHMTs & CHMTs	Partners
planning and implementation		hotspot districts		
Orient health promotion/risk communication focal mobilizers eg. CHWs	Percentage of hotspot villages/ hamlets with skilled community mobilizers	100%	RHMTs & CHMTs	Partners

Conduct sensitization meetings on Cholera prevention and control to influential people, and special groups	Percentage of hotspot districts which have influential/special community gate keepers sensitized on Cholera prevention and control	100%	RHMTs & CHMTs	Partners
Orient and support school health teachers to strengthen WASH clubs.	Proportion of schools in hotspots areas with functioning WASH clubs	100%	RHMTs & CHMTs	Partners
Supporting CHWs, and influential people to conduct mobile and outreach programs promoting Cholera prevention and Control-	Number meetings of mobile and outreach programs conducted	At least 90%	CHMTs and HF	Partners
Conduct Radio and TV programs on Cholera prevention and control measures.	Number of Radio and TV programs broadcast	At least 80% of the Region and districts	RHMTs and CHMTs	Partners

Objective 3: To enhance evidence generation, community feedback and community mechanism to guide RCCE interventions on Cholera prevention and control				
National level				
Conduct annual assessment to identify social-cultural factors, myths, misconceptions, and rumours	Number of studies (baseline assessment conducted)	100%	MoH &PO-RALG	Partners
Disseminate findings and use the findings to inform strategic planning and implementation	Dissemination meetings report	100%	MoH &PO-RALG	Partners
Conduct annual supportive supervision and mentorship to sub national level.	Report of supportive supervision and mentorship in place	100%	MoH &PO-RALG	Partners
Strengthening community feedback through Afya call centre and social listening platforms	Reports produced in place	100%	MoH &PO-RALG	Partners
Sub national Level				
Orient CHWs on community feedback reporting mechanisms.	Number of reports submitted	100%	RHMTs and CHMTs	Partners

Objective 4: Enhance capacity of community leaders and Health care/para social workers in provision of mental health and psycho social support services for self-care and psycho social first aid (PFA) by December 2027				
National Level				
Train RHMT, CHMT and Health workers on provision of mental health and psychosocial care	Number of RHMT, CHMT and Health workers trained on mental health and psychosocial care	At least 90% reached	MHPSS TOTs	Partners
Develop self-care guideline for MHPSS Service providers	Self-care guideline developed	100%	MHPSS	Partners
Conduct quarterly review meeting with stakeholders	Number of meetings with stakeholders conducted per year	At least 50% of meeting conducted	MHPSS	Partners
Train mass media on psychological first Aid (PFA)	Number of media channels trained Number of media channel providing PFA	At least 50% of media channels providing PFA	MHPSS	Partners
Sub national level				
Conduct refresher training to MHPSS service providers at health facilities and at community level.	Proportional of MHPSS providers trained quarterly	At least 60% Of MHPSS of services provider trained	RHMT and CHMTs	Partners

6.5. Water, Sanitation and Hygiene (WASH)

Cholera has been linked with exposure to unsafe water, poor sanitation and unhygienic behavioural practices. Currently, population with access to water supply in Tanzania is (74% Rural and 86.5% urban) (Water sector report, 2022). Data and experiences have shown that, most of the country cholera hotspots are largely explained by lack of access to safe drinking water, inadequate sanitation services and poor hygiene practices among community members. These water, sanitation and hygiene (WASH) gaps are a critical issue needing a sector-wide solution and significant resources. The government of Tanzania proposes to increase population access to water and sanitation services consistent with SDG 6.

The Tanzania government has committed to achieve universal and equitable access to safe and affordable drinking water (SDG 6.1) by 2030 with target of 80% and 95% for rural and urban respectively. The Government is implementing Water Sector Development Programme Phase II (2016 – 2021) with the aim of increasing availability of clean and safe water supply by 95% and 80% for urban and rural population respectively. Under this program MoW developed water safety plans which are implemented by all water supply utilities for water quality monitoring. RUWASA Service Delivery Management System (RSDMS) is done by tracing project functionability and mapping of domestic points (DP), however, water quality management is still a challenge only as few Water points are assessed on quarterly basis.

The country emphasizes on household water treatment at point of use and safe storage, which is monitored on quarterly basis by ward Environmental Health Officer in collaboration with Village Executive Officers and community health volunteers. Household water treatment and safe storage (HWTS) is envisioned to reach 35% by 2024 from the current level of 22.7% (NSMIS, 2022).

In addition, the Government has committed to achieve 100% of basic and 57% of safely managed sanitation by 2025.Through NSC phase II, the country aims to raise the country coverage of improved toilets from 71.7% (NSMIS, 2022) to and access to basic hand washing facilities (hand washing point, water and soap) from 42.2% (NSMIS, 2022) to 60% by 2025 (NSASHA).

Strategic Objectives

1. Universal access to safe water supply services in urban areas over 95% and provision of over 80% of the rural population with water supply services improved
2. Proportion of household sanitation facilities Coverage of sanitation increased
3. Proportion of households with hand washing facilities with soap increased
4. Adoption of drinking water treatment at the point of use is improved
5. Quality monitoring of food and water safety at community level is improved
6. WASH preparedness and response to cholera outbreaks improved

Milestones

Indicators	2021/22	2022/23	2023/24	2024/25	2025/26	2026/2027
Population with access to water services in urban areas	86.5	87	88	89	89.5	90
Population with access to water services rural areas	74.5	75.5	77	79	80	81
Population with access to improved sanitation (toilets with washable floor) (%)	71.9	72	75	80	85	90
Access to hand washing facilities (Hand washing point, water and Soap) (%)	42.2	50	55	65	70	75
Households practicing safe drinking water storage (%)	22.7	30	35	45	60	75
Elimination of Open Defecation (%)	1.4	1.0	0.5	0	0	0

Water, Sanitation and Hygiene (WASH)				
Activities	**Indicators**	**Desired target (No,%)**	**Responsible**	**Responsible Partners**
Objective 1: To increase access to safe water supply to 80% and 95% of population living in cholera hotspot areas in rural and urban settings respectively by 2027				
National level				
Rehabilitation of existing water supply system in cholera hot spot councils	Proportion of water supply system rehabilitated	80% of water systems rehabilitated in all hotspots areas by 2027	MoW	WB, KfW. UNICEF, WHO, Water Aid, GIZ and others
Construction of new and extension of existing water supply schemes into cholera hotspots areas	Number of water supply schemes constructed	60 new water supply schemes constructed in all hot spot areas by 2027	MoW	WB, KfW. UNICEF, WHO, Water Aid, GIZ and others
	Proportion of existing water supply schemes extended	80% of existing water supply schemes extended in hotspots areas by 2027	MoW	WB, KfW. UNICEF, WHO, Water Aid, GIZ and others
Subnational Level (Regional & LGAs)				
Develop and implement water safety plans for each water utilities into cholera hotspots areas	Proportion of water utilities with water safety plans developed	95% of water utilities developed and implementing water safety plans	Water Supply utilities	WB,US Aid, UNICEF, WHO, Water Aid, GIZ and others

		by 2027		
Conduct water quality monitoring of all water sources in cholera hot spots Councils	Proportion of water sources monitored	100% of. water source monitored by 2027	MoW, Water Utilities	WB,US Aid, UNICEF, WHO, Water Aid, GIZ and others
	Proportion of samples from water points tested negative with *E.Coli*	100% of water source free from *E.Coli* by 2027	Water Supply utilities	WB,US Aid, UNICEF, WHO,
	Proportion of samples from water source tested free chlorine residues with > or = 0.2 mg/L	100% of water source tested free chlorine residues with > or = 0.2 mg/L by 2027	Water Supply utilities	Water Aid, GIZ and others
	Number of private water vendors registered	100% of private vendors registered by 2027	Water Supply utilities, LGAs, Region	WB,US Aid, UNICEF, WHO,
Procurement of water monitoring equipment and reagents for water quality testing in cholera hot spots Councils	Number of monitoring equipment procured	71 water monitoring equipment procured	MoW, MoH	DFID, WB, UNICEF, WHO, Water Aid, GIZ and others
Conduct training to water technicians and Environmental Health Officers on water quality monitoring	Proportion of Cholera hot spot Councils with trained water quality	100% of hotspots councils with trained personnel by	MoW, MoH	WB, UNICEF, WHO, Water Aid, GIZ and others

	monitoring personnel	2027		
Install simple CLEAN water treatment facilities in all 53 cholera hotspots Councils	Proportional of hotspots Councils with treatment facilities	100% of hotspots Councils with treatment facilities	MoW, MoH	WB, UNICEF, , Water Aid, GIZ and others
Construct or rehabilitate fecal sludge treatment infrastructure in all hot spot council	Proportion of hot spot Councils with fecal sludge treatment infrastructure	100% of hot spot Councils with fecal sludge treatment infrastructure	MoW	WB, UNICEF, WHO, Water Aid, GIZ and others
Objective 2: To increase the coverage of improved latrines in urban and rural areas from 71.9% to 85% by 2027				
National level				
Mobilize resources for implementation of Sanitation and Hygiene	Proportional of key actors engaged	75% of key actors engaged	MoH, MoW, PORALG,	Development Partners
	Proportion of financial commitments secured	75% of proposed financial commitments secured	MoH, MoW, PO-RALG,	Development Partners
Provide technical guidance on the implementation of Sanitation and Hygiene at Regional and Council levels	Percent of RS and Councils successfully mentored	100% of RS and Councils mentored	MoH, MoW, PORALG,	WB, UNICEF, WHO, Water Aid, and others
Capacity development to Regional and Council levels on matters pertaining to Sanitation	Proportion of RS and LGAs capacitated	100% of RS and LGAs capacitated	**MoH**	WB, UNICEF, WHO, Water Aid,

and Hygiene				and others
Conduct supportive supervisions and mentorship on WASH on WASH interventions implementation in all 18 regions and 53 hotspot Councils	Proportion of hotspot RS and councils supervised	100% of RS and LGAs supervised	MoH, MoW, PO-RALG,	WB, UNICEF, WHO, Water Aid, and others
Subnational Level (Regional & LGAs)				
	Proportion of householdwith improved sanitation	Coverage for improved sanitation increased from 71.9% to 85%	MoH,PO-RALG	WB, UNICEF, WHO, Water Aid, GIZ and others
Conduct mapping and refresher training to masons on updated low cost sanitation options and technology	Proportion of masons mapped and trained	100% of mapped masons trained	MoH,PO-RALG	WB, UNICEF,UN Habitats Water Aid, GIZ and others
Conduct sensitization meetings on construction and use of improved latrines through the use of Community Led Total Sanitation (CLTS) approach	Proportion of villages in cholera hot spots conducted sensitization meetings	100% of all villages in hot spot areas sensitized by 2027	MoH,PO-RALG	WB, UNICEF, WHO, Water Aid, GIZ and others
	Proportion of villages in cholera hot spots with signed declaration forms	100% of all villages in hot spot areas with signed declaration forms by 2027	MoH, PO-RALG	WB, UNICEF, WHO, Water Aid, GIZ and others

Construction of safely managed sanitation facilities to all CTC in hotspots areas	Proportion of CTCs with safely managed sanitation facilities	100% Safely managed facilities constructed in all CTC	MoH and PORALG	WB, UNICEF, WHO, Water Aid, GIZ and others
Conduct Public Private Partnership meetings for strengthening sanitation marketing	Proportion of cholera hot spot wards with engaged partners for sanitation marketing	100% of hotspots wards having one sanitation product supplier	MoH and PORALG	WB, UNICEF, WHO, Water Aid, GIZ and others
Enforcement of by laws on construction and use of latrine	Proportion Head of Households saved with legal notice	85% of head of Households without improved latrines saved with legal notice	MoH PORALG RS LGAs Community	
	No. of prosecutions/ advisory sessions recorded	50% of head of Households without improved latrines prosecuted	MoH PORALG RS LGAs Community	
Conduct Open Defecating Free (ODF) verification to all villages	Proportion of villages in Cholera hot spot areas certified ODF	100% of Cholera hotspots villages with certified ODF	PO-RALG and MoH	WB, UNICEF
Conduct quarterly monitoring of sanitation and hygiene indicators in cholera hot spot areas and report through NSMIS	Proportion of hot spot LGAs monitored	100% of LGAs conducted quarterly monitoring	MoH Regions and LGAs	

Construction/rehabilitation of water, sanitation and hygiene facilities in schools and HCFs in Cholera hot spot areas	Proportion of school achieved drop hole ratio 1:40 for girls and 1:50 for boys	100% of schools with appropriate toilet drop hole ratio by June, 2023	MoEST, MoW, PO-RALG	WB, UNICEF, WHO and others
	Proportion of HCF with improved WASH facilities	100% of HCF with improved WASH facilities by 2027	MoW, PO-RALG	WB, UNICEF, WHO and others
	Proportion of schools with improved WASH facilities	100% schools with improved WASH facilities by 2027	MoEST, MoW,PO -RAL G	WB, UNICEF, WHO and others
Conduct village sensitization meetings on proper hand washing practices in cholera hot spot areas	Proportion of villages conducted sensitization meetings	100% of villages sensitized by 2027	MoH	WB, UNICEF, WHO and others
Establish/strengthen school health clubs to promote hygiene in cholera hot spot councils	Proportion of schools with functional school health clubs	100% of schools with functional school health clubs	MoEST, MoW,PO -RALG	WB, UNICEF, WHO and others
Conduct advocacy meeting with public and private organization to support WASH interventions on cholera control and prevention in cholera hot spot councils	Proportion hotspot councils conducted advocacy meeting with public and private organizations.	100% of hot spot council conducted advocacy meeting with public and private	MoH, PORALG, RS, LGAs	

Objective 3: To ensure quality monitoring of food and water safety at community level in cholera hot spot areas by 2027				
National level				
Equip RS and LGAs with working tools i.e rapid water testing kits and training on water quality testing in cholera hot spot councils	proportional of RS and LGAs equipped with rapid water testing tools	100% of regions and LGAs equipped with rapid water testing tools	MoH, MoW, PORALG,	WB, UNICEF, WHO and others
	Number of RS and LGAs trained on water quality testing	100% of regions and LGAs trained on water quality testing	MoH, MoW, PO-RALG,	WB, UNICEF, WHO and others
Conduct dissemination of DTS-PoU guideline and advocacy to leaders and stakeholders on DTS-PoU from higher to lower administrative levels in cholera hot spot councils	Proportion of leaders/decision makers and stakeholders engaged on DTS-PoU	75% of leaders/decision makers and stakeholders engaged on DTS-PoU	MoH, PO-RALG,	WB, UNICEF, WHO and others
Mobilize financial resources for implementation of DTS-PoU activities in cholera hot spot councils	Proportional of key actors engaged	75% of key actors engaged	MoH, MoW, PO-RALG, MoEST,	Development Partners
	Proportion of financial commitments secured	75% of proposed financial commitments secured	MoH, MoW, PO-RALG, MoEST	Development Partners

Subnational Level (Regional & LGAs)				
Conduct village sensitization meetings to promote household water treatment and safe storage (HWTS)	Proportion of villages conducted sensitization meetings	100% of villages conducted sensitization meetings	MoH, RS, LGAs and community	WB, UNICEF, WHO and others
Create awareness and community engagement on HWTS laws and by-laws enforcement at cholera hot spot areas	Proportion of villages conducted sensitization meetings	100% of villages conducted sensitization meetings	MoH, RS, LGAs and Community	WB, UNICEF, WHO and others
Conduct quarterly monitoring of households to ensure drinking water safety at cholera hot spot areas	Proportion of HHs treating drinking water	100% of HHs treating drinking water	MoH, RS, LGAs and Community	
	Proportional of water samples collected and analyzed	100% of water samples collected and analyzed	MoH, RS, LGAs and community	
	Proportion of HHs with safe drinking water storage facilities	100% of HHs with safe drinking water storage facilities	MoH, RS, LGAs and community	
	Proportion of HHs with free residual chlorine in drinking water	100% of HHs with free residual chlorine in drinking water	MoH, RS, LGAs and community	
To conduct inspection of food and public food premises in cholera hot spot councils	Proportion of food premises inspected	100% of food premises inspected	MoH, PO-RALG, RS, LGAs and community	

Enforcement of laws and by-laws on food safety and hygiene	Proportion of food premises owners saved with legal notice	100% Food premises owners saved with legal notice	MoH, PO-RALG, RS, LGAs and community	
	No. of prosecutions/ advisory sessions recorded	50% of food premises owners who defaulted prosecuted	MoH, PORALG, RS, LGAs and community	
Objective 4: To increase WASH preparedness and response to cholera outbreaks by 2027				
Subnational Level (Regional & LGAs)				
To equip adequate WASH and facilities in CTC and mobile cholera camps.	Proportion of CTCs with adequate WASH facilities	100% of CTCs with adequate WASH facilities	MoH	WB, UNICEF, WHO and others
To conduct WASH assessment in cholera hotspot areas	proportion of hot spot LGAs assessed	75% of Hot spot LGAs assessed	MoH	WB, UNICEF, WHO and others
To equip emergency WASH facilities in affected and at-risk populations during outbreaks	Proportion of hot spot LGAs equipped with emergency WASH facilities	100% of Hot spot LGAs with emergency WASH facilities	MoH	WB, UNICEF, WHO and others
To equip adequate waste management facilities in CTC and mobile cholera Camps.	Proportion of hot spot LGAs with waste management facilities	100% of Hot spot LGAs with waste management facilities	MoH	DFID,WB, UNICEF,WHO and others

6.6. Logistic

Logistics				
Objective 1: Stock piling of key medicines, medical supplies and material required for management of Cholera prior and during the outbreak				
National Level				
Conduct Quantification workshop to build up assumptions, determine quantity, establishing supply plan and consolidation of demand and supplies from stakeholders by June 2023.	Availability of quantified health commodities report	At least 80% accuracy	MoH &PO-RALG	Development Partners and IPs,
Procurement of medicines, medical supplies and lab. Reagents for cholera	Availability of health commodities at central Medical Store Department	100%	MoH &MSD	Development Partners and IPs
Distribution of health commodities at all levels	Availability of health commodities at service delivery point	100%	MoH &PO-RALG	Development Partners and IPs
To conduct health commodities tracking to 49 hotspot districts	health commodity tracking report	100%	MoH & PO-RALG	Development Partners and IPs

6.7. Use of Oral Cholera Vaccine (OCV) as an intervention

Cholera vaccination has been used complementary to cholera prevention and control measures, primary prevention measures such as safe water and sanitation do play a major role in controlling Cholera. Improving access to clean potable water, adequate sanitation, and promotion of good WASH practices, thus remain the mainstay of prevention of both endemic cholera and cholera outbreaks.

Tanzania has experience in using the oral cholera vaccines. In 2010, OCV was administered in Zanzibar and was effective in the reducing the incidence of cholera cases in the subsequent years. In 2015, OCV was again successfully administered, under a crisis of asylum seeks influx, to the population living in the refugee camp and surrounding communities in Kigoma Region.

To further guide and enhance the use of OCV, Tanzania will conduct a needs assessment and evaluate the implementation in the stated areas, before introduction of the OCV in the country. Key activity which will include conduction of comprehensive assessment of the need for the introduction of OCV in hot spot districts is expect to be completed by 2023.

7. Monitoring and Evaluation

There will be development of a robust monitoring and evaluation (M&E) mechanism across all priority areas. Both the National and Subnational levels, the Cholera NTF will oversee the implementation of the plan and oversee the indicators. All strategic objectives, activities and indicators within each priority area will be tracked and reported on a quarterly basis to ensure that activities are implemented as intended and to follow up with adjustments or corrective actions where activities are not implemented, as needed.

A simple supervision and monitoring tool will be developed to facilitate work in tracking the progress based on the targets. Some selected indicators will include but not limited to;

i. Increase in number of regions and districts with locally adopted funded multisectoral cholera prevention and control plan
ii. Reduction of cholera cases overall and also specific in regions and districts. Measures will include;
    a. Annual # of suspected deaths attributed to cholera
    b. Annual # of suspected cases attributed to cholera
    c. Attack rates i.e. proportion of persons at risk that develop cholera
iii. Reduction in cholera case fatality rate overall and also specific in regions and districts
iv. Increase in safe water coverage in hotspot in districts

Additionally, there will be regular production and dissemination of reports on cholera as well as analysis of risk factors on and off to enable timely remedial actions. Research studies will also be done to better understand issues pertaining to recurrent cholera and best practices will be shared. Field Epidemiology and Laboratory Program(FELTP program will be used, as well as other training programs.

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Annex I – Comprehensive Monitoring and Evaluation Framework

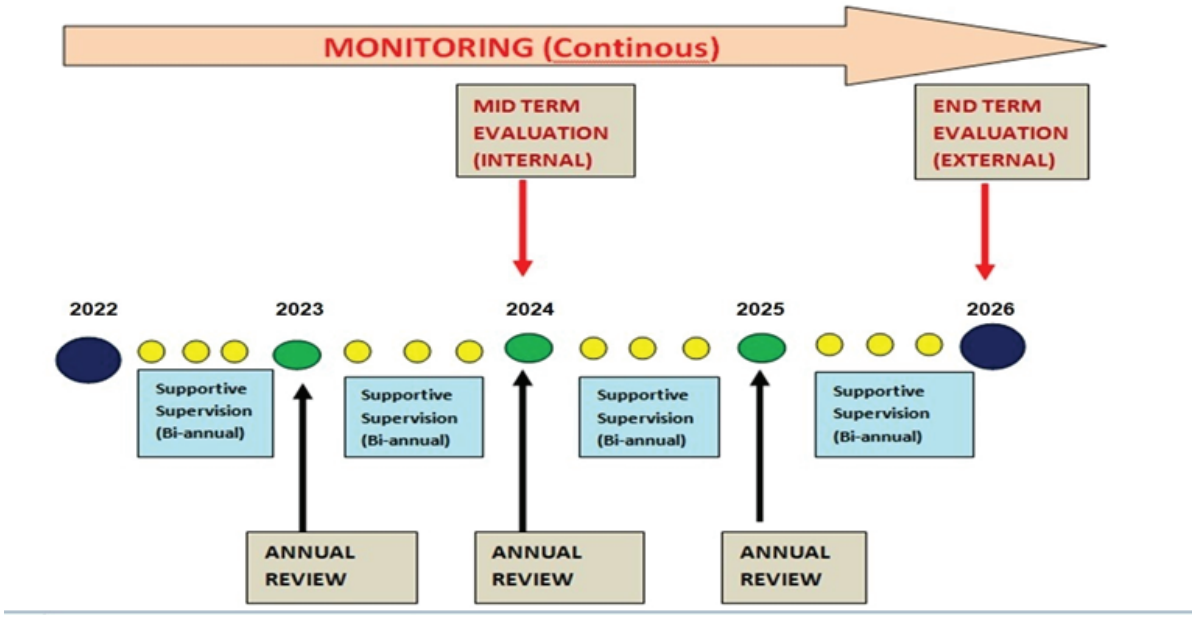
The Monitoring and Evaluation (M&E) plan identifies indicators against which performance will be assessed. These indicators will be tracked regularly to ensure that targets are met and the implementation of the plan is on course. M&E functions of the plan will be implemented at national, regional, and Local Government Authority (LGA) level. Specifically, the plan targets **the 49 identified cholera hotspots districts in 18 regions** of Tanzania.

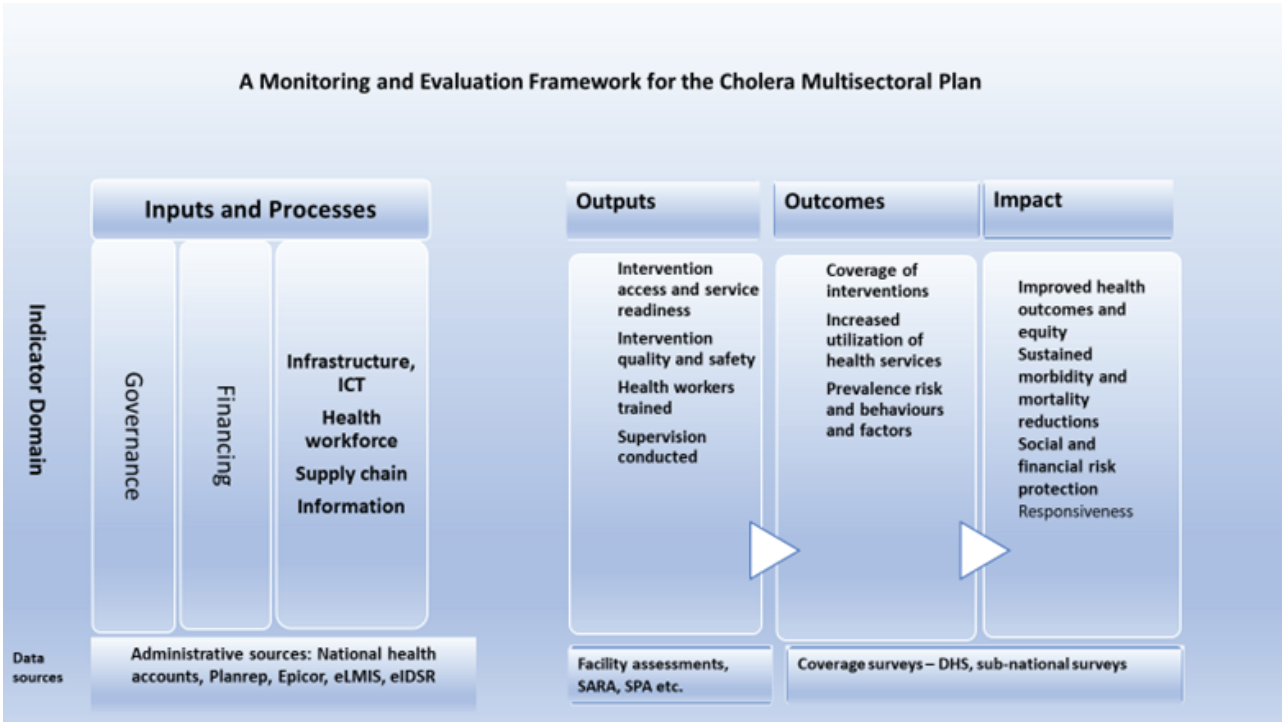
The Ministry of Health (MoH) will be the lead ministry overseeing implementation of the plan, M&E of the NMCPCP at the national level. The One Health Coordinating Desk of the Prime Minister's Office will assist the Ministry in coordinating the sectors to ensure NMCPCP implementation. PORALG will overseeing the implementation at regional and council levels. The Regional and Council Health Management Team (R/CHMT) will be oversee the development of the specific Regional and Council Multisectoral Cholera Prevention and Control plans tailored to their own specific needs and context.

The M&E plan addresses key elements including the strategic priorities of the National Multisectoral Cholera Prevention and Control Plan (NMCPCP). It provides an integrated framework for M&E of all priority areas through the logical framework; presents the selected indicators and targets for tracing progress and specifies country mechanisms for data collection, analysis and review.

Schematic presentation of the Monitoring and Evaluation of the plan is shown below:
In order for the cholera plan to achieve its set goals; inputs such as finance and human resource need to translate into outputs such as commodities and delivery systems for medicines and other essential commodities, capacity building, improved services etc. If these outputs are well designed and reach the populations for which they were intended, the cholera plan will translate into positive short-term effects or outcomes such as improve case management and Infection, Prevention and Control measures at health facilities etc.

Typically input and process indicators rely upon administrative and data systems; outputs and outcomes are measured through health management information systems (HMIS) which are routine data and sub-national surveys. Measuring impact requires extensive investment in evaluation which involves specific population-based surveys to measure the overall reduction in





Monitoring

Monitoring of the multisectoral cholera plan will involve routine and continuous tracking of planned activities. There will be a robust monitoring mechanism across all priority areas. All strategic objectives, activities and indicators within each priority area will be tracked and reported on a regular basis to ensure that activities are implemented as intended and to follow up with adjustments or corrective actions where activities are not implemented, as needed.

Table 1 below presents the Logical Framework, with an overall description of the vision, goal, objectives, outcomes targets, strategic interventions and activities. The interventions are organized into five priority areas, each with a range of 2 to 4 strategic interventions. The implementation of activities under each of the five priority areas will result in the reduction of cholera cases in the hotspot regions for the realization of the targets by 2026

Table 4. The Cholera Multi-Sectoral Plan M & E Logical Framework

Vision
A healthy nation that is free from the economic and social disruptions caused by cholera

Goal
Elimination of cholera epidemics through **e**nhancement of prevention and control interventions

Objective
Reduction of Morbidity and Mortality due to cholera by 90% in cholera hotspots districts in Tanzania by 2023

Specific objectives:

a) To strengthen capacity and readiness to response to cholera outbreaks
b) To strengthen coordination of multi-sectors and partners for prevention and control of cholera at National, Regional, and District levels
c) To strengthen, support and build capacity for detection, reporting and case confirmation of cholera organism (*Vibrio cholerae)*
d) To improve case management and IPC at CTC and health facilities
e) Promote safe use of water, WASH in health facilities and communities
f) To enhance community engagement for adoption of appropriate and sustainable mechanisms and practices for protection and prevention against cholera
g) To promote operational research in order to document and disseminate lessons learnt, best practices, challenges and evidence-based solutions
h) To ensure effective M &E of cholera preparedness and responses activities

Strategies

a) Improve Multisectoral Coordination structures for cholera prevention and control
b) Enhance epidemiological and laboratory surveillance in hot spot areas to detect, confirm and respond rapidly to cholera outbreaks
c) Promote safe use of water, WASH practices
d) Improve risk communication and social mobilization to promote positive behavioral change; quick access to case management and IPC services;
e) Stockpile key essential logistical services to rapidly respond to the cholera threat

Expected Outcomes

a) Improved information sharing; effective multisectoral collaboration and coordination for resources and technical support; and strengthened partnership among stakeholders for cholera control and prevention at all levels.
b) Reduced Cholera Case Fatality rate to below 1%
c) Improved accessibility of quality drinking water, sanitation and hygiene
d) Enhanced and communities' engagement to appropriate cholera preventive practices
e) Cholera new cases prevented through enhanced accessibility to improved water, sanitation and hygiene services, intensive health promotion and education interventions and a well-established surveillance system

PRIORITY AREA 1: Multisectoral Coordination for Cholera Prevention and Control							
TARGETS 1. At least 4 multisectoral national public health emergency management committee (PHEMC) meetings annually on cholera prevention are held by 2026 2. At least 80% resource have been mobilized for implementation of National Multisectoral Cholera Prevention and Control Plans 3. All cholera hotspot districts hold 4 multisectoral PHEMC meetings annually on cholera prevention by 2026 4. All hotspot districts have cholera Multisectoral Cholera Prevention and Control plans by June 2026							
Strategic intervention I: Strengthen the coordination and information sharing mechanism between the Government and stakeholders at all levels							
S/N	**Activities**	**Indicators**	**Desired Targets (No, %)**	**Means of verification**	**Assumptions**	**National Responsible Person**	**Stakeholders/ Partners**
National level							
1.	Printing 1000 NMCPCP for dissemination to the national (100), regional (250), hotspots districts	Number of NMCPCP copies	1000	Available copies	Funds are available	MoH	Development partners and IPs

	(600), partners and other stakeholders (50)						
2.	Launching and high-level advocacy to Permanent Secretaries, Regional and District Commissioners from the cholera hotspots and other stakeholders on NMCPCP and its implementation plan.	Number of advocacy meetings conducted	1	Report	Funds are available	MoH	Development partners and IPs
3.	Disseminate NMCPC plan to national level stakeholders	Number of dissemination meetings	2	Reports	Funds are available	MoH	GoT, WHO, CDC, UNICEF
4.	Conduct resource mobilization meetings to all stakeholders for implementation of the	% of required resources secured Annually	At least 80%	Proportion of budget allocated for cholera	Availability of stakeholders and funding	MoH, MoW, PMO	MoW, PORALG, WHO, UNICEF, WaterAid, CDC, PATH

	cholera plan at the National level						
5.	Mapping and updating inventory of stakeholders for cholera control at National level	Updated Inventory of stakeholders in place Number of stakeholders mapped, engaged and coordinated at national level	Inventory of stakeholders in place List of stakeholders identified	Updated inventory of stakeholders in place Availability of database at respective levels; Meeting reports and TOR availability	Registers already available for existing partners	EOC	PMO-DMD, MoW, WHO, RAS, DED PORALG Development partners and IPs

6.	Support PHEOC Operations	% of budgeted funds secured out of allocated from partners and GoT	At least 80%	Proportion of budget allocated for cholera	Funds available	MoH,	Development partners and IPs
7.	Conduct bi Annual multi-sectoral coordination meetings at National level (National PHEMC)	Number of required meetings conducted	1 meeting every quarter	Minutes of meetings	Key members are available on planned times	PMO, MoH, MoW and PoRALG	Development partners and IPs
8.	Develop TOR/LoA of key sectors in the cholera prevention and control	Number of key sectors who signed MoU/LoA	100% of stakeholder sign MoU	TOR/LoA document		PMO, MoH, PoRALG	Development partners and IPs
9.	Develop MoU to facilitate information sharing with PMO's office	Number of partners who signed MoU	Endorsed MoU in place	MoU document		PMO, MoH, PoRALG	Development Partners and IPs
10.	Hire consultant to oversee the implementation of the plan	Consultant available	NA	Consultation report	Funds availability	MoH	Development partners and IPs

11.	To conduct Intra Action Review during outbreak of cholera	Report submitted	At least 80%	Number of report submitted	Funds available	MoH& PORALG	Development partnes and IPs
12.	To conduct After Action Review to identify the strengthsand gaps exhibited during the response	Report submitted	At least 80%	Number of report submitted	Funds available	MoH& PORALG	Development partnes and IPs
13.	To conduct supportive supervision on cholera multi-sectoral prevention and control plan implementation at subnational level	Number of report submitted	80%	Report submitted	Funds available	, MoH, MoW, PORALG, and PMO	Development partners and IPs
Strategic intervention II: Implement Council cholera multi-sectoral plans in line with the national multi-sectoral Cholera Prevention and Control plan							

Subnational Level (Regional & LGAs)							
S/N	**Activities**	**Indicators**	**Desired Targets (No, %)**	**Means of verification**	**Assumptions**	**National Responsible Person**	**Stakeholders/ Partners**
14.	Regions in collaboration with cholera hotspots LGAs to conduct high-level advocacy sessions at regional and district level (Political leaders, RCs, DCs, Religious leaders, Media Owners and Editors) on the implementation of NMCPCP	Number of advocacy sessions conducted	2 sessions conducted	Activity reports	Funds available	PO-RALG, RAS, DED	Development partners and IPs
15.	Regions in collaboration with cholera hotspots LGAs to disseminate	Number of dissemination	4 meetings conducted	Report	Funds available	PORALG, RAS, DED	Development partners and IPs

	NMCPCP to cholera hotspots districts	meetings conducted					
16.	Regions in collaboration with cholera hotspots LGAs to map and update inventory of stakeholders for cholera control at LGA level	Number of stakeholders' inventory updated	1 update every quarter	Updated inventory of stakeholders in place	Registers already available for existing partners	PORALG, RAS, DED	Development partners and IPs
17.	Regions to conduct quarterly multi-sectoral coordination meetings at regional level (PHEMC)	Number of required cholera's PHEMC meetings conducted in hot spot regions with participants from relevant sectors and stakeholders	1 meeting every quarter	Minutes of meetings	Key members are available on planned times	RAS, RMO	Development partners and IPs
18.	Districts to conduct quarterly multi-sectoral	Number of required cholera's PHEMC meetings conducted in hot	1 meeting every quarter	Minutes of meetings	Key members are available	DED, DMO	Development partners and IPs

	coordination meetings at district level (PHEMC)	spot districts with participants from relevant sectors and stakeholders			on planned times		
19.	Support region and district to adapt cholera and prevention and control plan	Proposition of hotspot regions and district with cholera prevention and control plan	100%	Availability of region and district prevention and control plan	Funds availability	RAS DED	Implementing partners
20.	Adapt the TOR of key sectors in the cholera prevention and control at district level	Number of sectors TOR adapted	100%			RAS/DED	Implementing partners
21.	Mobilise resources for implementation of cholera prevention and control plan at regional and district council/ level	% of required resources secured	At least 80%			RAS/DED	Implementing partners

PRIORITY AREA 2: Surveillance and laboratory activities							
TARGETS 1. 100% of detected cholera cases investigated by 2026 2. 100% of cholera suspected cases are laboratory confirmed as per protocol by 2026 3. 100% of health facilities located in cholera hotspots with access to laboratory testing capacity by 2026 4. 100% of hotspot district analyses and utilise cholera data by 2026							
Strategic intervention I: Improve capacity for early detection and reporting of cholera outbreaks							
S/N	Activities	Indicators	Desired Targets(No, %)	Means of verification	Assumptions	National Responsible Person	Responsible Partners
National level							
1.	To print and disseminate guideline for event-based surveillance to 13 hotspot Regions	Proportions of hotspot Regions with guideline for event-based surveillance	13 (100%)	Availability of guideline in hotspot Regions Delivery note	Availability of fund to support printing and dissemination	MoH -Epid	WHO/ CDC
2.	Conduct training to 99 ToT for event-based surveillance in hot spot Regions and District	Proportion of ToT trained	99 (100%)	Availability of TOTs Training reports	Funds, training package and trainees	MoH -EPID	WHO/CDC and other Partners

3.	To Conduct training to 1200 HCWs on event-based surveillance in hot spot districts	Proportion of HCWs trained out of targeted Districts	(1200) 100%	Training reports Availability of HCW trained	Funds, training package and trainees	MoH-Epid.	WHO/CDC and other Partners
		Proportion of hotspot Councils trained	30 (100%)	Training reports Availability of HCW trained	Funds	MoH-Epid	WHO/CDC and other Partners
4.	Conduct training to 2600 CHWs on event-based surveillance in hot spot Regions	Proportion of CHWs Trained out of targeted Regions	(2600) 100%	Training reports Availability of HCW trained	Funds, training package and trainees	MoH - Epid/PoRALG	

5.	Conduct training to 99 ToT on Cholera active case search and contact tracing in hot spot districts	Proportion of ToT trained	99 (100%)	Availability of TOTs Training reports	Funds, training package and trainees	MoH -Epid	WHO/CDC and other Partners
6.	To Conduct training to 1200 surveillance officers on Cholera active case search and contact tracing in hot spot districts	Proportion of surveillance officers trained	1200 (100%)	Availability of TOTs Training reports	Funds, training package and trainees	MoH -EPID	WHO/CDC and other Partners
7.	To Conduct training to CHWs 2600 on Cholera active case search and contact tracing in hot spot Regions	Proportion of CHWs trained	2600 (100%)	Availability of TOTs Training reports	Funds, training package and trainees	MoH -EPID	WHO/CDC and other Partners
8.	Print and distribute Swahili transalated cholera	Proportion of Hotspot Regions with Swahili	13 (100%)	Availability of guideline in hotspot	Availability of fund to support	MoH - Epid/PORALG	WHO/CDC and other Partners

	standard case definitions posters for CHWs in hot spot Regions and districts	translated cholera standard case definition posters for CHWs		Regions Delivery note	printing and disseminatio n		
		Proportion of Hotspot districts with Swahili translated cholera standard case definition posters for CHWs	30 (100%)	Availability of guideline in hotspot Regions Delivery note	Availability of fund to support printing and disseminatio n	MoH Epid /PORALG	WHO/CDC and other Partners
9.	Conduct biannual Physical supportive supervision to hot spot regions on IDSR focusing cholera	Proportion of hotspots regions supervised	13 (100%)	Supportive supervision reports	Availability of funds	MoH & PORALG	WHO/CDC and other Partners

Subnational Level (Regional & LGAs)							
10	To distribute guideline for event-based surveillance to 30 hotspot districts	Proportions of hotspot districts with guideline for event-based surveillance	30 (100%)	Availability of guideline in hotspot Regions Delivery note	Availability of fund to support printing and dissemination	RMO/DMO	WHO/ CDC and other partners
11.	To distribute guideline for event-based surveillance to 1200 facilities in hotspot districts	Proportions of facilities in hotspot districts with guideline for event-based surveillance	1200 (100%)	Availability of guideline in hotspot Regions Delivery note	Availability of fund to support printing and dissemination	DMO	WHO/ CDC and other partners
12	To Conduct training to 1200 HCWs on event-based surveillance in hot spot districts	Proportion of HCWs in hotspot Councils trained	(1200) 100%	Training reports Availability of HCW trained	Funds, training package and trainees	RMO	WHO/CDC and other Partners
13		Proportion of facilities in hotspot Councils trained	1200 (100%)	Training reports	Funds	RMO	WHO/CDC and other Partners

				Availability of HCW trained			
14	To Conduct training to 2600 CHWs on event-based surveillance in hot spot Councils	Proportion of CHWs in hotspot spots councils trained	(2600) 100%	Training reports Availability of HCW trained	Funds, training package and trainees	RMO	WHO/CDC and other Partners
15	To Conduct training to CHWs 2600 on Cholera active case search and contact tracing in hot spot Districts	Proportion of CHWs trained	2600 (100%)	Availability of TOTs Training reports	Funds, training package and trainees	RMO	WHO/CDC and other Partners
16	To distribute Swahili transalated cholera standard case definitions posters for CHWs in hot spot districts	Proportion of Hotspot CHWs with Swahili translated cholera standard case definition posters for CHWs	2600 (100%)	Availability of guideline in hotspot Regions Distribution list	Availability of fund to support printing and dissemination	DMO	WHO/CDC and other Partners

17	Conduct training on surveillance and outbreak investigation to clinicians from health facilities in hot spot districts	Proportion of Hotspots districts with trained clinicians	1960 (100%)	Availability of Trained clinicians Training reports	Funds, training package and trainees	RMO/DMO	WHO/CDC and other Partners
18	Conduct Quartery Physical supportive supervision to hot spot districts on IDSR focusing cholera	Proportion of hotspots districts supervised	30 (100%)	Supportive supervision reports	Availability of funds	RMO	WHO/CDC and other Partners
19	Conduct biannual Physical supportive supervision to hot spot regions on IDSR focusing cholera	Proportion of health facilities in hotspot districts supervised	1200 (100%)	Supportive supervision reports	Availability of funds	DMO	WHO/CDC and other Partners
Strategic Intervention 2: Improve analysis and utilization of cholera data by hotspot districts							
National level							
20	To conduct training for 288 RHMT, IDSR FP, and Lab FP at district and regional level on data analysis and	Proportion of RHMT, IDSR FP and Lab technician trained	100%	Availability of shared Sitrep	Availability of funds and trainers	MOH-Epid/PORALG	WHO/CDC/ PATH and other Partners

	generation of information products including situation report preparation						
21	Prepare and share Monthly national IDSR bulletin with stakeholders a t national level	Proportion of monthly bulletins produced	12 (100%)	Availability of Bulletins in MoH website Availability of shared Bulletins in respective Partner website	Human resource capacity available	MoH-Epid/PORALG	
22.	To conduct biannual data quality assessment	Proportion of quality assessments done	2 (100%)			MoH-Epid/PORALG	
23.	Prepare and share daily situation report (Sitrep) with stakeholders during	Proportion of daily Sitrep produces and shared	100%	Availability of shared sitrep	Human resource capacity available	MoH EC-Epid	

	outbreak						
Subnational Level (Regional & LGAs)							
24.	Prepare and share Monthly District and Regional IDSR bulletin with stakeholders a t district, Regional and National level	Proportion of monthly Regional bulletins produced and shared	12 (100%)	Availability of Bulletins in district and Regional website Availability of shared Bulletins in respective Partner website	Human resource capacity available	RMO & DMO	
		Proportion of monthly District bulletins produced and shared	12 (100%)				

25.	Regions and Councils to share daily SitRep to the next level of reporting when there is an active outbreak	Proportion of daily Sitrep Rep shared	100%	Availability of daily Situation reports during outbreaks	Trained Human Resource capacity available	DMO	Available partners in the Region and Districts

PRIORITY AREA 3: Case management

TARGETS

1) All hotspots districts have Case Fatality Rate below 1% by 2027
2) All CTC in hotspots districts have proper IPC measures by 2027
3) All hotspots districts have established community ORS points by 2027
4) All health care workers at CTC in all hotspots' districts have been trained and able to manage cholera cases by 2027

Strategic intervention I: Reduce the case fatality rate for cholera to less than 1% in all CTC

S/N	Activities	Indicators	Desires Targets (No, %)	Means of verification	Assumptions	National Responsible Person	Responsible Partners
National level							
1.	Print and distribute cholera case management, IPC guidelines, and job aid, standard operating procedures (SOPs) posters for all hotspot's	Proportion of councils supplied with printed copies of all materials	100%	Distribution list and supervision report	Funds and other resources are available Updated	MoH PORALG – HEALTH	GoT/WHO/ CDC/PATH /TBD

	areas				Documents for printing available		
2.	Conduct TOTs on case management and IPC in all Hotspot councils	Proportion of hotspot councils with at least 4 TOTS trained (clinician, Nurse, laboratory personnel and Medical attendant)	100%	Training reports	Resources availability	MoH PORALG – HEALTH	Development partners and IPs
3.	Quantify, procure and distribute health commodities for cholera treatment center	Proportion of hotspot councils supplied with health commodities for management of cholera	100%	eLMIS	Requirement schedule is in place	MoH PORALG	Development partners and IPs
4.	Conduct training for trainers (ToT) on case management and IPC from all 17 regions and 44 councils	Proportion of hotspot councils with trained health care workers trained on cholera case management and IPC.	100%	Training reports - Guideline distributio n list	Funds and other resources are available Updated case definition for cholera available	RAS/DED	Development partners and IPs

Subnational Level (Regional & LGAs)							
5.	Quantify, procure and distribute cholera health commodities to CTC	Proportion of CTC supplied with health commodities for management of cholera in all hotspot council	100%	eLMIS	Requirement schedule is in place	RAS/DED	Implementing partners
6.	Districts to conduct mentorship trainings to health care workers on cholera case management	Proportion of health care workers mentored on cholera case management	90%	List of mentored HCWs	Resources are available	DED	Implementing partners
7.	Provide management of cholera patients at CTC in hotspot councils during outbreak	Proportion of Regions and Councils with allocated resources for provision of case management services.	All councils have allocated resources for provision of case management	Council report	Funds available	RAS/DED	Implementing partners

Strategic intervention II: Improve early management of cholera cases							
National Level							
8.	Develop and disseminate a supervision and mentorship guides for case management and establishment of community points for ORSPs	Number of case management and community points for ORSPs g uides developed	10,000	Availability of guides in the ORSPs	Resources are available	MoH PORALG	Development partners and IPs
Sub-National level (Regional and councils)							
9.	Districts to establish ORS points at community level in all hotspot areas	% of cholera hotspots Village/Mtaa with at least one established ORSP's	100%	-List of ORS points established Availability of ORSPs during visit	ORS is available	DED	Development partners and IPs
10.	Districts to conduct training to HCW/attendant and other community workers, leaders working at ORS points on IPC and community cholera	Percentage of ORS points with at least one trained	100%	Attendance list for the training and training report	ORS is available	RAS, DED	Development partners and IPs GoT

	management	HCW/attendant, community worker and leader.					
11.	Districts to conduct cholera mortality audits during outbreak for each death	Proportion of cholera deaths audited	100%	Cholera death audit reports	Mortality audit committee available	RAS, DED	Development partners and IPs

PRIORITY AREA 4: RISK COMMUNICATION AND COMMUNITY ENGAGEMENT

TARGETS

1. A comprehensive coordination structure for Risk Communication and Community Engagement in cholera hotspot councils in place by 2026
2. 85% of RCCE focal points (community gate keepers) within hotspot councils with knowledge and skills on the principles for community engagement on Cholera control and prevention by 2026
3. 90% of population in hotspot councils having appropriate knowledge on Cholera prevention and control by 2026
4. 100% of people in need of psychosocial support in cholera affected areas get it by 2026

Strategic intervention I: Strengthen Coordination of Risk Communication and Community Engagement in cholera hotspot councils in place by June 2021.

S/N	Activities	Indicators	Desires Targets (No, %)	Means of verification ion	Assumptions	Responsible Ministry/entity	Responsible Partners
National level							
2.	Develop and review and disseminate cholera Risk Communication and Community Engagement Operational tool.	RCCE operational tool in place	RCCE Operational Tool guiding implementation of interventions at all levels	Availability of activity reports	RCCE activities well implemented	MoH/ HPS	UNICEF,WHO, USAID, Save the Children, TRCS & Other mapped stakeholders TBD
	Review/update existing	Availability of	RCCE Training	Activity	Resources	MoH/ HPS	WHO, UNICEF

2.	Develop and review and disseminate cholera Risk Communication and Community Engagement Operational tool.	RCCE operational tool in place	RCCE Operational Tool guiding implementation of interventions at all levels	Availability of activity reports	RCCE activities well implemented	MoH/ HPS	UNICEF,WHO, USAID, Save the Children, TRCS & Other mapped stakeholders TBD
3.	Review/update existing RCCE Training Package on Cholera context for use at regional and council levels	Availability of Cholera RCCE Training Package	RCCE Training Package in place	Activity reports on review of training package	Resources available to support this activity	MoH/ HPS	WHO, UNICEF
4.	Develop a communication strategy for prevention of diseases (cholera).	A developed communication strategy for Prevention of diseases (cholera).	Risk Communication Strategy in place	Communication Strategy in place	Resources available to support activity	MoH/ HPS, GCU	UNICEF, USAID Tulonge Afya
Regional, Council & Community Levels							
5.	Regions and hotspot councils to conduct mapping of RCCE stakeholders (including private sectors such as Telecom companies, Banks, FBOs etc.)	Proportion RCCE stakeholder of s mapped	100% RCCE Stakeholders identified at regional and council level	Availability of database at respective levels; Meeting reports and TOR availability	Availability framework/ database	RHMT, CHMT	UNICEF, TRCS, USAID, Tulonge Afya, Save the Children

6.	Regions and hotspot councils to conduct technical meeting for buy-in and support of RCCE interventions.	Proportion of technical meetings conducted over the scheduled time.	Quarterly meetings conducted	Stakeholder s' actively engaged and supporting RCCE interventions	Resources allocation for implementation of RCCE interventions	RHMT, CHMT	UNICEF, TRCS, USAID, Tulonge Afya, Save the Children
7.	Sensitize Community Mobilizers on the use of Risk Communication Strategy for prevention and control of diseases (cholera).	Proportion of Community mobilizers sensitized on the use of Risk Communication	100% community mobilizers in hotspot councils sensitized	Use of a Risk Communication Strategy	Resources available (fund, human)	RHMT/CHMT	UNICEF, TRCS, USAID, Tulonge Afya, Save the Children
		Strategy within hotspot council.					
Strategic Intervention II: Raise and sustain public awareness in hotspot councils to ignite risk perception and catalyse positive behavioural change on Cholera Control and Prevention							
National Level							
8.	Develop Cholera IEC/SBCC materials	Number of IEC/SBCC materials developed (per type).	95% of require IEC/SBCC materials developed	Activity reports in place	Resources allocated on IEC/SBCC materials development	MoH/ HPS, GCU	UNICEF, WHO, USAID, Save the Children, TRCS & Other mapped stakeholders TBD

9.	Conduct mass media dissemination of Cholera IEC/SBCC materials using different channels	Proportion of media channels disseminating Cholera prevention and control information	75% media channels disseminating Cholera information	Availability of media transmission schedules and distribution list (for print materials)	Available allocated Resource	MoH/ HPS	UNICEF, WHO, USAID, Tulonge Afya, Save the Children, TRCS/CDC/ PATH/ TBD
10.	Conduct media monitoring on reach of cholera messages	Proportion of media conducted	75% media channels disseminating Cholera information	Report	Availability of the scanning media software	MoH/P ORALG	UNICEF, WHO, USAID Tulonge Afya,
11.	Conduct biannual media orientation trainings (*60 national media personnel's*) on how to appropriately report on Cholera health education and lessons learnt.	Proportion of national media personnel oriented in a year. Number of orientation meetings conducted in a year.	100% media orientation conducted. orientation meetings conducted	Activity reports	Funding available	MoH/ GCU/ HPS	UNICEF,WHO, USAID, Save the Children, TRCS & other partners
12.	Conduct annual media orientation to *176 media personnel from hotspot councils* (zone wise) to promote correct and frequent reporting on Cholera health	Proportion of media personnel (Hotspot regions) oriented in a year	100% media orientation conducted. orientation meetings	Activity reports	Media reporting correctly on Cholera	MoHC/ GCU/ HPS	UNICEF, WHO, USAID, Save the Children, TRCS & other

	education and best practices	Number of orientation meetings conducted in a year	conducted				partners

At Regional, Council and Community Level							
13.	Distribute and preposition IEC/public awareness materials in strategic areas in hotspot council	Evidence showing availability of IEC/Public awareness materials in strategic areas	100% hotspots of councils	IEC material in strategic areas	Resources availability	MoH/ HPS; PO- RALG; RHMT/CHMT	UNICEF, WHO, USAID, Save the Children, TRCS & Other mapped stakeholders TBD
14.	Conduct community mobilization activities (using megaphones, PA systems with health experts) for public awareness and community Sensitization in hotspot councils.	Proportion of hotspots councils where community mobilization activities have been conducted	100% of Hotspot councils mobilized community activities	Availability of reports	Resources available to support community mobilization	CHMT/RCCE Focal person	Local Partners at council level (TBD)

Strategic intervention III: Strengthen community engagement for adoption of appropriate and sustainable preventive measures to support behaviour change and practices							
National level							
15.	Conduct 34 national facilitators (TOTs) trainings on adoption of appropriate and sustainable preventive measures.	Proportion of national facilitators (TOTs) trained	100% national facilitators trained	Availability of activity reports	Resources available to support this activity	MoH – HPS	UNICEF, WHO
At regional, council and community levels							
16.	Conduct trainings on adoption of appropriate and sustainable preventive measures to 132 Health Promotion Coordinators/RCCE Focal persons***(CBHPCo, NSHPCo, HPCo, WSO)*** from hotspot councils.	Percentage of hotspot councils with trained RCCE focal persons	100%	Availability reports	Financial resources availability	PO-RALG RHMT &	UNICEF,WHO, USAID, Save the Children, TRCS & Other mapped stakeholders TBD
17.	Orient Community Health Workers (CHWs) in hotspot councils on their role in Cholera control and prevention at community level	Percentage of hotspots councils with CHWs who have been oriented	80% hotspot councils having oriented CHWs	Availability of reports	Resources available to Support this activity	CHMT	UNICEF, TRCS, USAID Tulonge Afya, Save the Children, Local partners (TBD)

18.	Orient school health teachers to support health education on cholera prevention and control.	Percentage of hotspot councils where school health teachers and head of schools have been oriented.	75% hotspot councils reached	Availability of reports	Resources available to support this activity	CHMT in collaboration with Council Education Department	UNICEF, TRCS, USAID Tulonge Afya, Save the Children, Local partners (TBD)
19.	Identify and develop data base for community gate keepers (influential people and special groups) for Cholera control and prevention within hotspot councils (water vendors, fishermen, nomads, prisoners, miners, transporters, farm owners and farmers etc.)	Percentage of influential/special community gate keepers identified.	100% community gate keepers in hotspot councils identified	Availability of database for mapped community gate keepers	Resource availability	CHMT (RCCE Teams working with WASH team)	UNICEF,WHO, USAID, Save the Children, TRCS & Other mapped stakeholders TBD
20.	Conduct sensitization meetings to community gate keepers (influential people and special groups) within hotspot councils	Proportion of hotspot districts where influential people and community gate keepers have been sensitized	100% of community gate keepers sensitized	Availability of reports	Community gate keepers supporting Cholera control and prevention initiatives	Resource availability	UNICEF,WHO, USAID, Save the Children, TRCS & Other mapped stakeholders TBD
Strategic intervention IV: Scale up provision of Mental Health and psychosocial care and support services for individuals, families, communities and vulnerable population affected by cholera							
National level							

21.	Build capacity on PSS frontline workers (SWOs, Health care workers) on mental health, psychosocial care and support (PSS) in regions and 44 hotspot councils	Percentage of SWOs, Health care workers, and School Health Coordinators have been capacitated in 44 hotspot councils.	100%	Availability of activity reports	Availability of resources	MOH, PO-RALG, RHMTs & CHMTs	
22.	Review and dissemination of MHPSS guideline/SOPs training materials and job aids to be used by frontline workers	Number of guidelines/SOPs training materials and job aids are disseminated to councils and used by frontline workers	**100%**	Availability of activity reports	Availability of resources	MoH, PO-RALG, RHMTs & CHMTs	
23.	Orient managers and caregivers in institutions caring for vulnerable groups (MVCs and elderly people) on public health events. .	Managers and caregivers oriented on public health events in institution caring for vulnerable in all hotspots' councils.	**100%**	Managers and care givers with skills and knowledge to provide PSS to vulnerable group	Availability of resources allocated to institutions for Vulnerable groups.	MoH, PO-RALG, RHMTs & CHMTs	

PRIORITY AREA 5: Water, Sanitation and Hygiene (WASH)

TARGETS

1. 80% of the population in rural hotspots have access to safe water supply by 2026
2. 95% of population in urban hotspots have access to safe water supply by 2026
3. 100% of the households have access to basic sanitation (toilets with washable floor and intact slab) by 2026
4. 75% of households have access to hand washing facilities (Hand washing point, water and Soap) by 2026
5. 75% of households in hotpot practice safe drinking water storage by 2026
6. 100% of villages in the hotspot's councils are Open Defecation free by 2026

Strategic intervention I*:* Increase access to safe water supply to population living in cholera hotspot councils in rural and urban settings

S/N	Activities	Indicators	Desires Targets (No, %)	Means of verification	Assumptions	Responsible	Development Partners
National level							
1.	Rehabilitation of existing water supply system in 49 cholera hot spot councils	Proportion of water supply system rehabilitated	80% of water systems rehabilitated in all hotspots areas	Availability of report	The hotspot Councils have competent staff for carrying out Construction and supervision	MoW	WB, UNICEF, WHO, KfW Water Aid, GIZ and others

			b y 2026				
2.	Construction of new and extension of existing water supply schemes into hotspots areas	Number of water supply schemes constructed	60 new water supply schemes construct ed in all hot spot areas by 2026	Availability of report	The hotspot Councils have competent staff for carrying out Rehabilitation and supervision	MoW	WB, UNICEF, WHO, KfW Water Aid, GIZ and others
		Proportion of existing water supply schemes extended	80% of existing water supply schemes extended in hotspots areas by 2026	Availability of report	The hotspot Councils have competent staff for carrying out construction supervision	MoW	WB, UNICEF, WHO, KfW Water Aid, GIZ and others

3.	Install simple water treatment facilities in all 49 cholera hotspots Councils	Proportional of hotspots Councils with treatment facilities	100% of hotspots Councils	Availability of installed simple water treatment facilities	Resource availability	MoW, MoH	WB, UNICEF, WHO, KfW Water Aid, GIZ and others
4.	Conduct training to Regional and District Environmental Health Officers (EHO), water engineers, water laboratory technicians, Community based water supply organization management team in 49 Councils on water quality monitoring services	Proportion of hotspot councils and regions trained on	100%	Report	Councils have designated focal persons for water quality surveillance	MoH	WB, UNICEF, WHO, Water Aid, CDC and others
5.	Conduct supportive supervisions and mentorship on WASH intervention implementation in all 18	Proportion of hotspot councils supervised	All hotspot councils supervised	Activity report	Staff from all key institutions will be available for the activity as	MoH	WB, UNICEF, WHO, Water Aid, / CDC and

	regions and 49 hotspot Councils				per schedule.		others
6.	Conduct training to RUWASA and UWASAs water engineers for development of water safety plans for each water supply projects in hotspot areas.	Proportion of projects with safety plans	100%	Report	Water utilities have the capacity to develop water safety plans.	MoW	DFID, WB, UNICEF, WHO, Water Aid, GIZ / CDC/ PATH

Subnational Level (Regional & LGAs)							
7.	Hotspots Regions and Councils to purchase water monitoring equipment and reagents for water quality test kits in all 49 hotspot Councils	Proportion of Regions and Councils with reagents required	100%	Availability of reagents	The reagents, suppliers have the capacity to supply	MoW	WB, UNICEF, WHO, Water Aid, and others
8.	Urban Water utilities and RUWASA to develop and implement water safety plans for each water utilities all 49 hotspot Councils	Proportion of projects with safety plans.	95%	Availability of water safety plans	Water utilities will be available	MoW	WB, UNICEF, WHO,
9..	Conduct routine water quality testing of all water projects in hot spots villages.	Proportion of water sources tested for quality (Microbial load, Chlorine residue) in hotspot villages	100%	Monitoring reports	Councils have required transport facilities to access the water sources	RS, LGAs, & Water Utilities	WB, UNICEF, WHO Water Aid, and others
10.	Region and District to register and monitor water vendors (private boreholes, bowser or cart operators) in hotspot	Proportion of water vendors registered and monitored	100%	Inventory of registered water vendors in	Registration mechanism available	Water Supply utilities, RUWASA,	WB, UNICEF, WHO Water Aid, and

	Wards.			Wards			others
Strategic intervention II: Increase the coverage of improved latrines and hand washing facility in hot spot areas							
National level							
11.	Construct or rehabilitate fecal sludge treatment infrastructure in all hot spot council	Proportion of hot spot Councils with fecal sludge treatment infrastructure	100% of hot spot Councils with fecal sludge treatment infrastructure	Availability of fecal sludge treatment infrastructure	Resources availability	MoW, MoH	WB, UNICEF, WHO, GIZ, KfW, Water Aid, and others
12.	Mobilize resources for implementation of Sanitation and Hygiene in cholera hot spot areas	Proportional of key actors engaged	75% of key actors engaged	Report	Stakeholders' readiness to support WASH interventions	MoH, MoW, PORALG,	Development Partners
		Proportion of financial commitments secured	75% of proposed financial commitments	Report	Stakeholders' readiness to support WASH interventions	MoH, MoW, PORALG,	Development Partners

			secured				
13.	Provide technical guidance on the implementation of Sanitation and Hygiene at Regional and Council levels in all hot spot councils	Percent of RS and Councils successfully mentored	100% of RS and Councils mentored	Reports	Staff from all key institutions will be available for the activity as per schedule	MoH, MoW, PORALG,	WB, UNICEF, WHO, Water Aid, and others
14.	Capacity development to Regional and Council levels on matters pertaining to Sanitation and Hygiene in all hot spot councils	Proportion of RS and LGAs capacitated	100% of RS and LGAs capacitated	Reports	Staff from all key institutions will be available for the activity as per schedule	MoH	WB, UNICEF, WHO, Water Aid, and others
Subnational Level (Regional & LGAs)							
15.	Conduct sensitization meetings on construction and use of improved latrines through the use of Community Led Total	Proportion of villages in cholera hot spots conducted	100% of all villages in hot spot areas sensitized	Reports	Staff from all key institutions will be available	MoH	WB, UNICEF, WHO, Water

	Sanitation (CLTS) approach in cholera hot spot areas	sensitization meetings	by 2026		for the activity as per schedule		Aid, and others
		Proportion of villages in cholera hot spots with signed Declaration forms	100% of all villages in hot spot areas with signed declaration forms by 2026	Reports	Staff from all key institutions will be available for the activity as per schedule	MoH	WB, UNICEF, WHO, Water Aid and others
16.	Conduct mapping and refresher training to masons on updated low cost sanitation options and technology	Proportion of masons mapped and trained	100% of mapped masons trained	List of trained masons	Trained masons will be available	MoH	UNICEF, Water Aid, WB
17.	Conduct verification of Open Defecation Free (ODF) in all villages from cholera hot spot regions.	Proportion of villages ODF verified.	100%	ODF verification Certificate	Councils staff have been Trained on conducting ODF	PORALG, MoH	UNICEF, Water Aid, WB

					verification		
18.	Conduct quarterly monitoring of sanitation status in all hotspot villages and report through National Sanitation Management Information System.	Proportion of villages conducted quarterly sanitation and hygiene assessment and reported through NSMIS	100%	Reports	There is political stability in hotspot villages	MoH, PORALG, LGAs	UNICEF, Water Aid, WB

19.	Construct and rehabilitate water supply infrastructure, improved toilets with durable hand washing facilities to all schools in cholera hot spot Council.	Proportion HCFs with improved WASH infrastructure and facilities	All schools in hotspot council have improved toilet with hand washing facilities.	Availability of WASH facilities	Community have artisan locally for construction /rehabilitation of WASH infrastructure	MoH, MoEST, MoW, PORALG and LGAs	WB, UNICEF,

20.	Construct and rehabilitate water supply infrastructure, improved toilets with durable hand washing facilities to all HCFs in cholera hot spot Council.	Proportion HCFs with improved WASH infrastructure	All HCFs in hotspot Councils have improved WASH infrastructure and	Availability of WASH facilities	Community have artisan locally for construction /rehabilitation of WASH infrastructure	MoH, MoW, PORALG and LGAs	WB, UNICEF,
21.	Conduct advocacy meeting with public and private organization to support WASH interventions on cholera control and prevention to 49 cholera hot spot councils	Proportion hotspot councils conducted advocacy meeting with publicand private organizations.	All 49 hot spot council conducted advocacy meeting with public and private organization	Activity report	Availability of public and private organization in Councils	RS, LGAs	WB, UNICEF,
Strategic intervention III: To promote food and water safety management at community level in all hot spot areas.							
22.	Equip RS and LGAs with working tools i.e rapid	Proportional of RS and LGAs	100% of regions and	Availability of water	Suppliers will be readily	MoH PORALG RS, LGAs	WB, UNICEF,

	water testing kits and training on water quality testing in cholera hot spot councils	equipped with rapid water testing tools	LGAs equipped with rapid water testing tools	testing tools, training reports	available and have capacity to supply		WHO and others
23,	Printing and conduct dissemination of DTS-PoU guideline and advocacy to leaders and stakeholders on DTS-PoU from higher to lower administrative levels	Proportion of leaders/decision makers and stakeholders engaged on DTS-PoU	75% of leaders/decision makers and stakeholders engaged on DTS-PoU	Reports	Staff from all key institutions will be available for the activity as per schedule	MoH PORALG RS LGAs	WB, UNICEF, Water Aid, WHO and others
24.	Mobilize resources for implementation of DTS-PoU activities	Proportional of key actors engaged	75% of key actors engaged	Report	Stakeholders' readiness to support DTS-PoU interventions	MoH, MoW, PORALG,	Development Partners
		Proportion of financial commitments secured	75% of proposed financial commitments secured	Report	Stakeholders' readiness to support DTS-PoU interventions	MoH, MoW, PORALG,	Development Partners

Subnational Level (Regional & LGAs)							
25.	Districts to engage private sectors on supply of water treatment products (e.g. Chlorine, filters) to hotspot villages.	Proportion of private sectors in hotspot villages engaged on supply of water treatment products (e.g. Chlorine, filters) to hotspot areas.	All private sectors in hotspot villages engaged on supply of water treatment products (e.g. Chlorine, filters) to Hotspot areas.	Inventory of private sector engaged on supply of water treatment supplies.	Private sectors firms willing to participate.	MoH, M o W , RS and LGAs	WHO, UNICEF, Water Aid, CDC, other partners
26.	Conduct village sensitization meetings to promote household water treatment and safe storage (HWTS),	Proportion of villages conducted sensitization meetings	100% of villages conducted sensitization meetings	Reports	Communities readiness to implement household water treatment and safe storage	MoH, PORALG, RS LGAs	Development Partners

					(HWTS),		
30	Conduct quarterly monitoring of households to ensure drinking water safety in cholera hot spot councils	Proportion of HHs treating drinking water and have safe drinking water storage facilities	100% of HHs treating drinking water	Reports	Community readiness to implement household water treatment and safe storage (HWTS),	MoH, PORALG, RS LGAs	WHO, UNICEF, Water Aid, CDC, other partners
31.	Districts to conduct routine inspection of food and public food premises in hotspot villages	Proportion of food premises inspected in hotspot villages.	100%	Inventory of food premises	Councils have enough personnel for carrying out routine inspections of food premises	RS and LGAs	

32.	Enforcement of laws and by-laws on food safety and hygiene	Proportion of food premises owners saved with legal notice No. of prosecutions/ advisory sessions recorded	100% Food premises owners saved with legal Notice 50% of food premises owners who defaulted prosecuted	Copy of served legal notices, Reports of prosecutions/ advisory sessions recorded	Communities and leaders readiness to enforce laws and by-laws on food safety and hygiene	MoH, PORALG, RS, LGAs and Community	
Strategic intervention IV: Increase WASH preparedness and response to cholera outbreaks							
32.	Conduct assessment of WASH needs in all villages in hotspot Councils.	Proportion of hotspot council.	100% hotspot council supervised.	Availability of report	Staff from all key institutions will be available for the activity as per schedule.	MoH PORALG and RS	WB, UNICEF, WHO, Water Aid, GIZ, CDC and others

33.	To equip emergency WASH facilities in affected and at-risk populations during outbreaks	Proportion of hot spot LGAs equipped with emergency WASH facilities	100% of Hot spot LGAs with emergency WASH facilities	Availability of emergency WASH facilities	Staff from all key institutions will be available for the activity as per schedule.	MoH	WB, UNICEF, WHO and others
34.	To equip adequate waste management facilities in CTC and mobile cholera Camps.	Proportion of hot spot LGAs with waste management facilities	100% of Hot spot LGAs with waste management facilities	Availability of waste management facilities	Staff from all key institutions will be available for the activity as per Schedule.	MoH	WB, UNICEF, WHO and others
PRIORITY AREA 6: LOGISTICS							
Targets							
Strategic intervention I: Ensuring availability of health commodities required for management of Cholera							
SN.	Activities	indicator	Desired targets	Means of verification	assumption	Responsible person	Partners

1	Conduct Quantification workshop to build up assumptions, determine quantity, establishing supply plan and consolidation of demand and supplies from stakeholders by June 2023.	Availability of quantified health commodities report	At least 80% accuracy	report	Fund available	MOH &PORALG	Development partners and IPs
2	Procurement of medicines, medical supplies and material/equipment for cholera	Availability of health commodities at central Medical Store Department	100%	List of health commodities procured	Fund available	MOH &MSD	Development partners and IPs
3	Distribution of health commodities at all levels	Availability of health commodities at service delivery point	100%	Report of distribution list	Fund available	MOH &PORALG	Development partners and IPs
4	To conduct health commodities tracking to 49 hotspot districts	health commodity tracking report	100%	Report of tracking	Fund available	MOH &PORALG	Development partners and IPs

Supervision, Monitoring and Evaluation							
S/N	**Activities**	**Indicators**	**Desires Targets (No, %)**	**Means of verification**	**Assumptions**	**National Responsible Person**	**Responsible Partners**
National level							
1.	Comprehensive Biannual Supportive Supervision & Monitoring of cholera prevention and control activities to hotspot councils (RCCE, IDSR, case management & IPC, coordination	Proportion of hotspot councils supervised and monitored.	At least 70%	Supervision reports	Resources available and supervision tool	MOH & PORALG	CDC, UNICEF, WHO, REPPSI, USAID, Save the Children, TRCS & Other mapped stakeholders
2.	Conduct internal periodic evaluation of the implementation of National Cholera Multi-Sectoral Prevention and Control Plan.	Mid-Term Evaluation report available	A Mid-term evaluation conducted	Mid-term evaluation report	Approval by PHEMC and Resources available	MOH	WHO, UNICEF, CDC,
3.	Conduct annual Simulation Exercises at National Level.	Number of annual simulation	At least one per year	SIMEX report	Availability of resources Approval b	PMO-DMD, MOH	WHO, UNICEF, CDC,

		exercises conducte d.			y PHEMC		
4.	Conduct one After Action Review annually in any of the hotspot districts.	Joint After-Action Review conducted	At least one per year	AAR report	Presence of Cholera cases; funding available	MOH	WHO, UNICEF, CDC,
5.	Conduct two studies at each pillar to inform evidence- based strategies on Cholera control and prevention.	Number studies of conducted .	Two KAP studies and 1 Anthropolog ical research conducted	KAP studies done and informing RCCE strategies	Availability of resources to support researches	MOH/HPS/ NIMR RCCE	UNICEF, WHO
6.	Disseminate study findings and utilize the findings to inform evidence-based strategies on Cholera control and prevention.	Number of dissemination sessions conducted at respective levels	Dissemination sessions c onducted at national level and at least one zonal level	Dissemination meeting reports	Financial resources availability	MOHCDGEC & PO-RALG, RCCE	UNICEF,WH O, USAID, Save the Children, TRCS & Other mapped stakeholders TBD
7.	Conduct surveys to assess the uptake of cholera interventions in the cholera hotspots areas.	Survey conducted (Yes/No)	100%	Survey report	Resourc es available	MOH, PORALG HEALTH	GoT/WHO /UNICEF/ TBD

Regional level							
8.	Comprehensive biannual Supportive Supervision & Monitoring of cholera prevention and control activities to hotspot councils	Proportion of hotspot councils supervised annually	100%	Supervision reports	Resources available	RMO, RAS	WHO, UNICEF
Council level							
9.	Comprehensive biannual Supportive Supervision & Monitoring of Cholera prevention and control activities to lower levels in hotspot councils.	Proportion of hotspot village supervised.	100%	Supervision reports	Resources available HCW have been sensitized and capacitated establishment of ORSPs and on IPC measures	DMO, DED	CDC, UNICEF, WHO, USAID, Save the Children, TRCS & Other mapped stakeholders TBD
10.	Conduct and disseminate study's findings and utilize the findings to inform evidence-based strategies on cholera prevention and control.	Number dissemination sessions conducted at respective levels	Dissemination 1(One) session conducted at each zonal level	Dissemination meeting reports	Financial resources availability	RCCE, PO-RALG (RHMTs, CHMTs)	UNICEF, WHO, USAID, Save the Children, TRCS & Other mapped stakeholders TBD

11.	Conduct simulation exercises for cholera response at hotspot councils.	Proportion of hotspot council that conducted simulation exercises.	1 simulation exercise at each council per year.	Reports on drill exercises	Financial resources available	DMO, DED	WHO, UNICEF, partners

Data collection/data sources for M&E will include:

- Health Management Information System (HMIS) for facility-based service delivery data, implemented on the District Health Information System version 2 (DHIS2)
- Population-based surveys: DHS, MIS, PHIA, nutrition, STEPS, socio-economic surveys
- Surveillance systems: MDSR, IDSR
- CRVS and SAVVY: mortality, fertility, causes of death
- Health financing data: NHA, health expenditure reviews

Indicators set for consideration

- Output indicators
- Impact indicators
- Global indicators

Evaluation

Periodic (after every 2 years) evaluation will assess whether the objectives have been achieved. Indicators will be used to measure the extent of achievement of an objective for a particular program or activity. Additionally, there will be regular production and dissemination of reports on cholera as well as analysis of risk factors on and off to enable timely remedial actions. Research studies will also be done to better understand issues pertaining to recurrent cholera and best practices will be shared.

Mid and End Term Evaluation

Two evaluations will be conducted to determine the success of the plan. A joint mid-term evaluation after 2 years of the plan will be organized. This evaluation will focus on progress made in implementing the plan and the appropriateness of the overall strategic direction. The evaluation will be designed to inform the remaining period of the plan and recommend adjustments where needed.

An independent external evaluation in the final year of the Plan (end-term evaluation), focusing on achievements (impacts and outcomes) of the Plan, will provide contextual information for the future plans. Both evaluations will be conducted with significant involvement of stakeholders. The costs for the evaluations have been included in the budget.
Selected indicators for evaluation are shown in Table 2 below.

Table 5. Indicators & Targets for Monitoring & Evaluation of the Cholera Multi-Sectoral Prevention and Control Plan

Indicator	Targets				
	Baseline (2022)	**2023**	**2024**	**2025**	**2026**
Priority area 1: Multi-sectoral Coordination for Cholera Prevention and Response					
Number of multisectoral national public health emergency management committee (PHEMC) meetings on cholera prevention held annually	1	4	4	4	4
Numerator: Number of multisectoral meetings related to monitoring of NMCPCP implementation conducted in a year					
Denominator: N/A					
Source of data: PHEOC					
Proportion of the NMCPCP which is funded through domestic and external funding	10%	20%	30%	40%	50%
Numerator: Amount of funding received from donors and allocated by the government (respectively) for implementation of the national cholera plan for elimination or control					
Denominator: Total budget of the national cholera plan for elimination or control Target: 100%					
Source: Country information on resource allocated to the NMCPCP					
Proportion of cholera hotspot districts having functional multisectoral coordination structures		At least 30%		At least 60%	At least 80%
Numerator: Number of cholera hotspot districts with functional multisectoral coordination structures					
Denominator: Total number of cholera hotspot districts					
Source of data: PHEOC					
Proportion of hotspot districts with fully funded cholera multisectoral prevention & control plans		At least 30%		At least 60%	At least 80%
Numerator: Number of cholera hotspot districts with					
Denominator: Total number of cholera hotspot districts					
Source of data: PHEOC					

Priority area 2: Surveillance and Laboratory activities					
Proportion of hotspot districts having all detected cholera outbreaks investigated	50%	At least 70 %	At least 80%	At least 90%	At least 100%
Numerator: Number of hotspot district having all cholera outbreaks investigated					
Denominator: Number of hotspots district having cholera outbreaks (44)					
Source of data: Council outbreak investigation reports					
Proportion of peripheral health facilities in cholera hotspot with access to functional laboratory for cholera confirmation	30%	50%	70%	90%	100%
Numerator: Number of peripheral health facilities in cholera hotspots councils with access to functional laboratory for cholera confirmation					
Denominator: Number of peripheral health facilities in cholera hotspot Councils					
Sources of data: Council surveillance data					
Proportion of hotspot district with analysed and utilised data	10%	40%	60%	80%	100%
Numerator: Number hotspot councils with analysed and utilised data					
Denominator: Number of hotspot councils					
Sources of data: Council surveillance data					
Proportion of cholera suspected cases that are laboratory confirmed as per protocol	50%	At least 70%	At least 80% of	At least 90%	At least 100%
Numerator: Number of cholera case confirmed					
Denominator: Total number of suspected cases reported					
Source of data: Councils cholera surveillance data					
Cholera incidence in hotspot councils by 2026 (per 100,000 population)	73	At least 50	At least 40 of	At least 20	At least 0
Numerator: Proportion of suspected cases of cholera reported					
Denominator: Councils population					
Source of data: Councils cholera surveillance data					

Priority area 3: Case management					
Proportion of hotspot councils with functional IPC measures	50%	90%	100%	100%	100%
Numerator: Number of cholera hotspot councils with functional IPC measures					
Denominator: Total number of cholera hotspot councils					
Source of data: Assessment reports					
Proportion of hotspot councils *having established community ORS points*	0%	0%	70%	80%	95%
Numerator: Number of cholera hotspot councils with community ORS points					
Denominator: Total number of cholera hotspot councils					
Source of data: Assessment reports					
Cholera Case Fatality Rate	1.7				<1%
Numerator: Total deaths from cholera					
Denominator: Total number of reported cholera cases in hotspot councils					
Source of data: IDSR					
Proportion of trained health care workers at CTC in all hotspot's councils		0	50	80%	100%
Numerator: Total number of trained health care workers in treatment center hotspots councils					
Denominator: Total number of health care workers in hotspots councils					
Source of data: HMIS					

Priority area 4: Risk Communication and Community Engagement					
A comprehensive coordination structure for risk communication and community engagement in place in all cholera hotspot Councils		35%	55%	75%	100%
Numerator: Number of hotspot councils with comprehensive *coordination structure for risk communication and community engagement*					
Denominator: Total Number of hotspot councils					
Source of data: 1. RCCE Supportive Supervision Reports *2. DHIS 2 (HMIS Book 3)*					
Proportion of hotspot councils with RCCE meetings held annually		25%	50%	75%	100%
Numerator: Number of hotspot councils with RCCE meetings for implementation of Cholera prevention and Control Plan					
Denominator: Total Number of hotpot councils					
Source of data: 1. RCCE Supportive Supervision Reports *2. DHIS 2 (HMIS Book 3)*					
Proportion of RCCE trained focal points supporting community engagement on cholera prevention and control	20%	45%	55%	70%	85%
Numerator: Number of RCCE trained focal points to support community engagement on cholera prevention and control in hotspots Council					
Denominator: Total number of of RCCE trained focal points					
Source of data: 1. RCCE Supportive Supervision Reports *2. Training Report with database of trained personnel 3. HMIS (DHIS 2)*					
Proportion of the population in hotspots who have correct knowledge on Cholera prevention in communities within hotspot areas		40%	60%	80%	90%
Numerator: Number of Communities who have correct knowledge regarding cholera prevention in hotspots council per catchment targeted Population					
Denominator: Total number of Hotspot councils					
Source of data: 1. KAP surveys *2. DHIS2*					

Priority area 5: Water, Sanitation and Hygiene (WASH)						
Proportion of households with access to basic water supply in Urban	86.5%	87%	88%	89%	89.5%	90%
Proportion of households with access to basic water supply in Rural	74%	75.5%	77%	79%	80%	81%
Numerator: Number of households with basic sanitation						
Denominator: Total number of households in the locality in hotspot councils						
Source: National Five Years Development Plan (2016/2017-2020/2021)						
Proportion of households in hotspot councils with access to basic sanitation (toilets with washable floor)	71.9%	72.5%	75%	80%	85%	90%
Numerator: Number of households with basic sanitation						
Denominator: Total number of households in the locality in hotspot councils						
Source: National Strategy for Accelerating Sanitation and Hygiene for All (NSASHA), 2020 – 2025						
Proportion of the population in hotspot councils with access to hand washing facilities (Hand washing point, water and Soap)	42.2%	50%	55%	65%	70%	75%
Numerator: Number of Households with functional hand washing points						
Denominator: Total number of households in the locality in hotspot councils						
Source: National Strategy for Accelerating Sanitation and Hygiene for All (NSASHA), 2020 – 2025						
Proportion of households that practice safe drinking water storage	22.7%	30%	35%	45%	60%	75%
Numerator: Number of Households with designated containers for safe storage of drinking water						
Denominator: Total number of households in the villages in hotspot councils						
Source: National Strategy for Accelerating Sanitation and Hygiene for All (NSASHA), 2020 – 2025						
Open Defecation Status	1.4%	1.0%	0.5%	0%	0%	0%
Numerator: Number of households without any form of toilet						
Denominator: Total number of households in the village						
Source: National Strategy for Accelerating Sanitation and Hygiene for All (NSASHA), 2020 – 2025						

Proposed Evaluation Committee

Representatives from MoH Epidemiology, EPRU, Quality Assurance Unit, EHS, Health Promotion, M&E unit, & Programs (NTD, IVD), NIMR
PO RALG, MoW, PMO, Hotspot regions and LGAs WHO, UNICEF, Red Cross Society
Country institutions: IHI, KCMC, UDSM, MUHAS, UDOM

Operational Plan

To ensure effective implementation of the M&E plan, the operational plan has been developed. The operational plan is detailed to provide the expected number of participants in different activities, timelines, and associated inputs. The implementation status of the operational plan will be reviewed quarterly at the PHEMC meetings, along with data collected on the different indicators identified in the M&E plan. The PHEMC meetings will provide a critical forum for reviewing progress of the implementation of the Plan and promptly instituting any necessary corrective measures.

Assumptions for the Successful Implementation of the M&E Plan

The successful implementation of this M&E plan hinges on the assumption that the MoH will rally all key stakeholders to implement the strategic activities identified in the Plan. Stakeholders will commit to targets set and fulfill their responsibility in attaining the targets. Another assumption is that implementing partners will harmonize their support for M&E-related activities based on the operational plan. A budgetary provision of 7–10 percent of the total cost of implementing the strategic activities in the Plan will be set aside for M&E-related activities.

8. Annexes

8.1. Annex I: Budget

COORDINATION							
S/N	**Activity Description**	**Total Budget**	**2023**	**2024**	**2025**	**2026**	**2027**
Strategic intervention I: Reduce the case fatality rate for cholera to less than 1% in all CTC							
National Level							
1	Printing 1000 NMCPCP for dissemination to the national (100), regional (250), hotspots districts (600), partners and other stakeholders (50)	100000		10,000			
2	Launching and high-level advocacy to Permanent Secretaries, Regional and District Commissioners from the cholera hotspots and other stakeholders on NMCPCP and its implementation plan.	71,800,000		71,800,000			
3	Disseminate NMCPC plan to national level stakeholders	20,000,000		20,000,000			

4	Conduct resource mobilization meetings to all stakeholders for implementation of the cholera plan at the National level	15,000,000		10,000	5,000		
5	Mapping and updating inventory of stakeholders for cholera control at National level	30,250,000		30,250,000			
6	Procure and equip the existing National PHEOC						
7	Support PHEOC Operations	27,000,000			9,000,000	9,000,000	9,000,000
8	Conduct bi annual quarterly multi-sectorial coordination meetings at National level (National PHEMC)	740,000,000		185,000,000	185,000,000	185,000,000	185,000,000
	Sub-total	**869,095,000**	**0**	**287,090,000**	**194,005,000**	**194,000,000**	**194,000,000**
Subnational Level (Regional & LGAs)							
9	Regions in collaboration with cholera hotspots LGAs to conduct high-level advocacy sessions at regional and district level (Political leaders,	49,200,000		49,200,000			

	RCs, DCs, Religious leaders, Media Owners and Editors) on the implementation of NMCPCP						
10	Regions in collaboration with cholera hotspots LGAs to disseminate NMCPCP to cholera hotspots districts	100,000,000		100,000,000			
11	Regions in collaboration with cholera hotspots LGAs to map and update inventory of stakeholders for cholera control at LGA level	524,480,000		524,480,000			
12	Regions to conduct quarterly multi-sectoral coordination meetings at regional level (PHEMC)	688,800,000		172,200,000	172,200,000	172,200,000	172,200,000
13	Districts to conduct quarterly multi-sectoral coordination meetings at district level (PHEMC)	1,726,000,000		431,500,000	431,500,000	431,500,000	431,500,000
	Sub- total	**2,988,490,000**	**0**	**1,177,390,000**	**603,700,000**	**603,700,000**	**603,700,000**

Strategic intervention II: Implement Council cholera multi-sectoral plans in line with the national multi-sectoral plan							
Subnational Level (Regional & LGAs)							
14	Regions in collaboration with LGAs to develop Council Multisectoral Cholera Prevention and Control Plan	326,480,000		163,240,000	163,240,000		
15	Regions in collaboration with LGAs to conduct advocacy and sensitization meetings for high level (policy and decision makers) coordination for cholera control at District level	124,300,000		124,300,000			
16	Regions in collaborations with districts to mobilize resources for implementation of the cholera plan at district/ council level	13,200,000		3,300,000	3,300,000	3,300,000	3,300,000
	Sub- total	**463,980,000**	**0**	**290,840,000**	**166,540,000**	**3,300,000**	**3,300,000**
	TOTAL COST - COORDINATION	**4,321,565,000**	**0**	**1,755,320,000**	**964,245,000**	**801,000,000**	**801,000,000**

SURVEILLANCE AND LABORATORY							
S/N	**Activity Description**	**Total Budget**	**2022**	**2023**	**2024**	**2025**	**2026**
Strategic intervention I: Improve early detection and reporting of cholera outbreaks							
	National Level						
1	Print and disseminate guideline for event-based surveillance for 30 hot spot district in 13 regions	45,000,000		45,000,000			
2	To conduct 3 days training to 1200 HCWs on event-based surveillance, Cholera active case search and Contact tracing to remaining 30 hot spot districts once by December 2023	543,040,000		543,040,000			
3	To Conduct 3 days training to 2600 CHWs on event-based surveillance, active case search and contact tracing in 13 hot spot regions once by December	770,060,000			770,060,000		

	2024						
4	To Print and distribute 9000 Swahili translated cholera standard case definitions posters for CHWs in 18 hot spot regions by December 2023	90,000,000		90,000,000			
5	To Conduct Biannualy (Virtually/Physical) supportive supervision to 18 hot spot regions on IDSR focusing on cholera	2,542,300,000	508,460,000	508,460,000	508,460,000	508,460,000	508,460,000
6	To Conduct training on surveillance and outbreak investigation to clinicians from health facilities in 49 hot spot districts in 18 regions by December 2024	373,920,000			373,920,000		
	Sub Total	**4,274,410,000**	**508,460,000**	**1,096,590,000**	**1,652,440,000**	**508,460,000**	**508,460,000**

	Subnational Level (Regional & LGAs)						
7	Conduct quarterly (Virtually/Physical) supportive supervision to hot spot districts on IDSR focusing choleric	789,920,000	157,984,000	157,984,000	157,984,000	157,984,000	157,984,000
	Sub Total	**789,920,000**	**157,984,000**	**157,984,000**	**157,984,000**	**157,984,000**	**157,984,000**
Strategic Intervention 2: Improve analysis and utilization of cholera data by hotspot councils							
	National Level						
8	To conduct 5 days of training to 288 IDSR FP and Lab technicians at district and regional level on data analysis and generation of information products including the situation report preparation by December 2023	372,330,000		372,330,000			
9	To conduct biannual data quality assessment to 18 hot spot regions	2,169,150,00	433,830,000	433,830,000	433,830,000	433,830,000	433,830,000

10	To conduct training of district surveillance officers on sitrep development in hotspot districts	174,060,000		174,060,000			
	Sub Total	**2,715,540,000**	**433,830,000**	**980,220,000**	**433,830,000**	**433,830,000**	**433,830,000**
Strategic Intervention 3: Increase Laboratory capacity for testing and confirming cholera cases							
	National Level						
17	Provide sufficient equipment, reagent and supplies and shipping of samples in 17 hot spot regional laboratories	2,775,168,000		693,792,000	693,792,000	693,792,000	693,792,000
18	Update or develop testing protocol defining SOPs and job aids,	14,419,000		10,814,250		3,604,750	
	supervision checklist for cholera specimen collection, transportation, testing and confirmation.						
19	Print and disseminate testing						

	protocols, SOPs and job aids, for cholera specimen collection, transportation, testing and confirmation.	5,865,000		4,398,750		1,466,250	
20	Prepare annual external quality controls materials for hot spot regional laboratories						
21	Conduct training to 27 laboratory staff on PCR and genotyping for cholera at National Public Health Laboratory	16,219,000			16,219,000		
22	Conduct mentorship on cholera testing to 17 hot spot regional laboratories	18,560,000			10,000,000	8,560,000	
23	To conduct external quality assurance assessment at 17 hot spot regional laboratories for cholera testing	73,944,000		18,486,000	18,486,000	18,486,000	18,486,000
	Sub Total	**2,904,175,00**	**0**	**727,491,000**	**738,497,000**	**725,909,000**	**712,278,000**

		0					
	Subnational Level (Regional & LGAs)						
24	Regions and Councils to prepare schedule of requirements/stockpile for cholera reagents and essential supplies for diagnosis for the councils and HFs including cholera rapid diagnostic tests (RDT)						
25	Region to Conduct cascade refresher training on the use of RDT, sample collection, packaging and transportation, to hot spot district laboratories	101,485,000		60,891,000		40,594,000	
	Sub Total	**101,485,000**	**0**	**60,891,000**	**0**	**40,594,000**	**0**
TOTAL COST SURVEILLANCE & LAB		**6,747,835,000**	**0**	**1,421,177,000**	**1,752,752,000**	**2,072,173,000**	**1,501,733,000**

CASE MANAGEMENT							
	Activity Description	**Total Budget**	**2023**	**2024**	**2025**	**2026**	**2027**
Strategic intervention I: Reduce the case fatality rate for cholera to less than 1% in all CTC							
	National Level						
1	Print and distribute cholera case management, IPC guidelines, and job aid, standard operating procedures (SOPs) posters for all hotspot's areas	112,200,000		56,100,000	56,100,000		
2	Conduct TOTs training on case management and IPC in all Hotspot regions	210,180,000	157,635,000	52,545,000			
3	Conduct training for Healthcare workers at hotspot districts on Cholera case management	840,720,000	280,240,000	280,240,000	280,240,000		
4	Quantify, procure and distribute health commodities for cholera treatment center (under	400,840,000		100,210,000	100,210,000	100,210,000	100,210,000

	logistics)						
	Sub Total	**1,563,940,000**	**875,750,000**	**489,095,000**	**436,550,000**	**100,210,000**	**100,210,000**
	Subnational Level (Regional & LGAs)						
5	Improve Health care waste management infrastructure and practices to reduce secondary health care associated cholera infections	2,200,000,000		1,100,000,000		1,100,000,000	
6	Quantify, procure and distribute cholera health commodities to CTC	743,368,000		185,842,000	185,842,000	185,842,000	185,842,000
7	Districts to conduct mentorship trainings to health care workers on cholera case management	460,000,000		230,000,000	230,000,000		
8	Provide management of cholera patients at CTC in hotspot councils during outbreak (extra duty allowances, Logistic costs,	5,668,400,000		1,417,100,000	1,417,100,000	1,417,100,000	1,417,100,000

	electricity, water, etc)						
	Sub Total	**9,071,768,000**	**0**	**2,932,942,000**	**1,832,942,000**	**2,702,942,000**	**1,602,942,000**
Strategic intervention II: Improve early management of cholera cases by establishing ORS points at the community level							
	National Level						
8	Develop and disseminate a supervision and mentorship guides for case management and establishment of community points for ORSPs.	563,430,000			187,810,000	187,810,000	187,810,000
	Sub Total	**563,430,000**	**0**	**0**	**187,810,000**	**187,810,000**	**187,810,000**
	Subnational Level (Regional & LGAs)						
9	Districts to establish ORS points at community level in all hotspot areas	85,640,000			42,820,000		42,820,000
10	Districts to conduct training to HCW/attendant and other community workers, leaders working at ORS points on IPC and community cholera	259,400,000			129,700,000	129,700,000	

	management.						
11	Districts to conduct cholera mortality audits during outbreak for each death	222,200,001			74,066,667	74,066,667	74,066,667
	Sub Total	**567,240,001**	**0**	**0**	**246,586,667**	**203,766,667**	**116,886,667**
TOTAL COST - CASE MANAGEMENT		**12,204,253,001**	**875,750,000**	**3,422,037,000**	**2,703,888,667**	**3,194,728,667**	**2,007,848,667**
RISK COMMUNICATION AND COMMUNITY ENGAGEMENT							
S/N	**Activity Description**	**Total Budget**	**2023**	**2024**	**2025**	**2026**	**2027**
Strategic intervention I: Strengthen Coordination of Risk Communication and Community Engagement stakeholders at national, regional, council and community level							
	National Level						
1	Conduct annual coordination and review meetings	**395,900,000**	79,180,000	79,180,000	79,180,000	79,180,000	79,180,000

2	Develop Risk Communication and Community Engagement standard tool	**20,890,000**	**20,890,000**	0	0	0	0
3	Conduct annual advocacy meetings (political & religious leaders, Media Owners, Water authority bodies and Editors etc) on Cholera prevention and control	**167,025,000**	33,405,000	33,405,000	33,405,000	33,405,000	33,405,000
4	Conduct biannual coordination and review meetings	**380,250,000**	76,050,000	76,050,000	76,050,000	76,050,000	76,050,000
5	Develop and implement Risk Communication and Community Engagement cholera prevention and control plan	**52,540,000**	**52,540,000**	0	0	0	0
6	Conduct annual advocacy meetings (political, religious and other influential people, Media Owners, CBWOs and Editors etc.)	**1,791,450,000**	358,290,000	358,290,000	358,290,000	358,290,000	358,290,000
7	Revitalize Health, Education and Water committees (At	711,000,000	142,200,000	142,200,000	142,200,000	142,200,000	142,200,000

	district and village/street levels) to sustain promotion of positive sanitation and hygiene practices						
	Sub Total	**1,077,840,000**	**0**	**200,500,000**	**338,420,000**	**378,820,000**	**160,100,000**
Strategic intervention II: Raise and sustain public awareness in hotspot councils to ignite risk perception and catalyse positive behavioural change on Cholera Prevention and Control							
	National Level						
8	Annual Training of media personnel (including local media) on RCCE and WASH	**151,700,000**	30,340,000	30,340,000	30,340,000	30,340,000	30,340,000
9	Conduct nationwide mass media campaign on Hygiene and Sanitation practices once a year (*especially during rainy season*)	**234,000,000**	46,800,000	46,800,000	46,800,000	46,800,000	46,800,000
11	Orient Regional and District Education, Development & social welfare and Health section to promote WASH practices.	**610,575,000**	122,115,000	122,115,000	122,115,000	122,115,000	122,115,000

12	Develop Risk Communication and Community Engagement standard tool	**29,890,000**	**29,890,000**	0	0	0	0
13	Production and dissemination of IEC/BCC materials.	**1,384,700,000**	276,940,000	276,940,000	276,940,000	276,940,000	276,940,000
14	Develop a communication strategy for prevention of cholera to the community	**51,185,000**	**51,185,000**	0	0	0	0
15	Engage artists to promote cholera prevention and control measures	**16,000,000**	3,200,000	3,200,000	3,200,000	3,200,000	3,200,000
	Sub Total	**2,782,220,000**	**148,196,000**	**620,034,000**	**671,330,000**	**671,330,000**	**671,330,000**
	Subnational Level (Regional & LGAs)						
16	Orient CHWs on cholera prevention and control measures including reporting mechanisms	**2,919,590,000**	583,918,000	583,918,000	583,918,000	583,918,000	583,918,000

17	Conduct sensitization meetings on Cholera prevention and control to influential people, and special groups	**2,370,400,000**	474,080,000	474,080,000	474,080,000	474,080,000	474,080,000
18	Orient and support school health teachers to strengthen WASH clubs.	1,012,270,000	506,135,000	0	0	506,135,000	0
19	Supporting CHWs, and influential people to conduct mobile and outreach programs promoting Cholera prevention and Control-	**5,000,000,000**	1,000,000,000	1,000,000,000	1,000,000,000	1,000,000,000	1,000,000,000
20	Conduct Radio and TV programs on Cholera prevention and control measures.	**622,000,000**	124,400,000	124,400,000	124,400,000	124,400,000	124,400,000
	Sub Total	**2,574,000,000**	**257,400,000**	**627,000,000**	**563,200,000**	**563,200,000**	**563,200,000**
Strategic intervention III: Strengthen community engagement for adoption of appropriate and sustainable preventive measures to support behaviour change and practices							

	National level						
21	Conduct annual assessment to identify social-cultural factors, myths, misconceptions, and rumors	**225,000,000**	45,000,000	45,000,000	45,000,000	45,000,000	45,000,000
22	Disseminate findings and use the findings to inform strategic planning and implementation	**85,900,000**	17,180,000	17,180,000	17,180,000	17,180,000	17,180,000
23	Conduct annual supportive supervision and mentorship to sub national level.	**605,700,000**	121,140,000	121,140,000	121,140,000	121,140,000	121,140,000
24	Strengthening community feedback through Afya call centre and social listening platforms	**76,500,000**	15,300,000	15,300,000	15,300,000	15,300,000	15,300,000
	Sub Total	**95,790,000**	**0**	**95,790,000**	**0**	**0**	**0**
Subnational Level (Regional & LGAs)							
25	Priting and dissemination of reporting tools to CHWs..	**85,750,000**	17,150,000	17,150,000	17,150,000	17,150,000	17,150,000
	Sub Total	**1,163,870,00**	**0**	**225,815,000**	**426,215,000**	**511,840,00**	**0**

		0				**0**	
Strategic intervention IV: Scale up provision of Mental Health and psychosocial care and support services for individuals, families, communities and vulnerable population affected by cholera							
National Level							
26	Train RHMT, CHMT and Health workers on provision of mental health and psychosocial care	**684,360,000**	342,180,000			342,180,000	
27	Develop self-care guideline for MHPSS Service providers	**62,120,000**	31,060,000			31,060,000	
28	Conduct quarterly review meeting with stakeholders	**25,150,000**	5,030,000	5,030,000	5,030,000	5,030,000	5,030,000
29	Train mass media on psychological first Aid (PFA)	**9,132,500**	**9,132,500**				
	Sub Total	**1,589,385,000**	**0**	**355,252,000**	**752,297,000**	**436,836,000**	**45,000,000**
Subnational Level (Regional & LGAs)							
30	Conduct refresher training to MHPSS service providers at health facilities and at community level.	**631,260,000**	315,630,000				315,630,000

	Sub Total	**1,589,385,000**	**0**	**355,252,000**	**752,297,000**	**436,836,000**	**45,000,000**
TOTAL COST - RCCE		**9,619,615,000**	**437,256,000**	**2,295,689,000**	**2,793,795,000**	**2,608,772,000**	**1,484,103,000**
WATER, SANITATION AND HYGIENE (WASH)							
S/N	**ACTIVITY DESCRIPTION**	**Total Budget**	**2023**	**2024**	**2025**	**2026**	**2027**
Strategic intervention I: Increase access to safe water supply to population living in cholera hotspot areas in rural and urban settings							
	National level						
1	Rehabilitation of existing water supply system in 49 cholera hot spot Councils	**99,318,100,000**	19,863,620,000	19,863,620,000	19,863,620,000	19,863,620,000	19,863,620,000
2	Construction of new and extension of existing water supply schemes into hotspots areas	**126,423,185,000**	25,284,637,000	25,284,637,000	25,284,637,000	25,284,637,000	25,284,637,000
3	Install simple water treatment facilities in all 49 cholera hotspots Councils	**1,715,000,000**	343,000,000	343,000,000	343,000,000	343,000,000	343,000,000

4	Conduct training to Regional and District Environmental Health Officers (EHO), water engineers, water laboratory technicians, Community based water supply organization management team in 49 Councils on water quality monitoring services	**366,055,000**					
5	Conduct quarterly supportive supervisions and mentorship on WASH intervention implementation in all 18 regions and 49 hotspot Councils	**753,300,000**	150,660,000	150,660,000	150,660,000	150,660,000	150,660,000
6	Conduct training to RUWASA and UWASAs water engineers for development of water safety plans for each water supply projects in hotspot areas	52,530,000					
	Sub Total	**228,628,170,000**	**46,060,502,000**	**45,641,917,000**	**45,641,917,000**	**45,641,917,000**	**45,641,917,000**

	Subnational Level (Regional & LGAs)						
7	Conduct routine (quarterly) water quality testing of all water projects in hot spots villages.	343,000,000	68,600,000	68,600,000	68,600,000	68,600,000	68,600,000
8	Region and District to register and monitor water vendors (private boreholes, bowser or cart operators) in hotspot Wards.	343,000,000	68,600,000	68,600,000	68,600,000	68,600,000	68,600,000
	Sub Total	**686,000,000**	**137,200,000**	**137,200,000**	**137,200,000**	**137,200,000**	**137,200,000**
Strategic intervention II: Increase the coverage of improved latrines and hand washing facility in hot spot areas							
	National level						
9	Construct or rehabilitate fecal sludge treatment infrastructure in 49 hot spot council	**8,872,325,000**	1,774,465,000	1,774,465,000	1,774,465,000	1,774,465,000	1,774,465,000
10	Capacity development to Regional and Council levels on matters pertaining to Sanitation	**365,835,000**	365,835,000				

	and Hygiene in cholera hot spot Councils						
	Sub Total	**9,238,160,000**	**2,140,300,000**	**1,774,465,000**	**1,774,465,000**	**1,774,465,000**	**1,774,465,000**
	Subnational Level (Regional & LGAs)						
11	Conduct sensitization meetings on construction and use of improved latrines through the use of Community Led Total Sanitation (CLTS) approach in cholera hot spot Councils	210,435,000	210,435,000				
12	Conduct mapping and refresher training to masons on updated low cost sanitation options and technology	320,685,000	320,685,000				
13	Conduct verification of Open Defecation Free (ODF) in all hot spot villages	210,435,000	42,087,000	42,087,000	42,087,000	42,087,000	42,087,000
14	Conduct quarterly monitoring of sanitation situation in all hotspot villages and report through National Sanitation	**1,156,956,000**	231,391,200	231,391,200	231,391,200	231,391,200	231,391,200

	Management Information System.						
15	Construct and rehabilitate water supply infrastructure, improved toilets with durable hand washing facilities to all schools in 49 hot spot Council.	14,700,000,000	2,940,000,000	2,940,000,000	2,940,000,000	2,940,000,000	2,940,000,000
16	Construct and rehabilitate water supply infrastructure, improved toilets with durable hand washing facilities to all HCFs in 49 hot spot Council	12,250,000,000	2,450,000,000	2,450,000,000	2,450,000,000	2,450,000,000	2,450,000,000
17	Conduct advocacy meeting with public and private organization to support WASH interventions on cholera control and prevention to all cholera hot spot Councils	36,675,000	36,675,000				
	Sub-total	**47,361,506,000**	**10,511,873,200**	**9,212,408,200**	**9,212,408,200**	**9,212,408,200**	**9,212,408,200**

Strategic intervention III: Quality monitoring of food and water safety at community level in cholera hot spot areas							
	Sub national level						
18	Procure and distribute water quality monitoring kits for all 49 Councils	237,300,000	237,300,000				
19	Printing and conduct dissemination of DTS-PoU guideline and advocacy to leaders and stakeholders on DTS-PoU from higher to lower administrative levels	566,200,000	566,200,000				
20	Districts to engage private sectors on supply innovative water treatment products (e.g. Chlorine, filters) to 49 hotspot Councils	81,350,000	81,350,000				
21	Conduct village sensitization meetings to promote household water treatment and safe storage (HWTS) to 49 hotspot councils	210,435,000	210,435,000				

22	Conduct quarterly house to house inspection to monitor food and water safety to 49 hotspots councils	6,649,035,000	1,329,807,000	1,329,807,000	1,329,807,000	1,329,807,000	1,329,807,000
23	Districts to conduct routine inspection of public health guideline adherence at public and food vending premises (markets, restaurants, mama lishe vending points) in hotspot villages	250,000,000	50,000,000	50,000,000	50,000,000	50,000,000	50,000,000
	Sub-total	**7,994,320,000**	**2,475,092,000**	**1,379,807,000**	**1,379,807,000**	**1,379,807,000**	**1,379,807,000**
Strategic intervention IV: Increase WASH preparedness and response to cholera outbreaks							
24	Conduct assessment of WASH needs in all villages in 49 hotspot Councils.	790,125,000	158,025,000	158,025,000	158,025,000	158,025,000	158,025,000
25	To equip adequate WASH facilities and supplies in CTC and mobile cholera camps in 49 hotspot councils	9,552,000,000	1,910,400,000	1,910,400,000	1,910,400,000	1,910,400,000	1,910,400,000

26	To equip adequate waste management facilities in CTC and mobile cholera camps to all cholera hot spot Councils	102,900,000	51,450,000			51,450,000	
27	Coordination, supervision and reporting of ongoing WASH interventions during an outbreak in all hot spot Councils	561,600,000	112,320,000	112,320,000	112,320,000	112,320,000	112,320,000
Sub-total		**11,006,625,000**	**2,232,195,000**	**2,180,745,000**	**2,180,745,000**	**2,232,195,000**	**2,180,745,000**
TOTAL COST - WASH		**295,310,786,000**	**63,557,162,200**	**60,326,542,200**	**60,602,542,200**	**60,377,992,200**	**60,628,542,200**
LOGISTICS							
S/N	**Activity Description**	**Total Budget**	**2023**	**2024**	**2025**	**2026**	**2027**
Strategic intervention I: Ensuring availability of health commodities required for manangement of Cholera outbreak							
National Level							
1	To conduct Quantification workshop to build up assumptions, determining	**85,270,000**		0	0	0	0

	quantity, establishing supply plan and consolidation of demand and supplies from stakeholders by june 2023		**85,270,000**				
2	Procurement of key medicines, medical supplies and materials for management of Cholera	16,896,000,000		4,224,000,000	4,224,000,000	4,224,000,000	4,224,000,000
3	Distribution of health commodities to 49 hotspot districts	325,360,000		81,340,000	81,340,000	81,340,000	81,340,00
4	Health commodity tracking to 49 hotspot districts	454,200,000	0	227,100,000	0	227,100,000	0
	Sub-total	**17,760,830,000**	**85,270,000**	**4,532,440,000**	**4,305,340,000**	**4,532,440,000**	**4,305,340,000**
	TOTAL COST - LOGISTICS	**17,760,830,000**	**85,270,000**	**4,532,440,000**	**4,305,340,000**	**4,532,440,000**	**4,305,340,000**

MONITRORING AND EVALUATION							
S/N	**Activity Description**	**Total Budget**	**2019**	**2020**	**2021**	**2022**	**2023**

1	Comprehensive bi-annual Supportive Supervision & Monitoring of cholera control activities to hotspot districts	1,010,520,000		252,630,000	252,630,000	252,630,000	252,630,000
2	Conduct internal Mid-term evaluation of the implementation of Cholera Multi-sectoral Plan	100,300,000			100,300,000		
3	Conduct external End term evaluation of the Cholera Multi-sectoral Plan	130,300,000					130,300,000
4	Conduct table top Simulation Exercises at National Level annually	105,600,000		26,400,000	26,400,000	26,400,000	26,400,000
5	Conduct one After Action Review annually in any of the hotspot districts	95,200,000		23,800,000	23,800,000	23,800,000	23,800,000
6	Conduct bi-annual comprehensive Supportive Supervision on cholera control activities to hotspot districts	408,000,000		102,000,000	102,000,000	102,000,000	102,000,000

7	Conduct quarterly Supportive Supervision on cholera Prevention and control interventions to lower levels in hotspot districts	567,720,000		141,930,000	141,930,000	141,930,000	141,930,000
8	Conduct quarterly drill exercises for cholera response at hotspot district	873,000,000		218,250,000	543,960,000	543,960,000	543,960,000
	Sub- total	**3,290,640,000**		**765,010,000**	**1,191,020,000**	**1,090,720,000**	**1,221,020,000**
	Subnational Level (Regional & LGAs)						
9	Regions in collaboration with LGAs to conduct mentorship and supportive supervision to hotspot districts	632,400,000			210,800,000	210,800,000	210,800,000
10	Conduct and disseminate study's findings and utilize the inform evidence-based strategies on cholera prevention and control.	56,000,000				23,000,000	33,000,000
11	Conduct simulation exercises for cholera response at hotspot councils.	165,000,000			100,000,000		65,000,000

	Sub Total	853,400,000	0	0	310,800,000	233,800,000	308,800,000
TOTAL COST - M&E		4,144,040,000	0	765,010,000	1,501,820,000	1,324,520,000	1,529,820,000
GRAND TOTAL		87,257,550,801	437,256,000	48,272,718,000	14,210,308,467	13,632,053,667	11,682,344,667

8.2. Annex II – Identified Cholera hotspot areas in the country

Council	Council Total Population	Overall Epid Score	Overall WASH Score	Contextual factors	District Specific Population at Risk	Name of the Wards at Risk	Total Population of Risky Wards (2012)	*Total Population of Risky Wards (2019, Projection)
High Risk Hotspots								
Chunya District Council	177,049	10	3	Mining and poor water	Mining area and nomadic population	Chokaa	15,227	15,701
						Sangambi	9,772	10,076
Iringa District Council	268,840	10	1	Irrigation (rice farming)	Farmers	Mboliboli	8,500	0
						Mlenge	9,463	9,757
						Itundu	7900	0
Morogoro District Council	321,985	9.8	2.5	Poor water & sanitation coverage	Rural areas	Bwakila Chini	13,718	14,145
						Mngazi	9,528	9,824
						Mvuha	14,250	14,693
Kilosa District Council	492,879	9.8	1.5	Poor water & sanitation; Flood prone	Nomads/Township/Highway	Kidodi	9,106	9,389
						Dumila	21,288	21,950
						Mikumi	19,977	20,598
Kigoma-Ujiji	242,917	9.3	2	Poor access & utilization of toilets; Poor water; Poor hygiene practices: Cross border	Fishermen; Mobile population	Kibirizi	25,143	25,925
						Gungu	25,224	26,008
						Mwanga Kaskazini	25,184	25,967
Mpwapwa District Council	338,518	9.3	1.5	Poor water supply; Poor food hygiene	Nomads & businessmen	Lumuma	3,783	3,901
						Matomondo	17,131	17,664
						Mima	14,435	14,884
Uvinza District Council	432,532	9.3	2.5	Poor access & utilization of toilets; Poor water; Poor hygiene pratices: Cross border	Fishermen; Migrants	Sunuka	36,023	37,143
						Mwakizega		0
						Buhingu	16,973	17,501
Temeke Municipal Council	1,597,479	9.3	1	Low access to clean & safe water; Unplanned settlement; Low latrines coverage; Low capacity in collection & disposal of solid wastes; Poor sewerage infrastructure:	Casual labourers; Petty traders; Pupils: slums	Mbagala	52,582	54,217
Songwe District Council	157,089	9	2	Cross border; Use of contaminated river water; Mines; Inaccessibility of safe water	Farmers; Fishing: Pastoralist; Miners	Mkwajuni	15,292	15,768
						Mwambani	8,912	9,189
						Chang'ombe		0

Mbarali District Council	339,335	9	2	Irrigation scheme; Poor sanitation and water	Farmers	Chimala	16,633	17,150
						Rujewa	29,473	30,390
						Ubaruku	29,197	30,105
Sumbawanga District Council	359,008	9	1	Poor sanitation; use of contaminated rivers & lake	Farmers; Fishermen	Kipeta	25,755	26,556
						Muze	27,441	28,294
						Kaoze	2,636	2,718
Kinondoni Municipal Council	1231516	9	1	Low access to clean & safe water; Unplanned settlement; Low latrines coverage; Low capacity in collection & disposal of solid wastes; Poor sewerage infrastructure; floods	Casual labourers; Petty traders; slums	Mburahati	34,123	35,184
						Manzese	70,507	72,700
						Mburahati	34,123	35,184
Ngorongoro District Council	199,879	8.8	3	Open defecation; Poor water and latrine coverage; Social cultural behaviour	Nomadic	Endulen	13,537	13,958
						Piyaya		0
						Alailelali	7,351	7,580
						Malambo	14,226	14,668
						Ngoile		0
						Kakesio	5,537	5,709
						Olbalbal	8,969	9,248
Ukerewe District Council	400,522	8.8	2.5	Open defecation; Poor water and latrine coverage; Social cultural behaviour;	Fishermen	Irugwa	11,873	12,242
						Ilangala	38,008	39,190
Simanjiro District Council	209,420	8.5	3	Open defecation; Poor water and latrine coverage; Social cultural behaviour	Nomadic, Pastoralist	Loiborsoit		0
						Mlima Tembo		0
Kigoma District Council	238,529	8.5	2	Poor access & utilization of toilets; Poor water; Poor hygiene pratices: Cross border	Fishermen	Kagunga	16,972	17,500
Longido District Council	141,244	8.3	2.5	Open defecation; Poor water and latrine coverage; Social cultural behaviour	Nomadic, Pastoralist	Gelai Merugoi	9,173	9,458
Kiteto District Council	286,741	8.3	3	Open defecation; Poor water and latrine coverage; Social cultural behaviour	Pastoralist	Partimbo	20,669	21,312
Ilala Municipal Council	1,616,901	8.3	1	Open defecation; Poor water and latrine coverage; Social cultural behaviour	Slums	Buguruni	70,585	72,780
						Vingunguti	106,946	110,272

Musoma District Council	178,356			Low latrine coverage & use; Use of lake water; open defecation	Fishing community; mobile population	Bukima	18,537	19,114
						Murangi	16,933	17,460
						N/Tende		0
Mvomero District Council	312,109			Poor latrine coverage & Poor safe water	Farmers; Nomads	Dakawa	17,932	23,994
						Mlali	23,320	24,045
Tarime District Council	339,693			Poor water & latrine coverage; mining;	Miners	Matongo	19,176	19,772
						Kemambo	13,338	13,753
Korogwe Town Council	76,368	7.8	1.5	Poor water & latrine; use of contaminated Pangani river;		Kilole	8,208	8,463
High Risk Sub-Total	**9,128,751**						**1,048,049**	**1,080,643**
Moderate Risk Hotspots								
Nyasa District Council	162514	9	2	Use of contaminated lake water; Inaccessibility of safe water; Low latrine coverage	Farmers; Fishing; Pastoralist	Lipingo	8,945	9,223
						Ngumbo	3,933	4,055
Ulanga District Council	169853	9	1	Poor water & sanitation; open defecation	Nomads	Malinyi	16,860	23,117
Momba District Council				Irrigation and farming (rise farming; High water table; contaminated river/ lake water; Nomads with open defecation	Nomad and Famers	Tunduma Tc		
						Kamsaba	17,055	20,538
						Ivuna	18546	22952
Handeni District Council				Poor availability of the safe and clean water; inadequate awareness of hygiene and sanitation; risk social behaviour	Framers	Kwamatuku		
						Ndolwa		
						Sindeni		
Lindi District Council	203,415	9.5	2.5	Poor water supply & Poor toilet coverage & utilization: High water table		Mchinga	6,063	6,252
Moderate Risk Sub-	**535,782**						**18,941**	**19,530**
Low Risk Hotspots								
Same District Council	294,487	8.3	1	Irrigation and plantation area	Farmers;	Ruvu	14,261	14,705
Ilemela Municipal Council	398,032	8.3	1.5	Poor Sanitation and access to water supply	Petty Traders	Buhongwa	26,691	27,521

Lindi Municipal Council	82,606	8.5	1.5	Poor water & sanitation; Cross border: open defecation; Social cultural behaviour		Wailesi		0
Mkinga District Council	131,996	8.8	3	Poor water & sanitation; Cross border: open defecation; Social cultural behaviour	Population along the coast	Kwale		0
Kilwa District Council	199854	8.8	2	Poor water & sanitation; Cross border: open defecation; Social cultural behaviour	Population along the coast	Kivinje		0
Mpanda District Council	300,000	8.5	2			Ikola	17,659	18,208
Low Risk Sub-Total	**1,406,975**						**58,611**	**60,434**
Grand Total	**11,071,508**						**1,125,601**	**1,160,607**

Summary:	
Total Council:	**44**
Total Wards:	**73**
Total Targets Pop:	**1,169,070**