World Health Organization

Mid-term Evaluation of the Global Task Force on Cholera Control

Web annexes

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Cover photo: A frontline Health Worker vaccinating children against cholera in Kahda districts of Banadir region
Credit: © WHO Somalia

Contents

List of tables

List of figures

Acknowledgements

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Evaluation Steering Group

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Evaluation Reference Group

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Acronyms

AWD	Acute Watery Diarrhoea
BMGF	Bill and Melinda Gates Foundation
CDC	Centers for Disease Control and Prevention
CSO	Civil Society Organization
CSP	Country Support Platform
DRC	Democratic Republic of the Congo
EQ	Evaluation Question
ERG	Evaluation Reference Group
ESG	Evaluation Steering Group
FCDO	Foreign, Commonwealth and Development Office
FGD	Focus Group Discussion
GER	Gender, Equity, and Human Rights
GTFCC	Global Task Force on Cholera Control
ICG	International Coordinating Group
IFRC	International Federation of Red Cross
IRP	Independent Review Panel
KII	Key Informant Interview
LMIC	Low- and Middle-Income Countries
M&E	Monitoring and Evaluation
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organization
NCP	National Cholera Plan
NMCEP	National Multisectoral Cholera Elimination Plan
OCV	Oral Cholera Vaccine
PAMIs	Priority Areas for Multisectoral Interventions
RCCE	Risk Communication and Community Engagement
RDTs	Rapid Diagnostic Tests
SDG	Sustainable Development Goals
ToC	Theory of Change
TOR	Terms of Reference
WASH	Water, Sanitation, and Hygiene
WG	Working Group
WHA	World Health Assembly
WHO	World Health Organization

Terms of Reference

Mid-term independent evaluation of the Global Task Force on Cholera Control (GTFCC) 2017-2030

Terms of Reference – 25 January 2024

Summary

On behalf of the **Global Task Force on Cholera Control Secretariat**, the WHO Evaluation Office is commissioning an independent mid-term evaluation of the **Global Task Force on Cholera Control (GTFCC).**

Created in 1992 by the Director-General of the World Health Organization and adopted by the World Health Assembly, the GTFCC Secretariat is hosted by the WHO. The GTFCC operates in a complex multisectoral environment with a broad range of stakeholders. It brings together over 50 organizations working across multiple sectors and serves as a platform to implement a Global Roadmap to **reduce cholera deaths by 90 percent, eliminate** cholera in 20 countries by 2030, and avoid uncontrolled outbreaks. To do so, the Roadmap is underpinned by **early detection and quick response to contain outbreaks; a targeted multi-sectoral approach to prevent cholera recurrence; and an effective mechanism of coordination for technical support, advocacy, resource mobilization, and partnership at local and global levels.**

The successful implementation of the Global Roadmap may allow up to 50 percent cost savings compared with the ongoing average yearly cost of continuously responding to emerging cholera outbreaks. Most importantly, the proposed long-term cholera control investments should also significantly reduce the impact of all water-related diseases, while contributing to improvements in poverty, malnutrition, and education, thereby representing a significant step toward the achievement of the Sustainable Development Goals (SDGs) for the world's poorest people and toward a world free from the threat of cholera.

Solicited by the GTFCC Steering Committee and Secretariat, the evaluation of the GTFCC comes at an important milestone: the midway to the Roadmap's scheduled end point. Moreover, seven years after its launch, the cholera landscape has changed considerably globally and locally. Climate change, conflicts, and population displacements have contributed to increasing cholera outbreaks. At the same time, cholera vaccine shortage introduced a new vaccination schedule and has hindered the capacity to run both preventive and reactive campaigns at scale. Concerning, countries where cholera hasn't been present for decades, have recently reported new cases.

The evaluation aims to assess relevance, effectiveness, efficiency, coherence, sustainability of the GTFCC as well as a broad cross-cutting question that will provide a perspective on the inclusion of equity, gender, and human rights considerations in the Global Roadmap strategy. The evaluation will be used to inform the strategic and operational future of GTFCC while assessing the validity of the Roadmap and its instruments in a context of change.

These Terms of Reference (ToR) describe the background, purpose and objectives, suggested evaluation questions and methodological approach, evaluation management arrangements, and the required profile of the evaluation team.

Background

The Global Task Force on Cholera Control (GTFCC) is a partnership of more than 50 institutions (NGOs, academic and scientific institutions, UN agencies) to coordinate activities for cholera control and global, regional, and country levels. The GTFCC operates in a complex multisectoral environment with a broad range of stakeholders: it brings together organizations working across multiple sectors and serves as a coordination platform to support countries in the implementation of the Global Roadmap *(3)*to **reduce cholera deaths by 90 percent, eliminate** cholera in 20 countries by 2030, and avoid uncontrolled outbreaks. To do so, the strategy is underpinned by **early detection and quick response to contain outbreaks; a targeted multi-sectoral approach to prevent cholera recurrence; and an effective mechanism of coordination for technical support, advocacy, resource mobilization, and partnership at local and global levels.**

The GTFCC was created by the Director General of WHO in April 1991 and its establishment acknowledged by the WHA in May 1991. The GTFCC Secretariat is hosted by WHO. In 2017, On October 4, the GTFCC has convened a high-level meeting of officials from cholera-affected countries, donors, and technical partners to affirm their commitment to ending cholera as a threat to public health by 2030. The meeting, which marked the official launch of the Global Roadmap strategy, sought to solidify concrete commitments from key partners:

- From cholera-affected countries, to implement evidence- based cholera control and elimination plans;
- From GTFCC partners, to their active involvement as technical experts; and
- From key donors, to support the global mechanism and/or the country programmes.

GTFCC activities aim to raise the visibility of cholera as a public health issue, facilitate sharing of evidence-based practices, and contribute to capacity development in all areas of cholera control. The GTFCC is not responsible for developing any technical norms or standards. The objectives of the Task Force are to:

- Support the design and implementation of global strategies to contribute to cholera prevention and control globally;
- Provide a forum for technical exchange, coordination, and cooperation on cholera-related activities to strengthen countries' capacity to prevent and control cholera, especially those related to implementation of proven effective strategies and monitoring of progress, dissemination and implementation of technical guidelines, operational manuals, etc.;
- Support the development of a research agenda with special emphasis on evaluating innovative approaches to cholera prevention and control in affected countries;
- Increase the visibility of cholera as an important global public health problem through integration and dissemination of information about cholera prevention and control and conducting advocacy and resource mobilization activities to support cholera prevention and control at national, regional, and global levels.

Since the GTFCC formation, the global cholera landscape has changed dramatically. More, larger and deadly outbreaks have been registered due to increased levels of poverty and conflict. This has been exacerbated by climate change dynamics that caused an increased severity and frequency of floods and other adverse phenomena such as deforestation, water pollution and other interconnected environmental factors that influence cholera transmission dynamics.

At the moment of publication, the Roadmap focused on the 47 countries affected by cholera. Today, more than 51 countries are managing outbreaks. Some of these countries saw cholera remerge after decades free of

cases. The current trajectory shows a clear deterioration of the ongoing Cholera Pandemic which has increased the demand for life-saving commodities such as medical supplies and oral cholera vaccines (OCV). The lack of stock at the global level hinders the capacity to swiftly respond to new outbreaks adding further stress to an already challenging situation. The scale of the crisis is underpinned by inadequate surveillance capacity and sub-optimal case management caused by over-stretched healthcare workers and difficulties that communities face in accessing to timely care. Finally, the unprecedented demand for vaccines, paired with the lack of global manufacturing capacity, has undermined the use of OCV for reactive and preventing campaigns. A lack of investment in WASH remains a challenge. Together, these elements limit the delivery of the Roadmap as articulated in 2017.

Ending cholera, a global roadmap to 2030

In October 2017, cholera-affected countries, global donors, and partners of the GTFCC came together to launch a renewed global cholera control strategy. The Ending Cholera—A Global Roadmap to 2030 operationalizes the global strategy for cholera control at the country level and provides a concrete path toward a world in which cholera is no longer a threat to public health.

A key role of the Task Force is to promote and support the implementation of the Ending Cholera – A Global Roadmap to 2030 at country level by providing the advocacy, coordination, policy guidance and technical assistance necessary for countries to develop National Cholera Plans (NCPs) and implement them effectively. By implementing the strategy between now and 2030, the GTFCC partners will support countries to reduce cholera deaths by 90%. With the commitment of cholera-affected countries, technical partners, and donors, as many as 20 countries could eliminate disease transmission by 2030.

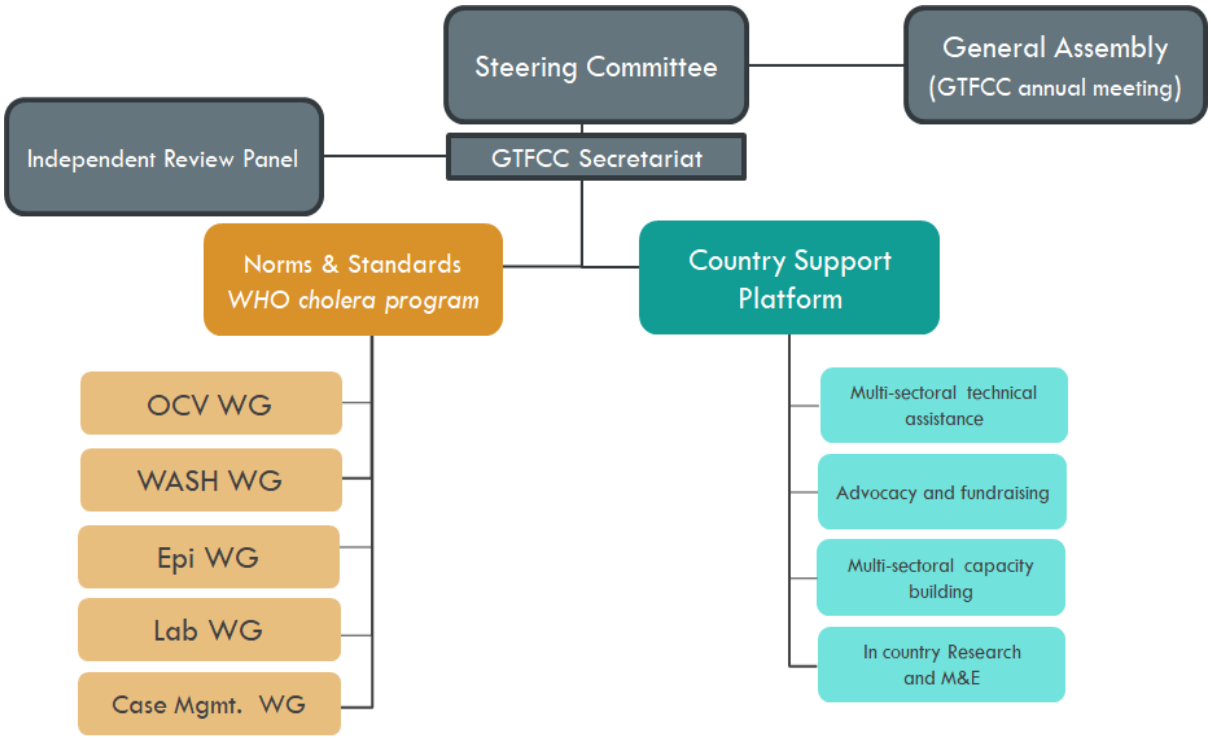
GTFCC partnership governance structure

The 2011 WHA 64.15 resolution ("Cholera mechanisms for control and prevention) *(1)* requested the WHO Director-General to revitalize the Global Task Force on Cholera Control ("GTFCC") and to strengthen WHO work in this area, including improved collaboration and coordination among relevant WHO departments and other relevant stakeholders.

In order to fulfil its above-mentioned missions, the global-level structure of the GTFCC follows the key principle of multi-sectorality, ensuring that all sectors, including health, emergency and development WASH and others are fully involved in short and longer-term efforts and programming for cholera control.

The operational model is designed to adapt the GTFCC structure to enhance support and influence at country level. Information below reflect the Operational model Terms of reference developed in 2019 (accessible on the GTFCC website *(2)*):

Figure 1: GTFCC governance structure



Roles and responsibilities within the GTFCC are detailed in table 1.

Table 1: Roles and responsibilities of GTFCC entities

Steering Committee (SC)	Responsible for oversight, strategic direction and accountability for the GTFCC as a whole, the Steering Committee includes GTFCC partner organizations (8), as well as representatives of endemic countries (3). It gives strategic direction at the global level to advocate for cholera control and elimination.
General Assembly	The GTFCC yearly meeting provides a forum for all relevant stakeholders, presents an opportunity to review progress and challenges and to give voice to countries to express their needs, and serves as an important advocacy conduit.
Independent Review Panel (IRP)	The IRP is an independent technical review mechanism responsible for transparent and in-depth review of NCPs. It advises the GTFCC Secretariat in the endorsement of country NCPs. The IRP includes technical experts from all sectors of cholera control, drawing upon expertise of the GTFCC partner organizations.
GTFCC Secretariat	The implementation of the Global Roadmap is guided and overseen by a partnership, the Global Task Force on Cholera Control (GTFCC) whose Secretariat is based at WHO Health Emergency Interventions Department at WHO headquarters (HQ/WRE/HEI). The GTFCC Secretariat (hereinafter referred to as the "Secretariat") is hosted at the WHO. The GTFCC Secretariat organizes the meetings of the Steering Committee. It also prepares and proposes the strategic priorities, the annual workplan and budgets, and identifies potential risks for review during the Steering Committee meetings. The Secretariat works under the supervision of and reports to the Steering Committee and ensures coordination between the WHO cholera program and the Country Support Platform.
WHO and GTFCC Technical Working Group	Working groups provide cholera-specific normative and programmatic guidance on (i) Oral Cholera Vaccine (OCV), (ii) WASH, (iii) Epidemiology, (iv) Laboratory, and (v) Case Management. The decision to establish a Risk Communication and Community Engagement (RCCE) working group has been endorsed, however, due to lack of funding and stakeholder engagement this has not yet materialised. Working groups are established to prioritize issues within a particular area and to mobilize external expertise and funding for answering specific questions identified by GTFCC when the issue is particularly complicated and additional time, expertise, and discussion are required. The work of the working groups are operationalized through the Country Support Platform.
GTFCC Country Support Platform (CSP)	A key role of the GTFCC is to promote and support the implementation of the Ending Cholera – A Global Roadmap to 2030 at the country level by providing the advocacy, coordination, policy guidance and technical assistance necessary for countries to develop National Cholera Plans (NCPs) and implement them effectively. In 2020, a Country Support Platform (CSP) hosted at the International Federation of Red Cross and Red Crescent Societies, was established. The CSP leads the multi-sectoral support that the GTFCC provides to countries for the implementation of their NCPs. Under the guidance of the GTFCC Secretariat, it coordinates technical assistance (short, medium and long term) to countries, the delivery of commodities, advocacy and fundraising for the NCPs, monitoring & evaluation of national plans, and the implementation of operational research projects. The CSP manages the short, medium and long-term deployment of GTFCC multi-sectoral expertise in countries, including for advocacy, coordination and policy guidance. The CSP operates under GTFCC Secretariat leadership and coordination.

In terms of process, for information exchanges, decision-making and advocacy, the GTFCC has the following ways of working:

Table 2: *GTFCC processes*

Information exchange	The GTFCC normally meets during the General Assembly and annual meetings of the Technical Working Groups; it may utilize face-to-face, teleconferences or other electronic communication meeting methods. Special meetings may be called to address emerging issues. Meetings and teleconferences are convened by the Secretariat and can be hosted by members as agreed.
Decision-making	Decisions concerning GTFCC activities are taken by consensus.
Advocacy Task Team	One of the proposed recommendations emerging from the 2021 GTFCC General Assembly was to regularly convene a group of partners dedicated to discussing coordination and strategic planning around policy, advocacy, and financing. In fulfilment of this recommendation, an *ad hoc* task team convening around a series of objectives intended to advance the policy, advocacy and financing objectives for cholera control and prevention at global, regional, national, and subnational levels, was set up end of 2021.

Purpose, objectives and scope of the mid-term evaluation

The GTFCC Operational Model terms of reference (July 2019), indicates that the structure will be evaluated after 3 years, and changes and amendments implemented as required. During the 10th GTFCC General Assembly (June 2023), Steering Committee Members acknowledged that as the Task Force has reached the mid-way landmark, it has grown quite a lot since 2017. SC Members unanimously agreed to launch a mid-term review to inform progress made so far by the Task Force, and identify challenges and possible bottlenecks (both internal as well as possibly external) that could prevent the Task Force from reaching its goals by 2030 in a constantly changing environment. The Steering Committee called for a mid-term evaluation of the Task Force with regard to the implementation of the Global Roadmap commissioned by the WHO Evaluation Office.

The **purpose** of the mid-term evaluation is to assess progress of the delivery of the GTFCC Global Roadmap and to draw the way forward to ensure successful adaptation to a global landscape marked by significant epidemiological, political and climatic changes, incorporating risk analysis and reprioritising accordingly. The evaluation will be used to generate evidence that will inform decisions about the strategic and operational future of GTFCC and include recommendations to optimize implementation until 2030.

The **objectives** of the evaluation are to:

- document the extent to which results have been reached at the country level, and assess progress and gaps as documented in the GTFCC monitoring and evaluation frameworks (Global Roadmap monitoring framework *(3)*, NCP Interim Guiding Document Monitoring and reporting section *(4)*), its indicators and targets and overall strategy milestones;
- identify key achievements, best practices, challenges, gaps, and areas for improvement in the design and implementation of the GTFCC;
- identify the key contextual factors and changes that are affecting cholera spread and transmission risk profile and influencing programme implementation;
- establish the adequacy of the governance structures, mechanisms and processes of the GTFCC, including its Secretariat, to achieve agreed goals; and
- make recommendations as appropriate on the way forward to improve performance and adaptation to a changed global landscape, and to ensure sustainability beyond 2030.

This evaluation will be of a **primarily formative and forward-looking nature**. It will strike a balance between elements focused on accountability and forward-looking aspects concerned more with learning and incorporating good practices into a potential new operational and strategic visions to enhance implementation and programme performance, as well as to inform future relevant discussions and decisions. It will cover areas such as the design and approach, achievement of results, coordination and collaboration, management, governance, and resourcing arrangements as well as guidance formulation.

The **scope** of the evaluation will cover progress of the GTFCC Global Roadmap implementation during the timeframe 2017-May 2024 across various organizational levels and partners with a particular focus on coordination and programmatic delivery at the global, regional, and country levels by relevant GTFCC entities, including the Secretariat. It will also consider the changing global landscape, and risk profiles.

Evaluation criteria and questions

The evaluation will be conducted in line with the WHO Evaluation policy *(1)*. The evaluation will follow the principles set forth in the WHO Evaluation Practice Handbook *(5)*, the United Nations Evaluation Group Norms and Standards for Evaluation (2016) *(6)* and its Ethical Guidelines. It will also respect the UNEG Guidance on integrating Human Rights and Gender Equality in Evaluation and the UN-SWAP Evaluation Performance Indicators.

The evaluation will address the OECD criteria of relevance, effectiveness, efficiency, coherence and sustainability, supplemented by a broad cross-cutting question that will provide a perspective on the inclusion of equity, gender, and human rights considerations in the design and delivery of the Global Roadmap strategy.

The proposed evaluation questions are tentative and expected to be prioritized and simplified/operationalised as relevant and refined during the inception phase of the evaluation, based on inception interviews and a desk-review of documents and careful consideration of which questions appear to be most helpful as well as feasibility.

Figure 2 shows the set of broad tentative questions suggested for this evaluation:

Figure 2: Potential evaluation overarching and sub-questions to be discussed, prioritized and validated at inception phase.

OECD Criteria and related overarching question	Evaluation sub-questions (to be refined/simplified as relevant and prioritized during the inception phase)
Relevance: To what extent are the GTFCC design and strategy adequate to support the achievement of the Roadmap's 2030 goals?	- How adequate are the GTFCC design, governance structures and mechanisms supporting the GTFCC (including the Secretariat) for the delivery of the objectives of the EndCholera Global Roadmap in terms of: i) engaging the right partners at global, regional and country level, and ii) providing an appropriate framework to steer and coordinate implementation of activities for maximum impact? - Considering the parameters of the original context in which it was launched, and accounting for the changed global landscape, to what extent does the GTFCC Roadmap (and related guidance) support adaptation to, i.e. i) global epidemiological, political, and climatic changes since 2017, and ii) changing risk profiles and emerging issues/contexts?

	- To what extent are measures being taken to ensure continuous adaptation of the Roadmap in line with: i) international best practices in providing coordination and support to countries and partners and ii) with national cholera strategies and tools?
Effectiveness: To what extent has the GTFCC achieved the Roadmap's expected results?	- What results have been achieved by the GTFCC, through its different entities in the implementation of the Roadmap, and how do they align with expected results in terms of: i) global progress towards achieving strategic objectives/outcomes, and ii) measurable country-level outcomes. - How have specific examples of success stories or best practices resulting from GTFCC interventions in different countries contributed to achieving global and national goals? - Which factors have influenced the implementation of the Roadmap to date, what challenges have emerged, and which opportunities could be tapped into for better results? - To what extent does the GTFCC provide quality guidance (including development process and implementation), and how has it contributed to achieving results at the national level?
Efficiency: How efficiently has the Roadmap been implemented by the GTFCC ?	- How efficiently has the Roadmap been implemented, in terms of: i) optimizing human and financial resource allocation to support countries in managing changing cholera risk profiles efficiently; ii) managing resources to deliver goals and maintain capacity in increasingly complex epidemiological scenarios; iii) monitoring implementation and responding to incoming information (e.g. risk-based decisions in response to changing circumstances), and iv) ensuring adequate resource mobilization and/or exploring the use of economic incentives or innovative financing mechanisms.
Coherence: How coherently is the GTFCC working to optimize the implementation of the Roadmap strategy ?	- How successfully has the GTFCC, through its governance structures and mechanisms (including the Country Support Platform, the Independent Review Panel, and the Working Groups) promoted complementarity – and synergy/integration - of different actors' interventions? What is the observable added value of GTFCC members acting together? - How well has the GTFCC, in particular through the Secretariat and Country Support Platform, coordinated and collaborated with other stakeholders to ensure coherent engagement at country level? In what ways ha the GTFCC facilitated communication, knowledge sharing and capacity building among countries and partners, promoting a more coherent approach to cholera control?
Sustainability: What steps has the GTFCC taken to ensure the sustainability of its interventions under the Roadmap?	- To what extent does the Roadmap include a framework or exit strategy? Have steps been taken by the GTFCC Secretariat to ensure the sustainability of achievements post 2030? - How has the GTFCC, through its entities in particular the Secretariat and the Country Support Platform, supported countries' efforts to ensure longer term sustainability of interventions in terms of integrating both with country programmes and with other disease areas and approaches, and adapting to changing risk profiles and emerging cholera situations? - To what extent are environmental aspects being considered for the future of global cholera prevention and control efforts? - To what extent does the Roadmap support capacity building within communities and institutions to implement sustainable interventions? - How well has the GTFCC Secretariat mobilized additional and required funding

Gender, equity and human rights (GER): To what extent has the Roadmap strategy included gender, equity and human rights concerns and how are they addressed in implementation?	- To what extent has the Roadmap addressed GER concerns? - How consistently and meaningfully are implementation activities informed by considerations of overall equity both globally (i.e. supporting work in areas where assistance is most needed) and at country level: i.e. to what extent: i) do data collection and analytical methods include disaggregated epidemiological and management data for vulnerability and social criteria (e.g. gender, equity, and geographic location) and ii) are such data and analysis used to inform decision-making and implementation?

Methodology and approach

This section provides preliminary guidance on the methodological approach foreseen for this evaluation. The approach will be adapted, refined and adjusted at the inception phase for the evaluation: e.g. with additions to the evaluation design; data collection and analysis methods; an evaluation framework and clarity on methodological limitations and mitigation measures.

With a strong focus on utilization, the approach of the evaluation will concentrate on engaging with principal users of the evaluation process and report. The evaluation is expected to be participatory and solicit the view of all partners of the GTFCC. The evaluation process and recommendations are intended to foster ownership and the evaluation team are expected to create opportunities for discussions with stakeholders and iterative feedback loops throughout the evaluation.

Primary users are GTFCC partners, the GTFCC Secretariat, the CSP, and Member States and secondary users are the WHO units, departments and offices as well as partners involved in the implementation of the Roadmap.

Findings should be based on triangulated evidence, and conclusions and recommendations should derive from findings. Multiple sources should be used to ensure that findings can be generalized and do not result from single sources or views. An evaluation matrix with a description of the methods to be used to address each evaluation question and data sources will be included in the inception report.

The evaluation is expected to use a **mixed methods** approach, so to collect and analyse both quantitative and qualitative data, to gain convergence and increase validity through triangulation, using the strengths of each technique to overcome the weaknesses of the other and, in the end, obtain a fuller picture. The evaluation team will establish a map of stakeholders and review and update the Theory of Change (ToC).

The following **data gathering methods** and approaches are suggested:

- **Desk review:** The GTFCC documents will be reviewed and assessed alongside evaluative evidence already available and literature on relevant good practices, definitions, and theoretical frameworks in international cooperation, public health, humanitarian and development assistance. Environmental data will be considered alongside health data as relevant. This documentation includes, but is not limited to, overarching strategies and frameworks, background papers, global results framework and related ToC, GTFCC learning reviews, previous reviews and other evaluative reports, monitoring reports etc. Selected regional- and country-level strategic materials will be included, especially for the deep-dive case studies to be identified. The GTFCC core partners will supply all information identified as relevant and may provide the

evaluation team with access to their intranet and management information systems for direct examination and searching.

- **Survey:** A survey will be conducted, to obtain the data from stakeholders at country level involved in the work of the GTFCC, including staff of GTFCC member entities, other implementing partners, government officials, academia, and civil society representatives.
- **Administrative and secondary data:** The use of administrative and secondary data will be essential to minimise the primary data collection to the greatest extent possible. The evaluation management team will support the evaluation team in gaining access to the administrative and secondary data.
- **Key informant interviews (KIIs) and focus group discussions:** Consultations will be conducted through interviews with a selected sample of key informants, including internal stakeholders across all levels of GTFCC member entities and key external partners directly contributing to the GTFCC's work, including representatives of cholera coordination mechanisms in cholera-affected countries. Focus group discussions are encouraged. As relevant, the evaluation will seek to involve communities, alongside technical experts, to ensure inclusivity and address diverse perspectives, including environmental considerations.
- **Country case studies (one per region/ 6 regions):** The evaluation team may undertake field missions to collect data, especially for the country case studies that will be further identified during the inception phase.

Evaluation management

This evaluation will be managed by the WHO Evaluation Office with the guidance of an **Evaluation Steering Group (ESG)** comprised of members from the GTFCC Steering Committee nominated by the Chair. The ESG has a validation role with regards to:

- The ToRs for the evaluation;
- The selection of the evaluation team;
- The factual accuracy of the final inception and evaluation reports.

The **Evaluation Manager** will facilitate the evaluation process, ensuring access to relevant documentation/ data and key interlocutors within and outside WHO, and dissemination of evaluation deliverables for comments.

The Evaluation Manager will be supported by a technical advisory **Evaluation Reference Group** (ERG), composed of GFTCC key stakeholders and technical experts on cholera control matters. The ERG will provide advice to the Evaluation Manager throughout the evaluation process and be kept informed throughout the evaluation process. The ERG will:

- Review the ToRs, with particular attention to evaluation questions;
- Offer insights on issues under discussion, particularly during the inception phase when methods, design and data sources are determined;
- Review the key draft deliverables (inception report, and the final draft report);
- Act as a source of knowledge for the evaluation.

The evaluation will be conducted by an **external independent evaluation team**, selected competitively. The evaluation team should have strong technical understanding of public health and the cholera context, and an appropriate skill mix of relevant evaluation methodologies. It is desirable that the team has relevant

experience in performing similar evaluations and understanding of WHO and the United Nations system. The evaluation team will be responsible for:

- Designing, planning and implementing the evaluation, drafting the evaluation report, using the approach to be agreed in the inception report, and for delivering in accordance with the ToRs specifications and timeline;
- Consulting and liaising, as required, with the Evaluation Manager, and to ensure satisfactory delivery of all deliverables;
- Scheduling and conducting all meetings, interviews, focus group discussions, presentations/debriefings with the GTFCC Steering Committee and ERG members, and the final workshop with stakeholders.

The evaluation team is expected to carry out the evaluation with a high degree of independence and manage their own travel and other administrative arrangements as relevant.

Evaluation deliverables and timeline

The proposed organization of the evaluation phases is as follows:

Inception report and presentation

During the inception phase, the evaluation team is expected to gain a deep understanding of the proposed documentation, assess possible information gaps, refining the scope, methods, and identify key stakeholders. The main deliverable for this phase will be the **inception report**, submitted to the Evaluation Manager. The Inception report will detail the evaluators' understanding of what is being evaluated and why, including an agreed set of reviewed and prioritized evaluation questions and showing how each evaluation question will be answered by way of: proposed methods and data sources and collection procedures. The inception report should include an evaluation matrix with a description of the methods to be used to address each evaluation question and data sources, proposed schedule of tasks, activities and deliverables, and identified key interviews.

The inception report will outline how the evaluation team will adhere to UNEG Ethical Guidelines *(6)* including: confidentiality and anonymity, do no-harm approaches in the administration of qualitative methods with respondents, data management and storage, and integration of appropriate cultural/language considerations.

The evaluation team will **present the main contents of the inception report to the evaluation manager and relevant stakeholders** (i.e. including ESG and GTFCC SC members, and ERG members) either online or in person. The draft inception report will be reviewed by the Evaluation Manager, the ESG/ ERG, and relevant stakeholders. The evaluation team will finalize the inception report taking into account comments received.

Presentation of preliminary findings and draft evaluation report

Based on the inception report, the evaluation team starts the data collection phase, keeping the Evaluation Manager informed of progress regularly. The data collection phase ends with the second deliverable, a **presentation of preliminary findings and conclusions** by the evaluation team either online or in-person to relevant stakeholders (i.e. the ESG, ERG and GTFCC Steering Committee members). The presentation is intended to validate findings and strengthen the ownership of key stakeholders. It will be based on an

evaluation matrix linking evaluation criteria, evaluation questions, key findings with conclusions and recommendations. The presentation is foreseen to be shared with key stakeholders during data analysis and early stages of report drafting.

The third deliverable is the **draft evaluation report** submitted by the Evaluation Team to the Evaluation Manager. The draft report is expected to present the evidence found in response to all evaluation questions and should be relevant to decision-making needs. The report will include findings, conclusions, and recommendations based on evidence derived directly from the evaluation findings and conclusions. The draft report will be reviewed by the evaluation team following discussion with key stakeholders, and considering comments received.

Stakeholder workshop PowerPoint presentation

The evaluation team will **present the draft report** (main findings, conclusions and recommendations), the revised ToC (as relevant), to the main stakeholders of the evaluation in a stakeholder workshop (e.g. Power Point presentation to be shared with the Evaluation Manager) to be held either online or in person.

Final draft evaluation report and communication documents

The evaluation team will submit a revised **final draft evaluation report**, including findings, conclusions and recommendations, to the Evaluation Manager after due consideration of comments received. The report will include an **executive summary**. The report will be disseminated internally and posted on the WHO Evaluation Office website.

The final draft report will be delivered together with a short **"two pager"** brief highlighting main findings/conclusions and recommendations. The final draft report is finalized and published by the WHO Evaluation Office. The evaluation team may also **collaborate with the Communication Expert at the WHO evaluation office** to deliver a short video clip with the main messages from the final evaluation report and/or for other communication products.

Timetable

A **tentative timeline** of around 8 months is envisaged for the evaluation, from March 2024 to October 2024. Key milestones envisaged for the evaluation are provided below (*indicative*):

- Terms of reference for the evaluation: January 2024
- Competitive selection of the evaluation team: end of February 2024
- Draft Inception report: End of April 2024
- Data collection: April - June 2024 *(for information and planning purposes for the evaluation GTFCC General Assembly scheduled on June 16-17-18, 2024)*
- Presentation of preliminary findings – End of June/Beginning of July 2024
- Draft report: End of August 2024
- Stakeholder workshop: September 2024
- Final draft report: End of October 2024

Revised evaluation questions

This section provides an overview of modifications made to the evaluation questions from the original Terms of Reference (ToR). Overall, the ToR overarching questions and sub-questions have been streamlined across nine updated evaluation questions. The OECD criteria have also been re-ordered in the following order: Relevance (EQ1 and EQ2), Coherence (EQ3), Efficiency (EQ4 and EQ5), Effectiveness (EQ6 and EQ7), Sustainability (EQ8) and Gender, Equity and Human Rights (EQ9).

Table 3 maps out the original evaluation questions and sub-questions as per the TOR against the updated evaluation questions.

Table 3: Overview of modifications to ToR

OECD Criteria and related overarching question as per TOR	Evaluation sub-questions	Relevant Evaluation Question (EQ)	Updated evaluation question under each criteria
Relevance: To what extent are the GTFCC design and strategy adequate to support the achievement of the Roadmap's 2030 goals?	• How adequate are the GTFCC design, governance structures and mechanisms supporting the GTFCC (including the Secretariat) for the delivery of the objectives of the End Cholera Global Roadmap in terms of: i) engaging the right partners at global, regional and country level, and ii) providing an appropriate framework to steer and coordinate implementation of activities for maximum impact?	Covered under EQ2	**Relevance** • EQ1. To what extent is the Roadmap relevant given the changing environment (e.g. epidemiological, political, climate and risk profiles)? To what extent have measures been taken to ensure continuous adaptation of the Roadmap in line with latest international best practices and guidelines and emerging needs at the country level? • EQ2. To what extent is the design of the GTFCC adequate to support the objectives of the Roadmap?
	• Considering the parameters of the original context in which it was launched, and accounting for the changed global landscape, to what extent does the GTFCC Roadmap (and related guidance) support adaptation to, i.e. i) global epidemiological, political, and climatic changes since 2017, and ii) changing risk profiles and emerging issues/contexts?	Covered under EQ1	
	• To what extent are measures being taken to ensure continuous adaptation of the Roadmap in line with: i) international best practices in providing coordination and support to countries and partners and ii) with national cholera strategies and tools?	Covered under EQ1	

OECD Criteria and related overarching question as per TOR	Evaluation sub-questions	Relevant Evaluation Question (EQ)	Updated evaluation question under each criteria
Effectiveness: To what extent has the GTFCC achieved the Roadmap's expected results?	• What results have been achieved by the GTFCC, through its different entities in the implementation of the Roadmap, and how do they align with expected results in terms of: i) global progress towards achieving strategic objectives/outcomes, and ii) measurable country-level outcomes.	Covered under EQ6	**Effectiveness** • EQ6. What results have been achieved by the GTFCC partnership in the implementation of the Roadmap at the global and country level? • EQ7. Which factors have influenced the implementation of the Roadmap to date? What opportunities could be tapped into for better results?
	• How have specific examples of success stories or best practices resulting from GTFCC interventions in different countries contributed to achieving global and national goals?	Covered under EQ6	
	• Which factors have influenced the implementation of the Roadmap to date, what challenges have emerged, and which opportunities could be tapped into for better results?	Covered under EQ7	
	• To what extent does the GTFCC provide quality guidance (including development process and implementation), and how has it contributed to achieving results at the national level?	Covered under EQ6	
Efficiency: How efficiently has the Roadmap been implemented by the GTFCC?	• How efficiently has the Roadmap been implemented, in terms of: i) optimizing human and financial resource allocation to support countries in managing changing cholera risk profiles efficiently; ii) managing resources to deliver goals and maintain capacity in increasingly complex epidemiological scenarios; iii) monitoring implementation and responding to incoming information (e.g. risk-based decisions in response to changing circumstances), and iv) ensuring adequate resource mobilization and/or exploring the use of economic incentives or innovative financing mechanisms.	Covered under EQ4 and EQ5.	**Efficiency** • EQ4. To what extent are the GTFCC operational structures set up efficiently to support the objectives of the Roadmap? • EQ5. How efficiently has the Roadmap been implemented by the GTFCC in terms of optimizing human and financial resource allocation to support countries in a changing cholera landscape?
Coherence: How coherently is the GTFCC working to optimize the	• How successfully has the GTFCC, through its governance structures and mechanisms (including the Country Support Platform, the Independent Review Panel, and the Working Groups) promoted complementarity – and synergy/integration - of different actors' interventions? What is the observable added value of GTFCC members acting together?	Covered under EQ3.	**Coherence** • EQ3. To what extent has the GTFCC, through its governance structures and mechanisms, promoted complementarity, synergy and integration between different members'

OECD Criteria and related overarching question as per TOR	Evaluation sub-questions	Relevant Evaluation Question (EQ)	Updated evaluation question under each criteria
implementation of the Roadmap strategy?	• How well has the GTFCC, in particular through the Secretariat and Country Support Platform, coordinated and collaborated with other stakeholders to ensure coherent engagement at country level? In what ways has the GTFCC facilitated communication, knowledge sharing and capacity building among countries and partners, promoting a more coherent approach to cholera control?		interventions at the global and the country level ? What is the added value of GTFCC members acting together?
Sustainability: What steps has the GTFCC taken to ensure the sustainability of its interventions under the Roadmap?	• To what extent does the Roadmap include a framework or exit strategy? Have steps been taken by the GTFCC Secretariat to ensure the sustainability of achievements post 2030? • How has the GTFCC, through its entities in particular the Secretariat and the Country Support Platform, supported countries' efforts to ensure longer term sustainability of interventions in terms of integrating both with country programmes and with other disease areas and approaches, and adapting to changing risk profiles and emerging cholera situations? • To what extent are environmental aspects being considered for the future of global cholera prevention and control efforts? • To what extent does the Roadmap support capacity building within communities and institutions to implement sustainable interventions? • How well has the GTFCC Secretariat mobilized additional and required funding?	Covered under EQ8	**Sustainability** • EQ8. What steps has the GTFCC taken to ensure the sustainability of its interventions under the Roadmap?
Gender, equity and human rights (GER): To what extent has the Roadmap strategy included gender, equity and human rights concerns and how are	• To what extent has the Roadmap addressed GER concerns? • How consistently and meaningfully are implementation activities informed by considerations of overall equity both globally (i.e. supporting work in areas where assistance is most needed) and at country level: i.e. to what extent: i) do data collection and analytical methods include disaggregated epidemiological and management data for vulnerability and social criteria (e.g. gender, equity, and	Covered under EQ9	**Gender, equity and human rights (GER)** • EQ9. To what extent has the Roadmap included GER concerns? To what extent have implementation activities factored equity considerations at the global and country level?

OECD Criteria and related overarching question as per TOR	Evaluation sub-questions	Relevant Evaluation Question (EQ)	Updated evaluation question under each criteria
they addressed in implementation**?**	geographic location) and ii) are such data and analysis used to inform decision-making and implementation?		

Evaluation matrix

The evaluation matrix is presented in Table 4. Methods are colour shaded to reflect the degree to which they were used to inform the assessment of each evaluation question (green = critical use, orange = significant/moderate use, red = limited/no use). The e-survey was used as an evidence base for all evaluation questions.

Table 4: Evaluation matrix

Evaluation criteria	Evaluation question	Key areas	Methods			
			Document review	KIIs	Quantitative data analysis	Country case studies
Relevance	EQ1. To what extent is the Roadmap relevant given the changing environment (e.g. epidemiological , political, climate and risk profiles)? To what extent have measures been taken to ensure continuous adaptation of the Roadmap in line with latest international best practices and guidelines and emerging needs at the country level?	• Ambitions of the Roadmap and whether these are still appropriate • Comprehensiveness of, and balance between, the three strategic axes of the Roadmap • Considerations regarding the relevance of the package of interventions to prevent and control cholera	Comprehensive review of GTFCC documents including the Roadmap, progress reports, General Assembly meeting reports, Steering Committee meeting minutes, country guidance documents	Interviews with a range of stakeholders, particularly the GTFCC Steering Committee, Secretariat, members representing partners and donors, country stakeholders etc.	n/a	Analysis of country documents including NCPs, stakeholders consultations at country level,

Evaluation criteria	Evaluation question	Key areas	Methods			
			Document review	KIIs	Quantitative data analysis	Country case studies
		• Alignment of the Roadmap GTFCC work with relevant global and regional frameworks • Measures have been taken to ensure adaptation of the Roadmap				
	EQ2. To what extent is the design of the GTFCC adequate to support the objectives of the Roadmap?	• Relevance and appropriateness of the objectives and activities of the GTFCC • Adequacy of engagement of countries	Comprehensive review of GTFCC documents including Roadmap, GTFCC TORs (GTFCC, SC, WGs, CSP, IRP), GTFCC operational model	Interviews with a range of stakeholders, particularly the GTFCC Secretariat, Steering Committee, members of working groups, country stakeholders etc	n/a	Stakeholders consultations at country level in particular feedback on CSP and country participation in GTFCC, survey responses
Coherence	EQ3. To what extent has the GTFCC, through its governance structures and mechanisms, promoted complementarity, synergy and integration between different members' interventions at the global and the country level? What is the added value of	At global and/or country levels • added value of GTFCC members acting together • contribution of GTFCC to promote alignment between partners • alignment to country priorities,	Comprehensive review of GTFCC documents including, particularly the Roadmap, national country plans, GTFCC partners strategy documents	Interviews with a range of stakeholders, particularly the GTFCC Secretariat, members of GTFCC, Steering Committee, WGs, CSP, IRP, country stakeholders etc.	n/a	Analysis of country documents including NCPs and existing country progress reports, stakeholders consultations at country level, survey responses

Evaluation criteria	Evaluation question	Key areas	Methods			
			Document review	KIIs	Quantitative data analysis	Country case studies
	GTFCC members acting together?	coherence of interventions with country needs				
Efficiency	EQ4. To what extent are the GTFCC operational structures set up efficiently to support the objectives of the Roadmap?	• Functioning of the GTFCC internal structures (SC, Secretariat, WGS, General Assembly, IRP, CSP)	Review of multiple GTFCC documents including the Roadmap, GTFCC TORs (GTFCC, SC, WGs, CSP, IRP), GTFCC operational model, progress reports, General Assembly meeting reports, Steering Committee meeting minutes	Interviews with a range of stakeholders, particularly the GTFCC Secretariat, Steering Committee, WGs, CSP, IRP, country stakeholders etc.	Evidence of GTFCC funding, resource allocation across structures.	Country stakeholders feedback (consultations, survey) in particular regarding CSP, coordination and functioning for outbreak responses and prevention interventions
	EQ5. How efficiently has the Roadmap been implemented by the GTFCC in terms of optimizing human and financial resource allocation to support countries in a changing cholera landscape?	• Use of resources allocated to the GTFCC • Implementation at country level (e.g., channelling of resources at country level, optimisation across partners etc.)	Review of GTFCC management and financial documentation.	Interviews with a range of stakeholders, particularly the GTFCC Secretariat, members of GTFCC, Steering Committee, WGs, CSP, IRP, country stakeholders etc	Evidence of GTFCC funding, resource allocation across GTFCC structures and to countries.	Analysis of country documents, stakeholders consultations at country level, NCPs and existing country progress reports, survey responses, cholera programmes and partners responses documents.
Effectiveness	EQ6. What results have been achieved by the GTFCC partnership in the implementation of the	Progress across Roadmap axes: • Axis 1 – improving outbreak containment and reducing the global	Review of key GTFCC documents including Roadmap, progress reports, General Assembly meeting	Interviews with a range of stakeholders, particularly countries, GTFCC Secretariat, Steering Committee,	Trend analysis on epidemiological data	Analysis of country documents, stakeholders consultations at country level, NCPs

Evaluation criteria	Evaluation question	Key areas	Methods			
			Document review	KIIs	Quantitative data analysis	Country case studies
	Roadmap at the global and country level?	burden of cholera through early detection and rapid response • Axis 2 – increasing prevention of disease occurrence through targeted multi-sectoral interventions in cholera hotspots • Axis 3 – ensuring effective mechanism of coordination for technical support, resource mobilization, and partnership at local and global levels	reports, Steering Committee meeting minutes, country progress reports	wider partners and donors, members of GTFCC, WGs, CSP, IRP etc		and existing country progress reports, survey responses, cholera programmes and partners responses documents.
	EQ7. Which factors have influenced the implementation of the Roadmap to date? What opportunities could be tapped into for better results?	• Factors that have aided implementation of the Roadmap • Factors that have hindered the implementation of the Roadmap	Review of key GTFCC documents including progress reports, General Assembly meeting reports, Steering Committee meeting minutes, country progress reports	Interviews with a range of stakeholders, particularly the GTFCC Secretariat, Steering Committee, members representing partners and donors, members of GTFCC, SC, WGs,	n/a	Analysis of country documents, stakeholders consultations at country level, NCPs and existing country progress reports, survey responses

Evaluation criteria	Evaluation question	Key areas	Methods			
			Document review	KIIs	Quantitative data analysis	Country case studies
		• Country level factors affecting progress		CSP, IRP, country stakeholders etc		
Sustainability	EQ8. What steps has the GTFCC taken to ensure the sustainability of its interventions under the Roadmap?	• Extent to which activities set out in the Roadmap aim to facilitate the sustainability of cholera interventions • Financial, programmatic and environmental considerations for sustainability	Review of key GTFCC documents including progress reports, Roadmap, General Assembly meeting reports, Steering Committee meeting minutes, country progress reports	Interviews with the range of stakeholders, particularly the GTFCC Secretariat, Steering Committee, WGs, CSP, IRP, wider partners and donors, country stakeholders etc	n/a	Analysis of country documents including NCPs and existing country progress reports, stakeholder consultations at country level, survey responses
Cross cutting: Gender, equity and human rights (GER)	EQ9. To what extent has the Roadmap included GER concerns? To what extent have implementation activities factored equity considerations at the global and country level?	• GER considerations in the design of the Roadmap • GER considerations in the implementation of the Roadmap	Review of GTFCC documents including RoadMap, progress reports, General Assembly meeting reports, Steering Committee meeting minutes, country progress reports	Interviews with the range of stakeholders, including partners and community representatives, country stakeholders etc	n/a	Analysis of country documents including NCPs, stakeholders consultations at country level, survey responses.

Evaluation Steering and Reference Groups

Table 5: ESG and ERG composition by stakeholder organization

Evaluation Steering Group (ESG)
ESG Chair
US CDC
BMGF
IFRC
MSF
UNICEF
Pakistan country representative
Evaluation Reference Group (ERG)
GTFCC Secretariat
CSP (IFRC)
US CDC
BMGF
Gavi
IFRC
International Centre for Diarrhoeal Disease Research (icddr,b)
MSF
UNICEF
WHO HQ
Zambia country representative
Pakistan country representative

Interview guides

This section provides select interview guides for the core phase interviews with global level stakeholders and country level stakeholders. The below guides are generic examples that were further tailored to specific stakeholders ahead of consultations.

Global stakeholder interview guide

This section presents an indicative guide used for consultation with global stakeholders such as GTFCC members, donors, partners and community representatives engaged in GTFCC, as well as research institutions.
Interview questions:

1. To what extent is the Roadmap still fit for purpose given the change in context since its design, in terms of (i) how appropriate are its ambitions and targets? (ii) the degree of focus/ emphasis on each of the three strategic axes of the Roadmap (outbreak response, prevention, coordination of human, technical and financial resources)? (iii) the proposed interventions to prevent and control cholera (e.g., WASH, leadership and coordination, case management, surveillance and reporting, OCV and community engagement) and (iv) the alignment of the Roadmap with relevant global and regional frameworks (e.g. focusing on pandemic prevention, preparedness, and response and emergencies)?
2. To what extent is the design of the GTFCC still fit for purpose to support the achievement of the Roadmap in terms of its focus and organizational structure? Specifically:
    i. Are the objectives of the GTFCC still the most relevant objectives in relation to the current priorities and country needs with regards to cholera? Does the GTFCC pursue the most relevant activities in support of these objectives? *The objectives include (i) supporting the design and implementation of global strategies; (ii) providing a forum for technical exchange, coordination, and cooperation on cholera-related activities to strengthen countries' capacity, (iii) supporting the development of a research agenda and (iv) increasing the visibility of cholera as an important global public health problem).*
    ii. How appropriate are the GTFCC governance and operational structures, specifically: (i) the GTFCC Secretariat and whether the roles and responsibilities allocated to the Secretariat are appropriate; (ii) the Steering Committee, its mandate and objectives as well as its composition and membership, (iii) the Independent Review Panel, its principles and purpose and composition; and (iv) the Working Groups, their areas of responsibility, composition and leadership.
    iii. In terms of the nature of the hosting relationship with WHO, is there a value-add by both WHO and GTFCC to each other's work, and are there clear separation of roles and responsibilities?
    iv. Is there adequate engagement of countries? Do you consider the role of the Country Support Platform (CSP) e.g. purpose, overall objective, structure to be appropriate? Should there be more of a shift to work at the regional and country level and if so, what resources do you think would be required for this?
    v. Are all relevant partners engaged with the GTFCC? If not, which partners are not engaged?

3. To what extent have the GTFCC internal structures (including the Steering Committee, Secretariat, CSP, the Independent Review Panel, and the Working Groups) been able to foster alignment between partners in terms of approach and interventions delivered within and between different pillars of the strategy to promote a coherent and balanced approach to cholera control?
    i. To what extent is the work of the GTFCC internal structures coherent with programs/ departments within WHO?
    ii. Given the GTFCC relies predominantly on voluntary partner contributions, what is working well and less well because of this, and are there sufficient incentives for action? What improvements could be made to strengthen: (i) stakeholders engagement and participation in the GTFCC (ii) Alignment and synergy between partners at global level and country level? (iii) wider stakeholders' engagement with GTFCC (e.g., partners, donors and countries not represented in the GTFCC or not currently engaged)?
4. What is working well/ less well it terms of the functioning of the GTFCC and what can be improved? Specifically, Regarding specific internal structures:
    i. Steering committee: What works well and less well with regards to its ability to be a strategic and agile decision-making body on behalf of the whole partnership?
    ii. Secretariat: What's working well or less well including its capacity to deliver as well as clarity regarding their role (e.g., supporting country outbreak responses currently when this was not expected in the GTFCC governance ToRs?
    iii. Working Groups: What's working well and less well including aspects such as membership and representation, leadership, understanding of roles and responsibilities, communications and management, operating processes and meetings? What factors have facilitated of hindered the work of the WGs?
    iv. General Assembly: How useful is it as a forum for all members to meet and take strategic decisions?
    v. Independent Review Panel: What's working well or less well including in terms of reviewing National Cholera Plans, its capacity and operating model to meet the needs of countries?
    vi. CSP: What is working well or less well in in terms its ability to support countries (e.g. country knowledge and clarity on CSP role, technical support, resource mobilization, coordination of partners in-country)?
5. How efficiently has the Roadmap been implemented by the GTFCC in terms of optimizing human and financial resource allocation to support countries in a changing cholera landscape? Specifically, use of resources allocated to the GTFCC (e.g. Secretariat, CSP, Working Groups) and the balance of funding across its activities and internal structures? To what extent is the GTFCC is able to channel resources (e.g., human, commodities) to meet country needs and how flexible is this support when countries ask for it?
6. What progress has been achieved in the implementation of the Roadmap with regards to (i) Axis 1: Improving outbreak containment and reducing the global burden of cholera through early detection and rapid response? (ii) Axis 2: Increasing prevention of disease occurrence through targeted multi-sectoral interventions in cholera hotspots? (iii) Axis 3: Ensuring effective mechanism of coordination for technical support, resource mobilization, and partnership at local and global levels? Specifically:
    i. For Axis 1 and 2, what have been the results of these efforts? How balanced have cholera interventions been at country level across the key strategic interventions of the Roadmap under

each axis (e.g., WASH, leadership and coordination, case management, surveillance and reporting, OCV and community engagement)?

ii. What has worked well or less well in the implementation of the GTFCC strategic approach under axis 2 (i.e., hotspot targeting)?

iii. What has the GTFCC achieved through its various functions, and what has worked well and less well? specifically: (a) being a forum for technical exchange, coordination, and cooperation on cholera-related activities to strengthen countries' capacity; (b) supporting the development of a research agenda; (c) conducting advocacy; (iv) technical working groups and their products and knowledge sharing (including how much this guidance has been used); (v) supporting implementation of country level activities including in CSP and non-CSP supported countries and (vi) ensuring adequate resource mobilization?

iv. To what extent has the GTFCC contributed to this progress? (Please give specific examples of areas where the GTFCC has made a clear contribution against each axis).

v. What would have happened in the absence of the work of the GTFCC?

7. What factors have facilitated or hindered progress of implementation of the Roadmap under each of these axes (e.g., resources, financing, GTFCC functioning, environmental and contextual factors, country level factors)?
8. To what extent is the Roadmap designed to enable sustainability of cholera interventions post 2030 in terms of financial, programmatic and environmental considerations?
9. How have gender, equity and human rights considerations been integrated in the implementation of the Roadmap?
10. What would be 2-3 recommendations you would like to share with regards to strengthening the GTFCC and accelerating progress of implementation of the Roadmap?

Country interview guide

This section presents an indictive guide used for consultation with country stakeholders (including during country case studies). This was tailored by stakeholder and for the country depending on what type of support they received from the GTFCC (e.g. CSP and non-CSP).

Interview questions:

1. What is your knowledge of, and how have you engaged with the GTFCC?
2. What is the current situation on cholera in your country? What progress has been achieved in the implementation of the cholera interventions with regards to (i) Improving outbreak containment and reducing the burden of cholera through early detection and rapid response? (ii) Increasing prevention of disease occurrence through targeted multi-sectoral interventions in cholera hotspots? (iii) Ensuring effective mechanism of coordination for technical support, resource mobilization, and partnership at local (and regional) levels? Specifically:

    i. How balanced have cholera interventions been at country level across the key strategic interventions to control and prevent cholera (i.e., WASH, leadership and coordination, case management, surveillance and reporting, OCV and community engagement)?

ii. What factors have facilitated or hindered progress of implementation of these interventions (e.g., resource mobilization, human resources, financing, environmental and contextual factors, country level factors)?

iii. To what extent has the GTCC contributed to this progress? What more could be done?

3. What type of support has the GTFCC been providing to the country *(e.g., (a) being a forum for technical exchange, coordination, and cooperation on cholera-related activities to strengthen countries' capacity; (b) supporting the development of a research agenda; (c) conducting advocacy; (iv) technical working groups and their products and knowledge sharing (including how much this guidance has been used); (v) supporting implementation of country level activities and (vi) ensuring adequate resource mobilization?)*

   i. How useful has this support been? Please give examples of support that have had the most impact or outputs which have been most useful.

   ii. How flexible is this support when your country has asked for it?

   iii. What would have happened in the absence of GTFCC support?

   iv. What could be improved and/or what other type of support would be useful?

4. What support have you received through the country support platform (CSP) provided by IFRC – i.e. support for the development and implementation of a National Cholera Plan (NCP) including technical assistance, the delivery of commodities, advocacy and fundraising for the NCP, monitoring & evaluation of NCP, and the implementation of operational research projects)?

   i. How useful has this support been? Please give examples of support that have had the most impact or outputs which have been most useful.

   ii. How flexible is this support when your country has asked for it?

   iii. What would have happened in the absence of CSP support?

   iv. What could be improved and/or what other type of support would be useful?

5. To what extent have the GTFCC been able to foster alignment between partners in terms of their interventions to promote a coherent and balanced approach to cholera control at country level?

6. What is working well/ less well it terms of the functioning of the GTFCC and what can be improved? Specifically, regarding specific internal structures *(depending on support provided by the GTFCC, consultee engagement and knowledge of the GTFCC)*:

   i. General Assembly: How useful is it as a forum for all members to meet and take strategic decisions? What benefits are there in terms of attending the General Assembly as a country representative? What could be improved?

   ii. Independent Review Panel: What's working well or less well in terms of support from the Independent Review Panel (i.e. reviewing National Cholera Plans)? How useful is this process? What could be improved?

   iii. Country Support Platform (CSP): What is working well or less well in in terms its ability to support countries (e.g. country knowledge and clarity on CSP role, technical support, resource mobilization, coordination of partners in-country)?

   iv. Steering committee: What works well and less well with regards to its ability to be a strategic and agile decision-making body on behalf of the whole partnership?

   v. Secretariat: What's working well or less well including its coordination function and support for countries through that?

vi. Working Groups: What's working well and less well including aspects such as membership and representation of country stakeholders, understanding of roles and responsibilities, communications and management? What factors have facilitated of hindered the work of the WGs from a country level perspective?

7. What is working well/ less well in terms of the CSP? Please include perspectives regarding its ability to support countries (e.g. country knowledge and clarity on CSP role, technical support, resource mobilization, coordination of partners in-country).

8. To what extent is the design of the GTFCC still fit for purpose to support the achievement of the Roadmap in terms of its focus and organizational structure? Specifically:

   i. Are the objectives of the GTFCC still the most relevant objectives in relation to the current priorities and country needs with regards to cholera? Does the GTFCC pursue the most relevant activities in support of these objectives? *The objectives include (i) supporting the design and implementation of global strategies; (ii) providing a forum for technical exchange, coordination, and cooperation on cholera-related activities to strengthen countries' capacity, (iii) supporting the development of a research agenda and (iv) increasing the visibility of cholera as an important global public health problem.*

   ii. Are country stakeholders sufficiently engaged with the GTFCC? If not, what do you suggest to improve engagement?

9. To what extent is the Roadmap still fit for purpose given the change in context since its design, in terms of (i) how appropriate are its ambitions and targets? (ii) the degree of focus/ emphasis on each of the three strategic axes of the Roadmap (outbreak response, prevention, coordination of human, technical and financial resources)? (iii) the proposed interventions to prevent and control cholera (e.g., WASH, leadership and coordination, case management, surveillance and reporting, OCV and community engagement)?

10. How efficiently has the Roadmap been implemented in your country in terms of optimizing human and financial resource allocation to support countries in a changing cholera landscape?

11. To what extent has sustainability been factored into cholera plans and activities in your country (in terms of financial, programmatic and environmental considerations? Can you please share examples in support of your answer?

12. How have gender, equity and human rights considerations been integrated in cholera plans and interventions in your country?

13. What would be 2-3 recommendations you would like to share with regards to strengthening the GTFCC and accelerating progress of implementation of the Roadmap at a country level?

Country case study selection

As part of this evaluation, the evaluation team conducted six case studies in selected countries to gather perspectives on the work of the GTFCC and implementation of the cholera Roadmap at the country level. The country case studies provided evidence for the evaluation across the evaluation framework questions from a country perspective.[1]

Key areas of exploration through the case studies included:

- The extent to which the Roadmap (i.e., in terms of its ambitions, strategic objectives and proposed interventions) is relevant and responsive to countries' needs; and the extent to which it has helped galvanise national efforts and actions on cholera;
- Country perspective on the added value of the GTFCC in practice and whether it has promoted more coherent partner activities in country;
- The extent to which the current design of the GTFCC enables meaningful country participation (e.g., through the Steering Committee, Working Groups, the annual general assembly) and elements of its governance, structures and processes that could be improved in that regard;
- Feedback on the GTFCC support provided to countries including through the CSP (for CSP supported countries) or through the Secretariat and partners (non-CSP countries); as well as what has worked well / less well across key activities/ areas of support (e.g., national country plan development, technical support and guidance, advocacy and resources mobilization and financial support);
- Evidence of progress with regards to cholera control achieved at the country level, the extent to which the GTFCC contributed to this progress as well as factors that have facilitated or hindered this progress; and
- The extent to which interventions at a country level have been implemented in a manner that facilitates sustainability, alongside integration of gender, equity and human rights considerations.

Countries for case studies were carefully selected to allow for diverse representation across key criteria for this evaluation and permit a deeper assessment of successes, challenges and lessons pertaining to the work of the GTFCC and implementation of the cholera Roadmap from a country perspective. Key criteria considered for selected countries for case studies include:

- Countries were shortlisted based on seven **primary inclusion criteria** including: (i) country regional/ geographical location to ensure a mix across regions; (ii) countries which were part of the original Roadmap priority list, (iii) countries where the GTFCC Country Support Platform (CSP) formally operates (CSP countries); (iv) countries where the CSP does not formally operate (non-CSP countries)[2]; (v) countries that have had a Priority Areas for Multisectoral Interventions (PAMI) exercise conducted; (vi) countries that have a National Cholera Plan (NCP); (iv) countries in fragile/conflict context.
- A **second selection** was conducted to (i) ensure that primary selection criteria were met in at least one country (and with a preference for countries which included a larger number of selection criteria)

[1] While providing evidence from a country perspective, the country case studies are not an assessment of national responses to cholera, but rather focus on the support provided to countries by the GTFCC and the implementation of the cholera roadmap at country level.
[2] Noting that non-CSP countries may still receive some support from CSP and other structures from the GTFCC.

and (ii) ensure feasibility to conduct the case studies based on country contexts as well as evaluation feasibility considerations (e.g. availability of countries to be included as a case study).

The final list of countries included Democratic Republic of Congo (DRC), Haiti, Kenya, Nepal, Nigeria and Somalia.

The table below presents the final country selection for case studies (Table 6.)

Table 6: Proposed country case study selection (green depicts criteria met)

Final country selection						
	DRC	**Nigeria**	**Kenya**	**Somalia**	**Nepal**	**Haiti**
Region	AFRO-WCA	AFRO-WCA	AFRO-ESA	EMRO	SEARO	AMRO-LAC
Roadmap priority list						
CSP						
Non-CSP						
PAMI						
NCP						
Fragile context						
Working language	French	English	English	English	English	French

Country case study Democratic Republic of Congo (DRC)

This Democratic Republic of Congo (DRC) country case study contributes to the Mid-term evaluation of the Global Task Force on Cholera Control (GTFCC). Following country background information and context (Section 1), country-level findings are presented for each of the evaluation criteria (Section 2): relevance (Section 2.1), coherence (Section 2.2), efficiency (Section 2.3), effectiveness (Section 2.4), sustainability (Section 2.5) and gender, equity and human rights (Section 2.6). A final conclusions section based on these findings from DRC follows (Section 3).

1. Introduction, background and country context

1.1 Introduction

This case study is one of six case studies which have the purpose to generate evidence for evaluation questions of the evaluation framework and be an evidence base for findings in the main evaluation report. This includes questions relating to (i) the work of the GTFCC and (ii) implementation of the cholera Roadmap from a country perspective.

Countries were selected to allow for diverse representation across key criteria for the evaluation and permit a deeper assessment of successes, challenges and lessons pertaining to the work of the GTFCC and the Roadmap. For DRC, this included: (i) being on the Roadmap priority list; (ii) being a country support platform (CSP) supported country (iii) having a national cholera plan (NCP), (iv) having received support to implement the Priority Areas for Multi-sectoral Interventions (PAMI) process and (v) being a country in a fragile/conflict context.

1.2 Methods

Development of this case study included a short (five day) consultation in DRC (specifically Kinshasa, with virtual calls made to respondents based in Goma and Bukavu). Data collection methods for this case study included a review of key documentation and stakeholder interviews (a list of references and consultees at the end of the case study). In addition, examples of support from the GTFCC in the DRC and key points regarding current status of the implementation of the cholera roadmap are presented in the case study.

Key informants were purposefully selected to take part in interviews. They were selected to ensure there was a mix of stakeholders from government including different national level ministries (e.g. Health, Hydraulic and Electricity resources), provincial representation from four provinces, representatives from different GTFCC partners (e.g. WHO, UNICEF, CDC), and representatives from research institutes. Key informant interviews (KIIs) were conducted using a semi-structured interview guide and the majority were conducted in person and a small minority conducted online. Data from KIIs and FGDs were analysed alongside documents to develop the findings for this case study. In total, KIIs were conducted with 41 interviewees.

Limitations included logistical challenges to undertake data collection and general limited availability of some key stakeholders within the timeframe available for the evaluation. In addition, interviews could not be conducted outside the capital city due to logistical issues and the complex and fragile political situation. In these instances, the evaluation relied on remote data collection for those parts of the country.

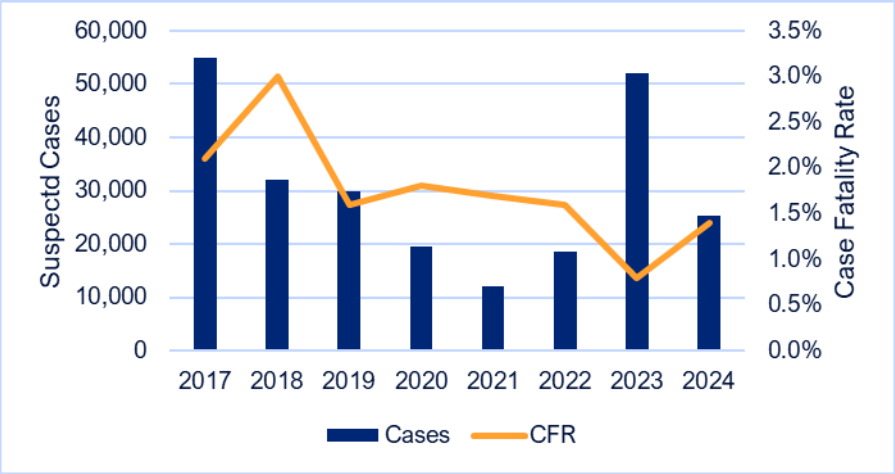
1.3 Key country characteristics and cholera context

The DRC is located in Central Africa straddling the Equator with an area of 2,345,409 square kilometres. By land area, the DRC is the second-largest country in Africa and the 11th-largest in the world, with a population of around 112 million. The national capital and largest city is Kinshasa, which is also the economic centre. It shares a border with nine neighbouring countries. The DRC is bordered to the North by the Central African Republic and South Sudan, to the West by the Republic of the Congo, to the East by Uganda, Burundi, Rwanda, and Tanzania, and to the South by Zambia and Angola.

The Democratic Republic of Congo (DRC) faces recurring cholera outbreaks, particularly in the eastern provinces, exacerbated by limited access to clean water, poor sanitation, and population displacement due to conflict. The DRC holds more than half of Africa's water reserves, and despite this vast potential, 33 million people in rural areas of the country still lack access to clean water. This lack of access to improved water resources is one of the factors causing cholera epidemics in the DRC. Cholera persists in the DRC with two different epidemiological profiles: Cholera is endemic in the East region of the country, while the West is prone to outbreaks followed by long periods of complete remission. The persistence of cholera in specific lacustrine health zones in Eastern DRC, designated as "sanctuary sites", perpetuates these endemic conditions. These sites act as reservoirs for the disease, consistently producing new outbreaks that subsequently spread to neighbouring regions.

The DRC is one of the countries most affected by cholera globally. Between 2008 and 2017, studies estimated that the DRC accounted for 189,000 cholera cases annually, i.e., 5%-14% of the global burden. The two epidemics that have marked the history of cholera in this country, each with over 50,000 cases, are the 1994 outbreak in the city of Goma following the Rwanda refugees crisis and the epidemic of 2017 (see Figure 3). In 2022, the DRC recorded significant cholera outbreaks in North Kivu, South Kivu, Tanganyika, and Haut-Lomami provinces, with a reported case fatality rate (CFR) of 1.6%, higher than the World Health Organization's (WHO) target of less than 1%. In 2023, the DRC reached about 50,000 cases of cholera due in part to military conflict in the North of the country. The CFR has also increased from ~0.7% in 2023, to ~1.4% as of 6th October 2024 with about 25,200 suspected cases. Cholera prevalence in the DRC is tied to socio-economic challenges, as poverty, insufficient infrastructure, and inadequate healthcare services hinder effective cholera prevention and control measures.

Figure 3: Annual incidence of suspected cholera cases 2017 to 2024[3]



1.4 Health system and policy landscape in DRC

The DRC's health system operates under a decentralised model with three levels of care: primary, secondary, and tertiary. However, the health infrastructure is fragile, with limited resources, trained personnel, and necessary medical supplies, particularly in rural and conflict-affected areas. The DRC faces significant political instability, particularly in the eastern regions, where ongoing conflicts between armed groups, intercommunal violence, and instability pose severe challenges for public health interventions, including cholera response efforts, rendering the population vulnerable to more outbreaks. The unstable environment often necessitates emergency-focused cholera responses rather than long-term, preventive measures, limiting the effectiveness of control strategies. Access to health care is often challenging due to logistical difficulties, insecurity, and financial barriers that prevent many people from receiving timely treatment for cholera and other infectious diseases.

The DRC faces a unique challenge in managing cholera epidemics, which often intersect with other emergencies such as Mpox and measles and insecurity (discussed below). Since implementing the first National Cholera Plan (NCP) in 2008-2012, the country has updated and improved the plan every five years. In October 2023, the government of DRC launched an ambitious plan to eliminate cholera by 2027: the Multisectoral Cholera Elimination Plan (PMSEC) 2023-2027. The DRC's PMSEC aims to reduce cholera incidence and mortality through improved WASH interventions, enhanced surveillance, and vaccination campaigns. The plan is characterised by a strategic approach that focuses on the key risk factors underlying population vulnerability to cholera onset and diffusion, notably limited access to safe drinking water and sanitation infrastructure and poor hygiene practices (WASH). The PMSEC is supported by international organizations like the WHO and UNICEF, and focuses on increasing community engagement in cholera prevention and promoting hygiene practices in vulnerable regions. In terms of WASH, the DRC has made progress on paper with various plans aimed at expanding access to safe drinking water and improving sanitation. Nonetheless, only around 52% of the population has access to improved water sources and rural WASH access rates are among the lowest in Africa. Implementation of WASH programs is also limited by funding shortages, weak governance, and challenging geographical conditions.[4]

[3] GTFCC 11th Annual Meeting Report

[4] GTFCC 11th Annual Meeting Report

1.5 Object of the evaluation and summary of GTFCC support to DRC

The GTFCC is a partnership of approximately 50 institutions to coordinate activities for cholera control at global, regional, and country levels. The GTFCC brings together organizations working across multiple sectors and serves as a coordination platform to support countries in the implementation of the Global Roadmap on ending cholera. The Roadmap is underpinned by early detection and quick response to contain outbreaks; a targeted multi-sectoral approach to prevent cholera recurrence; and an effective mechanism of coordination for technical support, advocacy, resource mobilization, and partnership at local and global levels. A key role of the GTFCC is to promote and support the implementation of the Ending Cholera – A Global Roadmap to 2030 at country level by providing the advocacy, coordination, policy guidance and technical assistance necessary for countries to develop National Cholera Plans (NCPs) and implement them effectively. By implementing the strategy between now and 2030, the GTFCC partners will support countries to try to reduce cholera deaths by 90%.

The GTFCC convenes multi-sectoral partners. In particular for countries, the work includes (i) tool development and technical guidance which the GTFCC Secretariat helps to coordinate and GTFCC technical working groups develop; (ii) support to the implementation of these tools and their translation into activities (CSP support in a small number countries and technical assistance provided by partners) and (iii) the independent review panel (IRP) has reviewed NCPs in a small number of countries, and is expected to soon be reviewing in relation to DRC (see below).

The DRC has received substantial support from the GTFCC including:

- The DRC is a CSP-supported country and has also received support from partners such as WHO, US CDC, and Johns Hopkins University (JHU), making it one of the leading countries in advancing long-term cholera response efforts through the GTFCC operational arm.
- The CSP and Secretariat technical working group focal points provided support to develop the National Cholera Plans (NCPs). The most recent, Multisectoral Cholera Elimination Plan PMSEC (2024), was finalized collaboratively by the Ministry of Health and WASH authorities, emphasizing a multisectoral approach to cholera response. Support has also been provided to undertake the mapping of Priority Areas for Multisectoral Intervention (PAMIs).
- The PMSEC was submitted to the Independent Review Panel (IRP) in June 2023, but feedback remains pending due to IRP resource challenges.
- A donor roundtable was held in early 2024 to mobilize funding for implementation of the NCP, highlighting the need to assess funding gaps and leverage partner networks. High-level government commitment, particularly from the Minister of Health, has been instrumental in advancing these efforts.

More detail on the specific examples of support received by the DRC from the GTFCC is provided at the end of the case study.

2. Key findings

2.1 Relevance

Q1: To what extent is the Roadmap relevant given the changing environment (e.g. epidemiological, political, climate and risk profiles)? To what extent have measures been taken to ensure continuous adaptation of the Roadmap in line with latest international best practices and guidelines, and emerging needs at the country level?

Q2: To what extent is the design of the GTFCC adequate to support the objectives of the Roadmap?

Relevance of Roadmap given the changing environment

The GTFCC Roadmap remains highly relevant in shaping the DRC's national cholera strategy, though its implementation faces challenges due to the evolving national epidemiological and political landscape.

Country level respondents perceive the GTFCC's Cholera Elimination Roadmap by 2030 as highly relevant for the DRC as it is used as a key reference tool for planning strategic interventions to combat cholera. The PMSEC 2023-2027 references the global Roadmap and outlines a context-specific national approach for epidemic control and cholera elimination centred around eight key strategic axes: (i) Strengthening overall surveillance activities, (ii) Curative care, (iii) Implementation of sustainable interventions related to improving access to clean water in cholera sanctuary zones, (iv) Implementation of interventions related to clean water, hygiene, and sanitation in areas affected by cholera, (v) Implementation of preventive vaccination activities in sanctuary zones and reactive in eligible epidemic zones or during humanitarian crises, (vi) Communication and community engagement, (vii) Operational research, and (viii) Coordination and advocacy. These initiatives are closely linked to the recommended multisectoral strategic interventions in the global Roadmap to enable integrated and comprehensive approaches within and outside the health sector, whilst addressing global risk factors like climate change and urbanisation. In line with this, DRC with the support of the CSP international OCV consultant, has a multi-year plan (2024-2027) for cholera vaccination, provision of rapid cholera testing kits, and strengthening operational research activities on cholera.

However, while respondents affirmed that the development of the PMSEC 2023-2027 is an important strategic framework to enable a multisectoral approach to cholera elimination, implementation remains a major challenge. Stakeholders highlighted the contrast between the ambitions of the Roadmap and the available resources at country level to implement the roadmap, especially concerning WASH aspects, community engagement, and financial allocations that do not meet the expectations set out by the Roadmap. These are discussed further below.

Design of the GTFCC to support objectives of the Roadmap

The GTFCC's design is appropriate for supporting the goals of the roadmap and its operationalisation in-country in the context of the DRC. This is facilitated by the provision of tailored technical assistance as well as through fostering multi-sectoral collaboration.

A relatively high number of stakeholders at the national level, and most stakeholders at the provincial level of the DRC, were not fully informed about the objectives of the GTFCC, its internal structures, or the extent of its activities. Provincial-level stakeholders consider that the CSP interacts more at the national level and that awareness of how the GTFCC operates has not been sufficiently disseminated to the provincial level (especially to government stakeholders such as provincial focal points), even though they have benefited from significant interventions by the GTFCC.

The key actors at the national level (including the Ministries of Health, Hydraulic and Electricity Resources, Agriculture, Water resources, Environment and PNECHOL, as well as technical and operational partners) with a good understanding of the internal structures and objectives of the GTFCC, confirmed that the structures and objectives of the GTFCC are appropriate for supporting the goals of the Roadmap and its operationalisation in-country. This alignment is achieved through the provision of tailored technical expertise, fostering multi-sectoral collaboration. The CSP and technical working groups play an important role in ensuring the implementation of actionable and sustainable interventions aligned with the Roadmap's long-term goals.

Respondents mentioned multisectoral assistance that spans technical support, advocacy, resource mobilization and fundraising, capacity building, and implementation of research projects is crucial, with a focus on cholera-endemic provinces (North Kivu, South Kivu, Haut-Lomami, and Tanganyika). Specific examples of support as highlighted by respondents include: funding for setting up the national cholera task force, national and international technical assistance to the National Cholera and Diarrheal Diseases Elimination Program (PNECHOL-MD), resource mobilization (at the international and national levels), recruitment of consultants for technical support (WASH, research, and PMSEC monitoring), mobilization of vaccine doses and rapid diagnostic tests, as well as country-level technical support for developing various operational plans for each pillar (with support from the technical working groups; Case management; Epidemiology; Laboratory, OCV and WASH), prioritising budgeted activities targeting cholera hotspots in eastern DRC.

2.2 Coherence

Q3: *To what extent has the GTFCC, through its governance structures and mechanisms, promoted complementarity, synergy and integration between different members' interventions at the global and the country level? What is the added value of GTFCC members acting together?*

The GTFCC fosters synergy and integration among the country stakeholders in the DRC through robust coordination and strategic support mechanisms, enhancing national cholera control capabilities and supporting coordination at the national, provincial and regional level.

Stakeholders shared positive feedback on GTFCC's support in the DRC, particularly through the CSP and the Secretariat. Most respondents confirmed that the GTFCC played an important role in coordinating cholera elimination efforts in the DRC. This support was considered by interviewees to have been instrumental in strengthening national capacities, enhancing coordination, and accelerating progress towards disease elimination. Most stakeholders noted that the GTFCC, and the CSP, was pivotal in establishing the national cholera task force in the DRC for the development of the PMSEC and to address cholera-specific issues such as case management, vaccination, and water and sanitation. These groups developed country-specific protocols, guidelines, and recommendations to advance field practices.

At the **national** level, the Ministry of Planning oversees cholera control coordination through the National Committee for Water, Hygiene, and Sanitation Action (CNAEHA) using a multisectoral, consensus-based approach with cross-cutting actions. Stakeholders recognized the GTFCC's support, via CSP's collaboration with CNAEHA and PNECHOL-MED, in strengthening coordination through regular weekly meetings with government actors and partners involved in cholera control. Cholera control partners, including WHO, UNICEF, MSF, CDC, and others, meet weekly under the PNECHOL-MD to assess the cholera epidemiological situation and coordinate response activities. This coordination framework spans national, provincial, and health zone levels, where each partner contributes according to its mandate and resources. At the **provincial** level, regular coordination meetings are held between state and non-state partners to unify response actions, while monthly health cluster meetings, led by WHO, help align financing and technical support activities among stakeholders. At the **regional** level, stakeholders have commended the CSP for facilitating collaboration between the DRC and neighbouring countries for cholera control and prevention, e.g. hosting transboundary meetings and developing joint action plans with neighbouring Zambia and Burundi. A collaboration protocol is being developed to promote the exchange of information not only for cross-border cholera surveillance but also for other potentially epidemic diseases in the region.

The National Multisectoral Cholera Elimination Plan 2023-2027 reflects DRC's multisectoral approach to cholera elimination - however cross-sectoral engagement, especially with the WASH sector, is a significant challenge. As noted above, the PMSEC reflects many aspects of the global Roadmap and includes advocating for a multisectoral approach to cholera elimination. Despite acknowledging the relevance of PMSEC's multisectoral approach, stakeholders noted that the Health ministry remains the leader and some sectors are insufficiently involved (e.g. water, energy, fishing, agriculture). Stakeholders from the other sectors cited the reason behind this as a lack of funding to carry out their activities in the fight against cholera. Although the multisectoral engagement needs to be improved, some respondents highlighted some collaborative activities between health and WASH actors, such as the Division Provinciale de la Santé (DPS's) participation in WASH cluster meetings, and UNICEF's coordination of WASH, Case-area Targeted Intervention (CATI), and Health, and Social Behaviour Change (SBC) activities.

2.3 Efficiency

Q4: To what extent are the GTFCC operational structures set up efficiently to support the objectives of the Roadmap?

Q5: How efficiently has the Roadmap been implemented by the GTFCC in terms of optimizing human and financial resource allocation to support countries in a changing cholera landscape?

Support provided by the GTFCC is considered efficient overall. However, the efficiency of the IRP warrants improvement.

Stakeholders aware of, or involved with, the GTFCC commented positively on the support provided, mainly through the CSP, IRP, OCV working group, and the Secretariat (discussed further in Section 2.4 on Effectiveness). There have been a number of examples of efficient coordination of GTFCC activities amongst GTFCC structures and stakeholders (e.g. between the Secretariat, CSP, WGs), demonstrating generally efficient implementation: in particular training planning processes, operations research, and resourcing initiatives.

On the other hand, some actors criticised the slowness of the IRP in processing the review of country's NCP. The country submitted its NCP to the IRP in June 2023, but the outcome had not been shared with the country at the time of this evaluation. The review process can face delays due to the complexity of evaluating multisectoral components, the need for technical validation, and the involvement of numerous stakeholders at

both national and international levels. However, this long delay highlights significant issues with the efficiency of this structure.

While resource mobilization efforts have been highly praised, even more robust resource mobilization efforts are needed given competing disease resource requirements in DRC.

The CSP's role in coordinating the mobilization of donor funds for cholera control was widely praised by stakeholders, as these resources have supported vaccination campaigns, epidemic control, and response efforts. With the assistance of CSP/ IFRC and PATH, the DRC hosted a roundtable for cholera elimination resource mobilization in March 2024 in Kinshasa, attended by high-level GTFCC representatives and key donors. Subsequently, in April 2024, the National Cholera and Diarrheal Diseases Elimination Program (PNECHOL-MD), supported by CSP/ IFRC and PATH, held two local resource mobilization workshops in Lubumbashi (Haut Katanga) and Kolwezi (Lualaba) under the leadership of provincial authorities. These sessions brought together leaders from various sectors, including mining, banking, telecommunications, pharmaceuticals, and members of the Federation of Entrepreneurs of Congo (FEC). To maximize these efforts, stakeholders emphasised the importance of monitoring resource mobilization activities. While the CSP has effectively coordinated fundraising efforts, stakeholders noted that additional advocacy is needed to achieve sufficient funding for cholera control. Stakeholders from the National Cholera Control Program specified that national funds for cholera control are predominantly allocated by the national or provincial government to address emerging epidemics. With the frequent occurrence of epidemic emergencies in the DRC, such as Ebola and more recently Mpox, government and partner resources are often diverted toward addressing these high-mortality diseases. Consequently, this prioritization limits the allocation of funding and attention to cholera-related activities, hindering the consistent implementation of the NCP. This situation underscores the need for even more robust resource mobilization efforts to ensure sustained support for cholera control alongside responses to other public health threats.

2.4 Effectiveness

Q 6: *What results have been achieved by the GTFCC partnership in the implementation of the Roadmap at the country level?*

Q 7: *Which factors have influenced the implementation of the Roadmap to date? What opportunities could be tapped into for better results?*

Strengthened cholera preparedness, early detection, and outbreak response systems in DRC, alongside expanded multisectoral prevention initiatives and community-based surveillance, have significantly enhanced national response capacity, though logistical challenges remain. The support provided by the GTFCC has been considered overall to have significantly aided the cholera response in the DRC.

In this section, key points regarding progress of implementation of the Roadmap are presented in line with Axis 1 (outbreak response), Axis 2 (prevention), Axis 3 (coordination) and key Roadmap pillars. In addition, assessments of the support provided by the GTFCC are included. Key points regarding current status of the implementation of the cholera roadmap are presented below.

Outbreak Response:

All endemic provinces have benefited from training in cholera outbreak preparedness and response, and tools for data collection, RDTs for cholera, and transport media for samples (Cary Blair) have been deployed in health zones to enhance testing. A project is underway to further decentralise cholera confirmation through the establishment of stool culture laboratories in all cholera-endemic provinces. Community-based surveillance has been strengthened, especially in North Kivu IDP camps. Some community health workers have been trained to enable early cholera detection using standard case definitions and RDTs and to refer cases to treatment centres. For instance, in Haut Katanga province, Cary Blair transport media are pre-positioned in health posts, with prior training on their use. An alert system has been established and supported (with communication credits and internet modems) in alert centres set up in six hotspot health zones in Haut Katanga. In 2023, robust surveillance efforts resulted in the detection of 17 cholera outbreaks across various regions, with emphasis given to seven high-risk health zones, maintaining continuous monitoring. The GTFCC and its partners (UNICEF, Bluesquare MSF-Epicentre and the Ministry of Public Health, Hygiene and Prevention) have set up the Integrated Outbreak Analysis Unit. This unit has helped to improve cholera surveillance in the hot-spot areas of eastern DRC. It carries out in-depth surveys of cholera cases in order to gain a better understanding of the risks specific to the context and improves the quality of existing data.

There has been less strengthening in the area of **logistics (particularly diagnostics)**, where intervention teams struggle to deploy within 24 to 48 hours due to logistical and accessibility challenges. Initial pilot projects using cholera rapid diagnostic tests (RDTs) have been funded by the US CDC and Epicentre, and a shipment of nearly 92,000 RDTs supported by Gavi is expected to expand the use of these tests in routine cholera surveillance. Stakeholders also noted a challenge in the sample collection rate for suspected cholera cases: in 2024 (up to week 40), the stool culture sample collection rate was at 33%, still below the 50% target set by the National Multisectoral Plan for Cholera Elimination (PMSEC). Some cholera cases are diagnosed based on epidemiological links, and many are treated until recovery as probable cases[5]. Stakeholders noted that the CSP-led training of trainers for cholera RDTs in the DRC improved local capacity in critical provinces (such trainings are typically coordinated by the WHO laboratory expert serving as the GTFCC laboratory focal person). This observation suggests potential gaps in visibility and distinction between the roles of different GTFCC arms, which could be addressed through improved communication and role clarification. Although direct support from the case management working group for patient management has been limited, respondents stated that the CSP's advocacy facilitated tool revisions for managing cholera and diarrheal diseases, enabling some response support at health zone levels.

Prevention:

The development of a multi-year **vaccination** plan (2024-2026) underscores the commitment to proactive prevention. The CSP with the OCV working group have also facilitated comprehensive planning for cholera vaccination in epidemic and sanctuary zones. A multi-year plan for OCV from 2024 to 2026 was developed, along with a significant vaccine request for a preventive campaign in high-risk zones, slated to begin in early 2025. Stakeholders from the national cholera elimination programme (PNECHOL-MD) appreciate and view the discussions on OCV shortage with CSP, OCV working group and WHO-HQ as indicative of proactive problem-solving for improved vaccination outcomes. In 2023, two reactive vaccination campaigns (with a budget of US$ 2,646,954) successfully immunised over 5 million people, significantly reducing the risk of outbreaks in high-

5 "Probable" in the general sense, not as an official case definition

risk areas. In addition, baseline surveys, targeted interventions, and the implementation of innovative approaches like Case Area Targeted Interventions (CATI) and Quadrillage have contributed to reducing transmission risks.[6]

WASH:

While the CSP has advocated for WASH improvements, stakeholders observed that these efforts remain under-resourced. Evaluations of basic WASH services in multiple health zones, including IDP sites, have highlighted urgent needs. For example, in the displaced camps in the city of Goma, North Kivu, water and latrine coverage is below 50%. The CSP with other partners (WHO and UNICEF) have coordinated WASH emergency responses, such as water trucking and latrine construction, in cholera-affected areas. However, sustainable funding and greater partner mobilization are necessary to effectively address long-term WASH challenges. Additionally, sectors other than health, such as water resources, planning, and environment, are increasingly involved, although their support in the response remains limited. Overall, this approach remains a weak link in the fight against cholera in the sub-bureau provinces because the health aspect predominates over other aspects like water, hygiene, and sanitation, which are typically the responsibility of other entities.

Coordination:

- In DRC, the implementation of the Roadmap has been materialised on the one hand through the support activities of partners such as WHO, UNICEF and CDC as part of the implementation of the DRC 2017-2022 multisectoral cholera plan, and on the other hand through the CSP with the development of the new National Cholera Plan 2023-2027 PMSEC, which is supported, validated, and endorsed by representatives of government and academic institutions, non-governmental organizations (NGOs), United Nations agencies, private sector donors and representatives of civil society. There are multi-sectoral committees at all levels (central, provincial, and local), although their functionality faces some issues, particularly in provinces and health zones affected by conflicts and crises. Furthermore, the GTFCC's cholera hotspot identification tool, tailored to the context of the DRC has helped define the priority health zones outlined in the DRC 2023-2027 PMSEC.
- In general, the national government's capacity to detect and respond to cholera epidemics has improved in recent years, however, the cholera context in the DRC remains largely unchanged since the pre-MCEP period. Respondents mentioned that there is increasing recognition that the country is strengthening its systems and human resources to respond to cholera epidemics. The CSP has significantly contributed to this progress by mobilising partners to train district health staff and field actors. Examples of capacity strengthening through the CSP and other areas of support provided are given at the end of the case study.
- The respondents noted that the technical and implementation partners play an essential role in supporting the country and **strengthening its preparedness, early detection, and response capacity** to epidemics. Implementation areas supported by these partners include case management and service delivery by MSF, emergency WASH activities by UNICEF, risk communication and community engagement with WHO and the local Red Cross, and capacity building of health personnel and human resources with WHO and CDC Africa. Partners also supply essential items such as emergency kits, cholera kits, RDTs, and WASH supplies. Stakeholders interviewed highlighted that partners have facilitated coordination efforts leading to significant improvements compared to the 2020 response. The DRC has also established a more robust epidemiological surveillance system, allowing for the early detection of suspected cholera cases, improved data quality, and faster data transmission.

6 GTFCC 11th Annual Meeting Report

National and provincial cholera response plans have been developed, supporting more efficient coordination during outbreaks. Stockpiles of medicines and medical supplies are now available for quick response. Additionally, digital tools and mobile applications have been deployed to facilitate data collection and analysis and improve communication among response actors.

- Support for health zones in implementing the PMSEC 2023-2027 operational plans has improved multi-sector collaboration for cholera elimination. While the CSP support is recognised as crucial, stakeholders stress the need for continued advocacy to align resources for sustainable WASH improvements in vulnerable regions impacted by conflict and cholera outbreaks. Stakeholders from the national cholera program posit that converting one-time humanitarian assistance into long-term support in cholera hotspots remains a critical goal, as purported by the 2023-2024 DRC Humanitarian Response Plan, which outlines objectives not only to save lives during crises but also to enhance affected populations' ability to recover and build resilience. Some respondents recommend that the CSP deepen its collaboration with DRC health zones and activate stronger advocacy for improved epidemic preparedness, including sustained access to cholera kits, clean water, and expanded community engagement.
- With regard to **operational research** to support evidence-based decisions, the CSP has sponsored research initiatives, hosted conferences on cholera and diarrheal diseases, presented findings on OCV impact, and engaged research consultants. This work supports an evidence-based approach to cholera control and furthers understanding of intervention effectiveness. The GTFCC Laboratory Working Group, with WHO HQ as the implementing partner and funding from the CDC, conducted laboratory capacity assessments in the DRC. Additionally, DRC participated in a global initiative led by Gavi, in collaboration with UNICEF and WHO, and received 90,000 rapid diagnostic tests (RDTs) for in-country cholera surveillance. The CSP played an active role in both instances, facilitating implementation. The CSP efforts to secure funding have included international resource mobilization in Kinshasa, coupled with local fundraising workshops targeting private sector operators in key provinces.

Factors that have influenced the implementation of the Roadmap

Leveraging international support, multisectoral collaboration, and national cholera program engagement have been pivotal in advancing the cholera Roadmap in the DRC, while challenges such as political instability, infrastructure weaknesses, and regional conflicts hinder progress. This emphasizes the need for strengthened resources, consistent leadership, and accessible healthcare infrastructure for sustainable success.

Prior to the start of the CSP support in late 2021, with partners including WHO, UNICEF intervened in the fight against cholera but most often to extinguish epidemic outbreaks in collaboration with the DRC government. UNICEF also supported the establishment of the online database of linear cholera lists in 2019, supporting community activities with Case-area targeted intervention (CATI) and gridding as well as financing the 2020 reframing activity of the DRC cholera plan 2018-2022. WHO has always supported the program during responses with the allocation of response inputs.[7]

From the interviews, stakeholders identified the following factors that have influenced the implementation of interventions against cholera (see Table 7).

[7] CSP country progress report

Table 7: Enablers and barriers to implementation of interventions against cholera

Category	Enablers	Barriers
Leadership and Coordination	1. WHO, as the GTFCC Secretariat coordinating partner, organising meetings to finalise, launch plans, and mobilize resources to support implementation. 2. Deployment of a CSP regional coordinator with expertise in DRC's context, fostering diplomacy and partnerships, notably for the National Cholera Plan and Multi-Year OCV Plan submission to Gavi. 3. International mobilization has attracted financial and technical resources from the global community. 4. Multi-sectoral partnerships among government, NGOs, and UN agencies align themselves with the logic of a global response to cholera. 5. Support from certain WASH partners has sustained CNAEHA[8] and CPAEHA[9] activities.	6. Political instability and armed conflicts disrupt healthcare delivery and supply chains. 7. Decentralisation of the healthcare system leads to regional disparities in intervention capabilities. 8. Regular turnover of trained care providers hampers consistent implementation. 9. Government and partner Task Forces allocate limited resources to cholera interventions.
Resources and Infrastructure	10. Availability of trained care providers, funds, vaccines, and focal points has strengthened response and preparedness with the support of the CSP. 11. National and provincial networks of parliamentarians' support for vaccination. 12. Technical support from the various technical working groups to establish protocols and guidelines for case management, surveillance, and epidemic response standards has improved intervention quality. 13. WASH surveys, assessments, and mapping have strengthened the foundation for future action, with WASH interventions playing a crucial role in outbreak responses.[10] 14. Technological advancements like GIS and mobile apps facilitate data collection and field coordination.	15. Shortages of qualified personnel, particularly in rural areas, limit intervention capacity. 16. Degraded healthcare infrastructure complicates service delivery and waste management. 17. Inaccessibility of certain PAMI areas during the rainy season and poor communication routes limit access to remote populations. 18. Limited WASH intervention funding hinders long-term implementation and impact.
Community and Environmental Factors	19. Community engagement, including hygiene promotion and awareness-raising, has supported cholera response efforts, although more effort is needed as technical assistance is needed to develop and implement risk communication related plans.	20. Entrenched local hygiene and sanitation practices lead to resistance to behaviour change. 21. Climate change and extreme weather events, such as floods and droughts, heighten vulnerability to cholera. 22. Poverty restricts access to clean water and sanitation, encouraging cholera spread. 23. Population movements, including internal displacements, elevate disease transmission risks. 24. Inter-ethnic conflicts and activities of armed groups (Maï-Maï, CODECO, M23[11]) obstruct responder access to affected areas.

[8] National Water, Hygiene and Sanitation Action Committee
[9] Provincial Water, Hygiene and Sanitation Action Committee
[10] GTFCC 11th Annual Meeting Report
[11] Any kind of community-based militia group formed to defend local communities and territory against other armed groups.

Category	Enablers	Barriers
		25. Low geographical accessibility and challenging terrain impede consistent intervention across DRC's vast landscape.
Vaccination and Public Health Initiatives	26. Development of multi-year OCV plan and vaccination protocols supports organized vaccination efforts.	27. Awareness gaps and logistical obstacles in some regions result in low vaccination coverage.

2.5 Sustainability

Q 8: What steps has the GTFCC taken to ensure the sustainability of its interventions under the Roadmap?

The GTFCC emphasises sustainability through long-term planning, WASH interventions, community engagement, and resource mobilization. However, significant challenges, including resource constraints and operational limitations, hinder progress towards achieving sustainable impact. Sustainability forms the backbone of the DRC National Cholera Strategic Plan 2023-2027, which integrates long-term planning and resource mobilization as the central pillars. The plan spans multiple years, incorporating a medium- to long-term approach to addressing cholera by dedicating 60% of its budget to sustainable WASH interventions. This focus aligns with the GTFCC Roadmap's commitment to achieving cholera elimination by 2030, moving beyond immediate epidemic control to building resilient infrastructure in water, sanitation, and health systems.

The plan targets priority health zones where cholera is persistent, underlining the commitment to lasting solutions. In these zones, sustainable healthcare structures have already been established, with semi-durable facilities being built since the plan's validation. This focus includes climate-sensitive waste management facilities designed to minimize environmental impact, illustrating the integration of climate awareness and sustainability into WASH infrastructure.

Some partner organizations contribute to sustainable surveillance and treatment systems, not only for cholera but also for other epidemics. For instance, the CATI strategy is reinforced through locally recruited pre-CATI teams, empowering community-level response capabilities. This approach ensures that communities are equipped to manage cholera outbreaks before response teams arrive. In parallel, local WASH facility management committees are reinforced to support the long-term maintenance of these facilities, with community members receiving training and support from local health and education authorities to gradually take over program management.

To further promote sustainable practices, some stakeholders recommend incorporating climate change awareness and sustainable waste practices into community health initiatives, such as using incinerators for waste in latrines and improving household waste management.

Whilst these points above are positive steps towards sustainability, significant risks to sustainability remain, including (i) resource constraints and (ii) a range of operational limitations including due to conflict.

2.6 Gender, equity and human rights (crosscutting)

Q 9: To what extent has the Roadmap included GER concerns? To what extent have implementation activities factored equity considerations at the global and country level?

There are some good examples of gender equity and human rights (GER) considerations in the cholera response in DRC, although there is room to strengthen the incorporation of these considerations, particularly through explicit inclusion in the DRC's National Cholera Strategic Plan. In DRC, gender inequalities are rooted in social and cultural norms – there are fewer women in leadership roles in healthcare and WASH, more limited access for women to training and decision-making opportunities, and restricted financial autonomy, all of which hinder equal participation and recognition of women in health and service sectors. While human rights and gender equality are not explicitly addressed in the NCP, stakeholders noted that gender issues are taken into account in DRC's cholera response and opportunities are designed to promote gender equality. For instance, a significant portion of activities on access to clean water focus on empowering women in priority health zones since they are primarily responsible for water sourcing. Additionally, in the recruitment of community health workers, a balanced quota between men and women is granted. Other gender-sensitive responses include: the construction of medical treatment structures provides for compartments separated by gender; WASH facilities also address gender considerations by providing facilities that take into account the gender of hospitalised patients and are managed in each treatment unit.

More broadly, while the DRC NCP 2023-2027 does not explicitly address human rights, the Congolese Constitution mandates equal access to healthcare for all citizens. Consequently, interventions implemented under the plan should prioritize equity and human rights considerations, such as equitably directing support towards affected or displaced populations, based on their assistance needs and universal human rights.

Conclusion

The mid-term evaluation of the GTFCC in the DRC highlights both the progress and ongoing challenges in the country's efforts to control and eliminate cholera. This evaluation underscores the significant benefit of support provided from the GTFCC, especially through the CSP, which has strengthened cholera control activities in line with the GTFCC Roadmap. Stakeholders also highlighted the CSP's involvement in supporting the drafting of the current NCP - PMSEC 2023-2027, which is aligned with the GTFCC's global Roadmap, with support from the technical working groups, focusing on cholera hotspots through a multi-sectoral approach.

Strengthened cholera preparedness, early detection, and outbreak response systems in DRC, alongside expanded multisectoral prevention initiatives and community-based surveillance, have significantly enhanced national response capacity, though logistical challenges remain. The support provided by the GTFCC has been considered overall to have significantly aided the cholera response in the DRC. The GTFCC support is considered by stakeholders in country to have strengthened epidemic response mechanisms, reinforced surveillance, and improved coordination among national and international stakeholders.

The major obstacles hindering the full realisation of cholera elimination interventions per the GTFCC Roadmap include underdeveloped multi-sectoral collaboration, and limited/ inconsistent funding for sustainable WASH interventions, especially in high-risk health zones. Moving forward, enhancing provincial-level awareness, speeding up the processing of the Independent Review Panel's feedback, and improving the speed and scale of interventions are essential for the successful operationalisation of the Roadmap. The complementarity of the

various actors, coupled with their ongoing technical and financial support, will continue to be critical in bridging the gap between strategic planning and effective, on-the-ground cholera control in DRC. Additionally, recurring insecurity in priority health zones in eastern DRC poses a significant bottleneck for effective cholera control interventions in hotspot areas. There is a need to further strengthen coordination among different sectors involved in cholera control, including health, water, sanitation, and environmental sectors.

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Consultee list

The case study was informed through consultations and focus group discussions with the following entities stakeholders:

Stakeholder Group	Organization (# of consultees)
Government	Ministry of Health / Department for Combating Infectious Diseases and Epidemics (1)
	PNECHOL (1)
	PEV (1)
	Ministry of Hydraulic and Electricity Resources (1)
	Ministry of Agriculture, Fisheries and Livestock: PNSECH CP (1)
	Ministry of the Environment: Water Resources Directorate (1)
	Ministry of the environment: Sustainable development department (1)
	Ministry of the Environment: Sanitation Directorate (1)
	Haut Lomami Provincial Health Division (1)
	Tanganyika Provincial Health Division (1)
	North Kivu Provincial Health Division (1)
	South Kivu Provincial Health Division (1)
Technical and Operational Partners	Emergency Program WHO - Country Office (1)
	WHO / Cholera (1)
	WHO / Infectious Hazard (1)
	WHO / Country Readiness and Response (1)
	WHO / Preparedness & International Health Regulation (1)
	WHO / Epidemiology (4)
	WHO / Office Management (1)
	UNICEF / Health Program (1)
	UNICEF / Cholera (1)
	UNICEF / Epidemiology (2)
	UNICEF / WASH (2)
	UNICEF / Health and Nutrition (1)
	MSF (1)
	CDC (1)
	CSP / GTFCC (2)
Research Institutes	One Health Africa National Institute (1)

	National Institute of Biomedical Research (2)
	John Hopkins University Uvira & Bukavu (5)

Specific examples of support from the GTFCC

Stakeholders shared specific cases of support provided by the GTFCC:

Strengthening of global surveillance activities:

- Assessment of the capacities of laboratories involved or potentially involved in the biological confirmation of cholera in the DRC provinces of Haut Katanga, Kasaï Oriental, North Kivu, South Kivu, and Tanganyika; led by led by the GTFCC Laboratory Working Group, with WHO HQ as the implementing partner with the support of the CSP.
- Development of a request to Gavi for the acquisition of nearly 92,000 cholera RDTs with the support of CDC US. The delivery began progressively in October 2024.
- Organization of transboundary meetings with the development of joint action plans for DRC-Zambia in April 2024 and DRC-Burundi in October 2024 with the support of the CSP.
- Under the advocacy of the CSP, in-depth investigations in epidemic provinces (Haut Katanga, Haut Lomami, Lualaba, Kasaï, Kasaï Oriental, North Kivu, Sankuru, South Kivu, and Tanganyika) with the establishment of online databases containing individual patient characteristics with the support of CAI-UNICEF.
- Under the leadership of the CSP, training of trainers on the use of cholera RDTs in routine cholera surveillance in the DRC with the support of CDC US. The training took place in four locations: Mbujimayi (provinces of Kasaï, Kasaï Oriental, and Sankuru); Bukavu (provinces of Ituri, Maniema, North Kivu, and South Kivu); Kinshasa (provinces of Equateur, Kinshasa, Kongo Central, Maindombe, and Tshopo); and Lubumbashi (provinces of Haut Katanga, Haut Lomami, Lualaba, and Tanganyika).
-

Case management: stakeholders have emphasized that this pillar of the DRC's PMSEC has not received significant support from the GTFCC. However, they have noted some advocacy efforts by the CSP that have led to a few interventions:

- Revision, validation, and dissemination of tools for managing cholera and other diarrheal diseases.
- Support for health zones and Provincial Health Divisions in responding to cholera outbreaks.

Implementation of sustainable interventions related to improving WASH in cholera sanctuary zones:
Stakeholders have pointed out that this pillar of the DRC's PMSEC has not received substantial support from the GTFCC and partners. However, they have noted some CSP advocacy efforts that have resulted in a few interventions:

- Evaluation of basic WASH in health zones of Kalemie (Tanganyika DPS), Uvira (South Kivu DPS), Mufunga Sampwe, Kisanga (Haut Katanga DPS), and Fungurume (Lualaba DPS) with the support of US-CDC.
- Prospective evaluation of basic WASH in the health zone of Fizi with CSP-IFRC in collaboration with the Red Cross DRC.

- Expansion of the water distribution network in the site of internally displaced populations in Bushagara, Nyiragongo health zone, North Kivu DPS with the support of UNICEF.

Implementation of emergency WASH interventions in areas affected by cholera outbreaks: stakeholders noted a few interventions of the CSP with other partners, which successfully coordinated activities of partners in the fight against cholera:

- Implementation of the community approach through the Grid Strategy in sites of internally displaced populations in the health zones of Goma, Nyiragongo, and Kirotshe in North Kivu and in other provinces that have experienced outbreaks with the support of UNICEF and WHO.
- Implementation of the CATI approach with the support of UNICEF.
- Water-trucking in sites of internally displaced populations (IDPs) in the North with the support of the Wash Cluster.
- Construction of latrines in IDP sites in response to the cholera outbreak in North Kivu with the support of the Wash Cluster.

Implementation of preventive vaccination activities in sanctuary and reactive zones in eligible epidemic areas or in humanitarian crises: Some stakeholders have confirmed the efforts made by the CSP in the context of cholera vaccination. Under the leadership of the CSP, there have been several interventions:

- Development of the Multi-Year Plan for oral cholera vaccination in the DRC, 2024-2026 with the support of CSP. The country benefited from the technical support of a consultant funded by the CSP and technical assistance from the OCV FP.
- Development of the OCV request for a reactive campaign in 15 health zones of 4 DPS. The quantity requested is 5,011,829 doses, and the budget is $2,646,954.8 USD with the support of CSP in October 2023, with the campaign taking place in December 2023 and January 2024.
- Discussions with WHO cholera program on the bottlenecks of reactive oral cholera vaccination activities in the DRC.

Communication and community engagement: stakeholders presented some CSP interventions with other partners in the fight against cholera in the DRC:

- Revision, validation, and dissemination of communication and community engagement tools as well as logistics tools.
- Revision of the Strategic Communication Plan and the Political Advocacy Strategy for the fight against cholera and other diarrheal diseases in the DRC. This activity was organized in collaboration and with the support of PATH.
- Preparation for filming activities related to the implementation of the PMSEC 2023-2027 with the support of CSP.
- Workshop with civil society for their involvement in advocacy for the fight against cholera in the DRC.

Operational research: Stakeholders presented some interventions by the CSP:

- Organization of scientific conferences on research conducted on cholera and other diarrheal diseases in the DRC in November 2023 and September 2024. These conferences enabled the initial mapping of all this research, but further work should be carried out by a research consultant with the support of the CSP.

- Presentation of the results of the impact study of OCV vaccination in Goma, North Kivu, and Bukama in Haut Lomami with funding from the Wellcome Trust and Gavi.
- Engagement of a consultant in operational research to conduct an overview of research, develop an operational research plan for PNECHOL-MD, and document scientific evidence published on cholera in the DRC for operational implementation by field actors.
- Participation in the workshop on cholera research with GTFCC in Mombasa, Kenya, from October 1st to 2nd, 2024, and in the workshop on evidence generated by research for decision-making on the use of OCV from October 3rd to 4th, 2024.

Coordination and advocacy: Stakeholders presented some interventions by the GTFCC:

- Joint mission by the Secretariat and CSP for the workshop set up to finalize the NCP (PMSEC) in November 2022.
- Joint mission by the Secretariat and CSP for the donor roundtable in March 2024.
- Political endorsement of the PMSEC 2023-2027 in November 2023.
- Popularization of the PMSEC 2023-2027 in the Lubumbashi pool, which brought together 22 stakeholders from health zones from 3 Health Districts (Haut Katanga, Haut Lomami, and Tanganyika), officials from Health Districts, the CNAEHA, and other divisions within the framework of multisectoral collaboration.
- Support to health zones in developing operational action plans related to the implementation of the PMSEC 2023-2027.
- Mobilization of resources from donors for the funding of the PMSEC 2023-2027 in March 2024.
- Mobilization of local resources in the provinces of Lubumbashi and Kolwezi from private sector operators (mining, telecommunications, banking) and decentralized territorial entities in April 2024 with the support of CSP and PATH.
- Development of terms of reference for the workshop to evaluate the first year of implementing activities of the PMSEC 2023-2027 in collaboration with the National Committee for Water, Hygiene, and Sanitation Action (CNAEHA). The workshop has been postponed to the 1st Quarter of 2025.

Country case study Haiti

This Haiti country case study supports the Mid-term evaluation of the Global Task Force on Cholera Control (GTFCC). Following background information and country context (Section 1), country-level findings are presented for each of the evaluation criteria (Section 2): relevance (Section 2.1), coherence (Section 2.2), efficiency (Section 2.3), effectiveness (Section 2.4), sustainability (Section 2.5) and gender, equity and human rights (Section 2.6). A final conclusions section based on these findings from Haiti follows (Section 3).

1. Introduction, background and country context

1.1 Introduction

This case study is one of six case studies which have the purpose to generate evidence for evaluation questions set out in the evaluation framework, and be an evidence base for findings in the main evaluation report. This includes questions relating to (i) the work of the GTFCC and (ii) implementation of the cholera Roadmap from a country perspective.

Countries were selected to allow for diverse representation across key criteria for the evaluation and permit a deeper assessment of successes, challenges and lessons pertaining to the work of the GTFCC and the Roadmap. For Haiti, this included: (i) being on the Roadmap priority list; (ii) being a country that is not a country support platform (CSP) supported country and (iii) being a country with a fragile context from the AMRO-LAC region.

1.2 Methods

Data collection methods for this case study included a review of key documentation, focus group discussions (FGDs) and stakeholder interviews. Key informants were purposefully selected to take part in interviews and FGDs. They were selected to ensure there was a mix of interviewees from government including different national level ministries (e.g. health and water), representatives from different GTFCC partners (e.g. WHO, UNICEF), and those that could cover the emergency response. Key informant interviews (KIIs) and FGDs were conducted using a semi-structured interview guide. In total, 15 individuals were consulted remotely. Data from KIIs and FGDs were analysed and triangulated with other sources including documents to develop the findings for this case study.

Limitations included the relatively small number of informants due to the limited availability of key stakeholders in the complex context of the country during the timeframe available for this evaluation. The fact that the case study was conducted remotely made it difficult to undertake a wider consultation exercise. This was mitigated by triangulating evidence with other data sources

1.3 Key country characteristics and cholera context

Haiti is a country located in the Caribbean, on the western side of the island of Hispaniola. The country has an estimated population of 11,772,557 people as of 2024, a population in steady growth that increased by 41.8%

from 8,303,151 inhabitants in 2000, and is projected to rise to 14,710,862 by 2050.[12] Life expectancy (LE) in Haiti remains lower than the average for the Region of the Americas, despite progress over the past two decades that brought LE to 65.1 years in 2024, from 58.2 in 2000. Access to healthcare remains challenging in the country as nearly 40% of Haitians do not have access to basic primary healthcare. Public expenditure on health was estimated to account for only 0.43% of gross domestic product (GDP) in 2021 (3.92% of total public expenditure), while out-of-pocket spending on health accounted for 43.53% of total health expenditure.

Access to health and health outcomes in Haiti have also been highly affected by the socio-political context of the country. Haiti has been facing acute challenges, including decades of chronic political instability and insecurity, a complex humanitarian crisis, and natural disasters. In 2010, the country experienced its first cholera outbreak, which lasted for almost a decade before ending in 2019. This outbreak came at the back of a devastating earthquake that killed over 200,000 people and displaced over 1 million. In October 2022, after 3 years with no cases, the country reported a resurgence in cholera cases. This new outbreak occurs in a context of strong political and social instability marked by social unrest, violence, and severe fuel shortages resulting in the degradation of health and water infrastructures and further limiting access to basic services. Several areas controlled by gangs have become inaccessible to government and health workers, restricting the delivery of basic supply services including healthcare, water, food, and sanitation to communities across the country. The current insecurity has also led to a complex humanitarian crisis with massive population displacements (nearly 600,000 internally displaced people (IDPs) according to recent estimates). Haiti continues to be affected by strong climate related disasters, including extreme flooding and landslides that further increase population needs and vulnerability to cholera.

1.4 Object of the evaluation and country engagement with GTFCC

The GTFCC is a partnership of approximately 50 institutions to coordinate activities for cholera control at global, regional, and country levels *(2)*. The GTFCC brings together organizations working across multiple sectors and serves as a coordination platform to support countries in the implementation of the Global Roadmap on ending cholera. The Roadmap is underpinned by early detection and quick response to contain outbreaks; a targeted multi-sectoral approach to prevent cholera recurrence; and an effective mechanism of coordination for technical support, advocacy, resource mobilization, and partnership at local and global levels. A key role of the GTFCC is to promote and support the implementation of the Ending Cholera – A Global Roadmap to 2030 at country level by providing the advocacy, coordination, policy guidance and technical assistance necessary for countries to develop National Cholera Plans (NCPs) and implement them effectively. By implementing the strategy between now and 2030, the GTFCC partners will support countries to try to reduce cholera deaths by 90%.

The GTFCC convenes multi-sectoral partners. In particular for countries, the work includes (i) tool development and technical guidance which the GTFCC Secretariat helps to coordinate and GTFCC technical working groups develop; (ii) support to the implementation of these tools and their translation into activities (CSP support[13] in a small number countries but not Haiti, and technical assistance provided by partners) and (iii) the independent review panel (IRP) has reviewed NCPs in a small number of countries, excluding Haiti.

[12] WHO (2023). Health data overview for the Republic of Haiti.

[13] The CSP was established in 2020 and leads the multi-sectoral support that the GTFCC provides to countries for the implementation of their NCPs. The CSP supports the short, medium and long-term deployment of GTFCC multi-sectoral expertise in countries. Five 'primary operational countries' have received substantial support: Bangladesh, Democratic Republic of Congo (DRC), Mozambique, Nigeria and Zambia. In addition, another four countries have received ad-hoc technical support.

Haiti has been engaged with the GTFCC over the years in a number of activities including:

- Support for Oral Cholera Vaccine (OCV) vaccination campaigns
- Select Ministry of Health representative participation in GTFCC Working Groups (WGs) such as (surveillance, OCV and engagement with the GTFCC Secretariat
- Select Ministry of Health representative attendance at GTFCC events (e.g., General Assembly, WHA side event)

Several GTFCC partners are supporting Haiti in the strengthening of its surveillance system to better detect and monitor cholera cases. In particular, WHO provides support to Haiti via a BMGF grant with three initiatives led since 2020 to support the strengthening of the surveillance system (ongoing project implemented by PAHO). PAHO, WHO regional office for the Americas and more specifically the Haiti WHO Country office, are very much engaged and supporting national authorities including on cholera. Haiti has not received Country Support Platform (CSP) support.

3. Key findings

2.1 Relevance

Q1: *To what extent is the Roadmap relevant given the changing environment (e.g. epidemiological, political, climate and risk profiles)? To what extent have measures been taken to ensure continuous adaptation of the Roadmap in line with latest international best practices and guidelines, and emerging needs at the country level?*

Q2: *To what extent is the design of the GTFCC adequate to support the objectives of the Roadmap?*

Relevance of Roadmap given the changing environment

The Global Roadmap is very relevant to Haiti's context both in terms of its objectives as well as proposed interventions, seeing the evolving needs and change in the cholera landscape in the country over the years. However, there is a gap in the operationalisation of the Roadmap for Haiti's context with limited guidance in translating the high level tenets of the Roadmap into specific mitigation or adaptation strategies required in complex settings, especially in conflict-affected countries such as Haiti.

Despite limited awareness of the Roadmap among stakeholders interviewed in Haiti, they were in general agreement with the Roadmap and noted it to be well-aligned with the National Cholera Plan (NCP) and organization of country response coordination mechanisms for cholera. Indeed, a review of the Haiti last NCP ("National Plan for the Elimination of Cholera in Haiti 2013-2022") highlighted a strong alignment of the country's vision and priorities with the Roadmap. Whilst the drafting of this NCP pre-dates the launch of the Global Roadmap, both documents are well-aligned in terms of the proposed strategic interventions for cholera prevention and responses to be implemented at country level. The last Haiti NCP proposed a comprehensive evidence-based strategy articulated around a multipronged multisectoral approach that included activities

across all strategic pillars recommended in the Roadmap (i.e., Surveillance and reporting, Healthcare system strengthening, OCV, WASH, and community engagement.). The current country response coordination mechanisms also clearly reflects the Roadmap's proposed approach, as demonstrated by the design of the government-led national cholera taskforce which has been organised in six dedicated thematic groups including a group on (i) coordination, (ii) epidemiology and surveillance, (iii) case management, (iv) WASH and infection prevention and control (IPC), (v) vaccination and (vi) community awareness and communication, including RCCE. These groups include representatives across key ministries such as the Ministry of Health/ Ministry of Public Health and Population (Ministère de la Santé Publique et de la Population (MSPP)), Ministry of Health Division for Health Promotion and Environmental Protection (DPSPE), Ministry of Water/ National Directorate for Water Supply and Sanitation in the Ministry of Public Works (DINEPA) etc.

Especially relevant to the context of Haiti, is the Roadmap recognition of the particular attention needed in countries that may progress towards cholera elimination and not be affected by cholera at a point in time but "where cholera could re-appear due to external events such as conflict, natural disaster, or political crisis increasing the risk of cholera". Between 2017 and 2024, the cholera landscape in Haiti has undergone several changes, from being at the tail end of a decade long catastrophic cholera outbreak which ended in 2019 to having no confirmed case of cholera for 3 years and being declared cholera-free in February 2022, before experiencing an upsurge in cases from October 2022 leading to a new large-scale outbreak that continues to this day. These changes have required a shift in the direction of focus and approach used to tackle cholera in the country which is highly aligned with the two axes approach described in the Ending Cholera: A Global Roadmap to 2030.

Despite the relevance of the Roadmap in the context of Haiti, there has been significant challenges to successfully implement it as elaborated further in this report (especially the effectiveness section). The Roadmap recognises strong links between cholera and external shocks and proposes mitigations to key risks around "unexpected events increasing the risk of cholera (e.g., natural disaster, conflict, etc.)" including by developing a strong monitoring system based on a series of indicators that can help trigger increased support from the GTFCC. However, these indications are provided at a high level in the Roadmap and there is not further documentation to provide specific guidance and adaptation to the specific complex setting of Haiti.

Design of the GTFCC to support objectives of the Roadmap

Whilst the objectives of the GTFCC are relevant for Haiti, it has thus far in its current design provided limited support to countries with complex contexts and significant support needs, especially in light of the GTFCC limited capacity and resources.

There was little awareness of the GTFCC across stakeholders in Haiti, with limited direct engagement through its internal structures, mainly the Secretariat and Working Groups, as well as through the GTFCC General Assembly. Country representatives have also been able to attend other GTFCC events such as the GTFCC WHA side event. Some interviewees were also indirectly aware of the GTFCC through the use of its resources (e.g., guidance documents from the website).

All stakeholders interviewed who were aware of the GTFCC shared that its objectives were appropriate and relevant to country needs, in particular its objectives around providing a forum for technical exchange, coordination, and cooperation, and increasing the visibility of cholera including through advocacy and resource

mobilization activities.[14] Interviewees commented on the value of the GTFCC as a global platform that brings together strong technical expertise across key technical areas required to ensure holistic cholera responses, etc. notably through the WGs that are structured around key strategic interventions (i.e., surveillance, laboratory, case management, WASH, OCV). They also shared that the GTFCC participation mechanisms provide opportunities for countries to collaborate and engage with different stakeholders (e.g., through the WGs or General Assembly) including with technical partners, donors, and other countries.

Stakeholders shared the need for an increased and more responsive engagement of the GTFCC with country stakeholders seeing the critical needs in Haiti. They also noted the need to integrate considerations around differential support depending on specific countries' contexts in the GTFCC operational model, especially for countries that do not have dedicated support through the CSP. The GTFCC is not active in Haiti through the CSP.

2.2 Coherence

Q3: *To what extent has the GTFCC, through its governance structures and mechanisms, promoted complementarity, synergy and integration between different members' interventions at the global and the country level? What is the added value of GTFCC members acting together?*

There is a strong collaboration and synergy between partners working on cholera in the country, many of which are also members of the GTFCC, although there is no evidence to suggest direct attribution to the GTFCC.

Many of the GTFCC members such as WHO/PAHO, UNICEF, MSF, ACF, CDC etc. are present at country level and/or actively engaged in cholera control and prevention activities in Haiti. Interviewees unanimously highlighted the critical role of these partners which have been instrumental in supporting cholera interventions in Haiti, especially in a context of acute needs and very limited government capacity. Whilst coordination remains limited overall, many interviewees reported significant improvement in partners coordination over the years as well as increased coherence of partners with country needs and government priorities. However, there was no evidence through stakeholder interviews to suggest that this improved coordination was influenced by these organizations' membership in the GTFCC or the collaboration of their global entities through GTFCC internal structures. In fact, the vast majority of interviewees, were unaware that their organization was part of the GTFCC, partly due to the lack of direct interaction. Some feedback flagged that there is an opportunity for the GTFCC to enhance communication with in-country partners to strengthen coherence, and promote better alignment of country actors.

2.3 Efficiency

Q4: *To what extent are the GTFCC operational structures set up efficiently to support the objectives of the Roadmap?*

Q5: *How efficiently has the Roadmap been implemented by the GTFCC in terms of optimizing human and financial resource allocation to support countries in a changing cholera landscape?*

[14] The objectives of the GTFCC are to support the design and implementation of global strategies, provide a forum for technical exchange, coordination, and cooperation, support the development of a research and increase the visibility of cholera including through advocacy and resource mobilization activities.

Overall, considering limited awareness of GTFCC in the country, views on its efficiency were limited. However, the need for GTFCC to encourage multisectoral engagement and engagement with non-traditional donors who can support Axis 2 of the Roadmap in particular was noted. There was a demand for in-country presence in Haiti and the CSP multisectoral engagement and with non-traditional donors who can support Axis 2 of the Roadmap. There was a demand for the CSP and in-country presence in Haiti.

Few interviewees considered that they had sufficient knowledge of the GTFCC to comment on its efficiency. However, some believed that the GTFCC structures were well set up, in particular, with respect to the strong technical expertise it brings together notably through the WGs. For example, one stakeholder mentioned finding their participation in the surveillance WG and the technical guidelines it produces useful. A few interviewees also commented on the diversity of the GTFCC structures which enables a flexible engagement approach both through formal engagement mechanisms (e.g., through participation in WGs, General Assembly) as well as less formal engagements (e.g., relationship with members of the GTFCC secretariat). In addition, they highlighted the value of the General Assembly as a platform that enables active country participation, lessons learning, and engagement with a wide range of partners.

Some aspects highlighted for improvement include: (i) need for wider stakeholder engagement from Haiti – both in terms of numbers overall and also diversity in terms of engaging members working on WASH; (ii) provision of direct support to Haiti through in-country presence (i.e. through the CSP); (iii) more direct interaction with in-country members from the GTFCC internal structure stakeholders (iv) greater awareness raising and dissemination of GTFCC resources; and (v) need to expand GTFCC membership beyond the traditional cholera donors. On this last aspect, interviewees highlighted significant challenges around resource mobilization for cholera interventions in Haiti due to donor fatigue as well as less engagement of partners outside of the outbreak periods. They shared that the GTFCC can be a beneficial platform to engage donors beyond traditional cholera stakeholders, such as humanitarian or health-focused organizations and also include donors that could support Axis 2 of the Roadmap which focuses on multisectoral prevention of cholera in countries

2.4 Effectiveness

Q 6: What results have been achieved by the GTFCC partnership in the implementation of the Roadmap at the country level?

Q 7: Which factors have influenced the implementation of the Roadmap to date? What opportunities could be tapped into for better results?

Haiti's cholera landscape has changed over the years, oscillating between two large scale outbreaks and an intermediate cholera free period. After early progress towards cholera elimination, the country has been facing a resurgence in cases due in part to a deteriorating political and security context as well as limited funding available for cholera interventions.

Between 2010 and 2019, Haiti faced one of the world's deadliest cholera outbreaks, which until 2017 caused at least 27,000 cases annually, cumulatively impacting more than 810,000 Haitians, and led to the death of nearly 10,000 people. After years of challenges to respond to the outbreak effectively (due in part to the lack of a strategic and coordinated approach, as well as to the fact that Haiti was encountering cholera for the first time), the country was ultimately able to design and implement a comprehensive response strategy using a multipronged approach that included strong community based responses, timely case management, strengthened surveillance, emergency water treatment, and targeted oral cholera vaccination campaigns. Thanks to these efforts, Haiti was able to progressively control and curb the outbreak between 2017 and 2019.

However, in October 2022, following years of no reported cases of cholera in the country, Haiti reported a resurgence of cholera. As of 31 January 2024, the Ministry of Health/MSPP reported 79,411 total suspected cases, 4,608 confirmed cases, 75,160 hospitalized cases, 887 institutional deaths, and 285 community deaths due to this new outbreak. The response mechanisms strengthened during the 2010-2019 outbreak provided a strong foundation that helped the country respond to this new outbreak in 2022. However, this upsurge of cholera occurs in the context of increased political instability, social unrest, acute humanitarian crisis, and increased levels of poverty, compounded by limited health and WASH services that highly hinders cholera response activities. In particular:

- The current insecurity and political instability context add significant challenges to the delivery of cholera responses across the country, including to the most vulnerable communities. Access constraints due to the blocking of national roads and sometimes the airport and control of key areas such as national ports by armed groups, have limited the delivery of supplies, the transport of laboratory specimens, and deployment of aid workers and health personnel to affected areas.
- The current political instability has also driven many partners and national actors away, including trained healthcare workers and response staff. Many interviewees flagged the impact of this brain drain which has significantly reduced the availability of skilled staff and the number of partners that support cholera responses and interventions in the country.
- Interviewees also highlighted that cholera interventions are very outbreak focused due to a lack of resources for preparedness and prevention activities. This has limited efforts to strengthen health and water systems, including during the 3 years of cholera-free period, which undermined the country's resilience to upcoming shocks**.** In Haiti, the majority of partners engaged in cholera are humanitarian and emergency response actors that may be limited in their mandate and resources to engage in preparedness and long term prevention interventions.
- In addition, interviewees commented on the lack of funding available for cholera activities as the government and partners have struggled to mobilize the resources necessary for cholera interventions. This is due in large part to donor fatigue, which creates strong funding gaps in a highly donor dependent cholera context, exacerbated by the many emergency situations and limited domestic resources available due to the economic instability in the country.

There has been mixed progress in the implementation of different measures towards cholera response in the country.

A number of national cholera responses mechanisms and systems were set up towards the end of the previous cholera outbreak (2010-2019) and were instrumental in curbing the recent outbreak. These response systems were also leveraged to respond to the recent outbreak which started in 2022, though with less success, seeing the heightened challenges linked to the political and security context as mentioned above. Progress across different implementation areas is described below, and were highlighted by interviewees, reference to GTFCC's work is included.

- One aspect cited as a **key factor of success was the country's adoption of case finding through community engagement and community health workers**. Interviewees unanimously praised the efforts made to embed active response systems within communities, by building on the existing network of community health workers (CWHs), recruiting and training additional CHWs, and setting up mobile response teams. The Ministry of Public Health and Population (MSPP), with technical and financial support from partners, was able to strengthen community response systems. This includes initiatives such as the Labo Moto strategy, which used "nurses on wheels" to reach people infected with cholera across the country by motorcycle, including hard-to-reach areas. Mobile Rapid Response Teams (Emira) and the Departmental Investigation and Response Teams (EDIR) were also set up to provide decentralised and timely responses in affected communities based on the GTFCC recommended case-area targeted interventions (CATIs) strategy, a "game changer" according to a stakeholder.

- **The effectiveness of surveillance and laboratory activities have been limited**. Interviewees notably mentioned the increased costs of surveillance and laboratory activities as samples from nine to ten departments had to be transported by flights (e.g., via SUNRISE and UNHAS) to the National Reference Laboratory (LNSP) due to ongoing insecurity and lack of access to many roads. The challenges in accessing certain areas affected by insecurity for initial investigations and responses by surveillance teams, coupled with insufficient capacity at the community level to detect cholera cases and identify potential outbreaks, as many people have fled these areas, have led to delays in case notification and confirmation with a ripple effect on the timeline to provide treatment to patients and stop disease transmission. A stakeholder mentioned that their engagement with the GTFCC had been beneficial in strengthening surveillance activities, mainly by participating in the GTFCC surveillance WG and having access to helpful technical guidance on this aspect.

- While the government and partners had set up additional cholera treatment centres and increased the number of health workers for cholera' during the previous outbreak to increase **case management, capacity has been highly reduced in this new outbreak** due to the current context as the country pains to retain trained staff. This has reduced the availability of skilled response staff and health workers significantly. Interviewees flagged challenges around the lack of an integrated approach to case management. Cholera treatment has very often been provided in standalone structures in the country rather than being integrated into the existing healthcare system. The Ministry of Health reportedly made efforts to strengthen the integration of cholera management by turning cholera-specific facilities into treatment centers for all diarrheal diseases (Centre de Traitement des Diarrhées Aiguës [CTDAs]), and advocating for care of cholera cases in all health facilities.

- The country **implemented several reactive cholera vaccination campaigns** both in the earlier outbreak as well as the most recent outbreak in 2022. [15] With the support of the GTFCC and country based partners, the Ministry of Health was able to request, receive, and deliver OCV vaccines in high-risk communities (e.g., vulnerable communities, prisons, IDP camps) as part of its emergency responses. Some interviewees noted challenges in the implementation and coordination of campaigns, inadequate communication between strategic levels to deliver the campaigns as well as

[15] With UNICEF support, Haiti kickstarts campaign to immunize about 1.7 million people against cholera.

delay in ordering the vaccines early in the outbreaks as potential factors that limited the effectiveness of vaccination campaigns.

- **Limitations of data to inform response activities have also been highlighted as a key weakness.** Documented evidence note a lack of data-driven, evidence-based management of response activities due to a lack of quality data, limited epidemiological analysis, and lack of identification and mapping of transmission contexts.[16,] Monitoring and evaluation of cholera activities, in general, remains weak. Whilst the previous NCP included a high-level M&E plan with key indicators of success to track progress on short, medium, and long term objectives, it was not implemented and there is little documented tracking of progress made on the NCP. Interviewees also highlighted the lack of after-action-review (AAR) exercises after responses to document the successes and challenges from previous responses and enable better learning and improvement that can help consolidate future responses. Whilst these challenges with data are noted, there are some positive efforts in terms of data sharing, analysis and dissemination. For example, the Laboratory Epidemiology and Research Directorate regularly publish a daily SITREP on the epidemic and regularly presented the situation at various coordination meetings, PAHO continues to produce a regular analysis of the epidemic (a weekly presentation has been available since the start of the 2022 epidemic) and takes part in the various cluster meetings (health, WASH) to present the situation in the spirit of Nowcasting, and there is a weekly presentation of areas with active outbreaks, with recommendations for response strategies and activities tailored to each outbreak.

Haiti faces extensive challenges in the WASH sector as access to safe water and efforts to strengthen water, sanitation, and hygiene systems remain highly insufficient. This is also an area where GTFCC could do more in the future.

Government and in-country partners' capacity to address WASH needs have been highly limited, further reduced in the current outbreak by the degradation of infrastructure, the deterioration of state services, staff shortage and high turn-over rates, and limited access to affected areas due to ongoing gang violence and political insecurity. Recent estimates highlight the scale of WASH challenges in Haiti:[17]

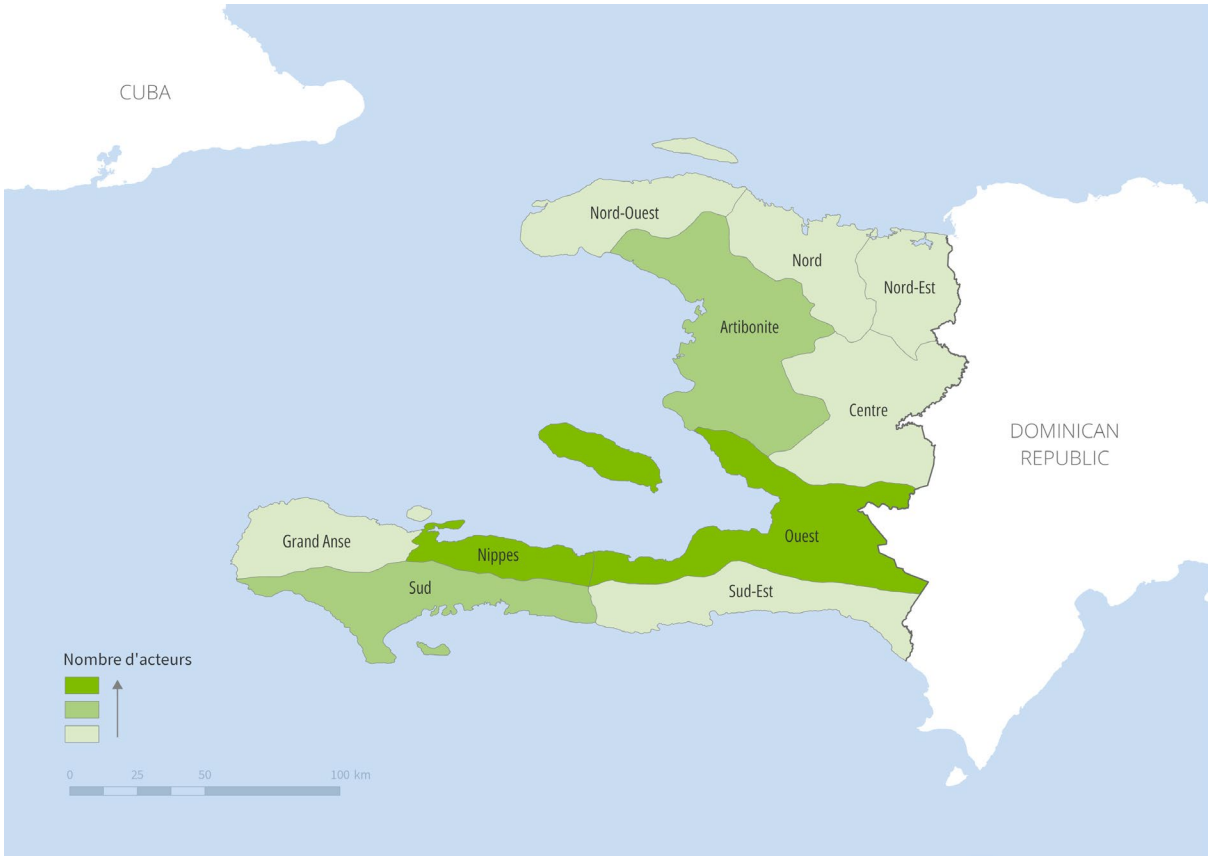
- 5.2 million people have no access to basic drinking water services and 26% of the population have no access to improved water sources with a high rural to urban disparity (41% in rural areas and 5% in urban areas),
- Only 25% of households have access to adequate handwashing facilities with soap and 32% do not have access to basic hygiene services
- 61% of people do not have access to at least basic sanitation facilities and 7 out of 10 people do not have access to an improved sanitation system
- 25% of households continue to resort to open defecation (36% in rural areas and 10% in urban areas).

Interviewees highlighted that community engagement and localization initiatives have been critical to maintain WASH service delivery in communities and have contributed to decrease in operational costs, to ensure access to essential WASH services. There have also been efforts to better coordinate WASH response and maximise the use of limited resources by mapping out available partners across the country (as presented in Figure 4) to identify areas that may require more support and promote a more balanced distribution of partners' presence. In addition, surveillance teams, through a strategy recommended by the GTFCC, provide

[16] UNICEF and DINEPA (2024). Haïti WASH Sector Emergency Briefing.
[17] UNICEF. Water, sanitation and hygiene (WASH).

an initial response to cases during investigation and response missions. These surveillance teams travel with medicines and inputs to 'secure' the area at risk before handing over to the other EMIRAs. It is considered by some stakeholders that this strategy contributed to interrupting the transmission chain. In addition, PAHO/ WHO supported the placement of WASH technicians in each health department, who aimed improve the quality of IPC conditions in the CTDAs, and helped define community response strategies in collaboration with the community surveillance and health teams.

Figure 4: Map of WASH actors by geographical region across the country



Regions	WASH actors by region (30 in total)
Nord-Ouest	ACF, Caritas, CRH, WWH and OREPA NORD/UNICEF (5)
Nord	HI, WVI and OREPA NORD/UNICEF (3)
Nord-Est	ACF, HI, PLAN, OIM and OREPA NORD/UNICEF (5)
Artibonite	ACF, ADRA, CARITAS, CRH, HAS, We World GVC Zanmi La Santé and OREPA CENTRE/UNICEF (7)
Centre	CARITAS, ADRA, WVI and CENTRE NORD/UNICEF (4)
Ouest	ACTED, ADRA, CRH, CRS, CEDUCC, CONCERN, GOAL, HI, SI, ORRAH, OIM and OREPA OUEST, UNICEF (12)
Sud-Est	PLAN, HELVETAS, CRH and OREPA SUD/UNICEF (3)
Nippes	CRS, CRH, HELVETAS, REFANIP, CEDDUC, We World GVC, MERCY CORPS, PROJECT HOPE, GOAL and OREPA SUD/UNICEF (10)
Sud	ACCODEP, CRS, IDEJEN, WORLD RELIEF, PROJECT HOPE, HELVETAS, GOAL and OREPA SUD/UNICEF (7)
Grande Anse	CRS, CRH, HEKS EPER, PROJECT HOPE, GOAL and OREPA SUD/UNICEF (4)

However, the WASH response activities remain insufficient overall. Documented evidence reports that less than 10% of suspected cases have been addressed with a rapid response including WASH items, although

stakeholder feedback indicates it is potentially much higher. This is due in part to a lack of WASH funding as only 30% of the $64M required for WASH responses had been received as of April 2024. In addition, stakeholders mentioned the limited number of WASH partners present in-country, as many left following the increase in violence and instability, which further reduced technical WASH capacity in the country. The lack of robust information management and monitoring systems for WASH activities, including the lack of a system for monitoring the quality of responses, hinders the effectiveness of WASH activities. This is despite reported efforts to strengthen monitoring tools and processes across relevant departments in the ministries of health and water (DRU/DINEPA).

2.5 Sustainability

Q 8: What steps has the GTFCC taken to ensure the sustainability of its interventions under the Roadmap?

The complex political and economic situation in the country, along with humanitarian needs, weak governance, and ongoing insecurity strongly hinders progress towards programmatic and financial sustainability.

Firstly, the national context highly influences the type of donors and partners that engage with the country, which are mostly humanitarian and emergency focused entities. This limits the ability of national actors to adopt a long-term approach to cholera interventions, particularly in the absence of financial resources for prevention and preparedness activities and lack of development focused partners, especially long term WASH actors. The challenge of increased insecurity also renders the context extremely volatile and unpredictable, preventing the scale-up of response activities, and further hinders long-term planning and forecasting of needs.[18] The lack of a collective vision between partners also contributes to ineffective implementation of initiatives, such as the replacement of water supply through tanker trucks by more sustainable and less costly investments over time, such as connection to the DINEPA network, or a “market approach” within the private sector.

There was limited feedback or evidence of steps taken to ensure environmental sustainability of cholera interventions, although a recent UNICEF document mentioned efforts to prepare for climatic hazards and earthquakes as part of current operational objectives in the WASH Sector.[19]

2.6 Gender, equity and human rights (crosscutting)

Q 9: *To what extent has the Roadmap included GER concerns? To what extent have implementation activities factored equity considerations at the global and country level?*

Despite efforts made to target the vulnerable communities during the cholera response, including prioritizing IDP camps and prisons for OCV campaigns, evidence suggests that there are significant disparities in the distribution and impact of cholera across the population in Haiti.

[18] UNICEF and DINEPA (2024). Haïti WASH Sector Emergency Briefing.
[19] UNICEF and DINEPA (2024). Haïti WASH Sector Emergency Briefing.

Recent outbreaks have been reported to affect rural households disproportionately, in particular due to poor WASH services in rural areas as well as the current insecurity that has isolated many parts of the country.[20] Poverty has also been a strong driving factor of cholera in the country, as the disease strongly impacts the poorest areas such as Cité Soleil, the largest urban-poor area in the capital city, as well as IDP camps, where overcrowding and lack of access to WASH services considerably augment the risk of cholera transmission.

In addition, children have been particularly affected by the disease, as recent data suggested that children accounted for 2 in 5 reported cholera cases in the country in 2022. Children have been particularly vulnerable due in part to lower immunity to the disease compared to adults, as well as high levels of severe malnutrition resulting from the current insecurity and humanitarian crisis in the country. In 2022, UNICEF reported that 9 in 10 confirmed cholera cases in Haiti had been reported in areas with a high burden of severe acute malnutrition.

3. Conclusion

The case study highlights the ongoing relevance of the Roadmap in complex settings, and the need for greater detail and specification of how to translate the broad tenets of the Roadmap for Haiti's context and what GTFCC would specifically contribute.

In general, Haiti's engagement with GTFCC has been limited over the evaluation period and there is a demand from country stakeholders for more engagement, including in-country presence such as through the CSP. Interviewees have opined on the different GTFCC structures – mostly positively in terms of their interactions with the WGs and General Assembly – but also indicated the need for the GTFCC to engage more widely with non-health and humanitarian partners (i.e. on WASH and other preventive areas) and with a wider donor base that can support country cholera prevention related efforts.

The cholera response program in Haiti has seen mixed progress, with WASH and wider preventive efforts significantly lagging behind the many efforts at outbreak response. This outbreak focus can be attributed to the outbreak circumstances in Haiti, but the lack of a long-term structure for cholera response in the country has contributed to increased challenges during successive outbreaks.

[20] UNICEF. Water, sanitation and hygiene (WASH).

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Consultee list

Stakeholder group	Organization (# of consultees)
Government	Ministère de la Santé Publique (MSPP) (2)
	Ministry of Water and Sanitation (DINEPA/DRU) (1)
Technical and operational partners	WHO / PAHO (4)
	UNICEF / WASH (4)
	UNICEF / Emergency (1)
	UNICEF / M&E (1)
	Humanité & Inclusion / Cholera (1)
	Action Contre la Faim (ACF) / WASH (1)

Country case study Kenya

This Kenya country case study supports the Mid-term evaluation of the Global Task Force on Cholera Control (GTFCC). Following background information and country context (Section 1), country-level findings are presented for each of the evaluation areas (Section 2): Relevance (Section 2.1), coherence (Section 2.2), efficiency (Section 2.3), effectiveness (Section 2.4), sustainability (Section 2.5) and gender, equity and human rights (Section 2.6). A final conclusions section based on these findings from Kenya follows (Section 3).

1. Introduction, background and country context

1.1 Introduction

This case study is one of six case studies which have the purpose to generate evidence for evaluation questions set out in the evaluation framework, and be an evidence base for findings in the main evaluation report. This includes questions relating to (i) the work of the GTFCC and (ii) implementation of the cholera Roadmap from a country perspective.

Countries were selected to allow for diverse representation across key criteria for the evaluation and permit a deeper assessment of successes, challenges and lessons pertaining to the work of the GTFCC and the Roadmap. For Kenya, this included: (i) being on the Roadmap priority list; (ii) having a national cholera plan (NCP), (iii) having received support to implement the Priority Areas for Multi-sectoral Interventions (PAMI) process and (iv) being a country that has received support from the GTFCC and is not a country support platform (CSP) supported country.

1.2 Methods

Development of this case study included a short (five day) visit to Kenya (specifically Nairobi and Kajiado county). Data collection methods for this case study included a review of key documentationand focus group discussions (FGDs) and stakeholder interviews.

Key informants were purposefully selected to take part in interviews and FGDs. The selection ensured a mix of stakeholders from government including different national level ministries (e.g. health and water), county and sub-county representation from one county, representatives from different GTFCC partners (e.g. WHO, UNICEF, MSF), and representatives from the different pillars of the cholera Roadmap (e.g. laboratory, surveillance, oral cholera vaccine (OCV), WASH etc). Key informant interviews (KIIs) and FGDs were conducted with 40 stakeholders using a semi-structured interview guide and the majority were conducted in person as well as a small minority conducted online.

Data from KIIs and FGDs were analysed alongside documents to develop the findings for this case study.

A limitation included that interviewees at the country level only had limited information on key aspects relating to GTFCC.

1.3 Key country characteristics and cholera context

Kenya is located in the Horn of Africa, bordered by the Indian Ocean to the southeast and sharing land borders with Ethiopia, Somalia, South Sudan, Tanzania and Uganda. The country is administratively divided into 47 counties and had a population of 55 million in 2023. The population has been growing at an annual rate of 2.2%, up from 37.7 million in 2009, with projections indicating a growth to 57.8 million by 2030.[21] A third of the population lives in urban areas, primarily in the two main cities of the country, Nairobi, the capital and Mombasa, the second largest city. The average population density in the country is estimated at 82/km^2 but varies greatly across the counties with densely populated areas such as Nairobi at 6,748/km^2 population density.

Cholera remains a critical public health issue in Kenya and is classified among the priority diseases in the Integrated Disease Surveillance and Response (IDSR) Technical Guidelines of 2023. The disease was first reported in Kenya in 1971, and the country has since experienced recurrent cyclic cholera outbreaks, around every five to seven years. Key risk factors of the disease include poor sanitation and hygiene with inadequate access to clean water and sanitation facilities, particularly in informal settlements and refugee camps. In addition, overcrowding with high population density in urban areas and camps for internally displaced persons (IDPs) exacerbates the spread of infectious disease, including cholera. Regarding IDP camps in particular, displacement due to natural disasters, conflict, and economic factors have led to the establishment of these camps. Conditions are often conducive to cholera transmission due to limited access to healthcare services, weak surveillance systems hindering effective response to cholera outbreaks, environmental factors, seasonal flooding and poor waste management which contaminates water sources.

Kenya operates a decentralized health system, with responsibilities shared between national and county governments. Each county is responsible for managing their own health services, which allows for autonomous decision-making and resource allocation. The Ministry of Health provides oversight, while 47 county governments manage the local health services. The Kenya health system is organized into six levels, as follows: community and primary healthcare (PHC) services provided at levels 1 to 3 (level 1, community services; level 2, dispensaries and clinics; level 3, health centres and maternity and nursing homes); level 4 includes sub-county hospitals and medium-sized private hospitals; level 5 is composed of county referral hospitals and large private hospitals; and level 6 of national referral hospitals and large private teaching hospitals. The system includes a mix of public and private healthcare providers, with the public sector serving the majority of the population. While health facilities exist across the country, access remains uneven, particularly in rural and hard-to-reach regions. Challenges include inadequate infrastructure, staffing shortages, and variability in service quality. The availability of essential health commodities, such as vaccines, medicines, and diagnostic tools, remains suboptimal due to recurrent supply chain issues and funding gaps. There is a significant shortage of healthcare professionals, affecting the quality of care and service delivery, further exacerbated by limited funding from domestic financing for health which hinders the implementation of health programs. There are ongoing efforts to strengthen Kenya's health system including investing in infrastructure and interventions to improve service delivery and enhancing access to essential health services through collaborative efforts between the government, NGOs, and international partners.

[21] Kenya State Department for Economic Planning (2023). The Annual State of Kenya and State of World Populations reports 2023 launch.

1.4 Object of the evaluation and summary of GTFCC support to Kenya

The GTFCC is a partnership of approximately 50 institutions to coordinate activities for cholera control at global, regional, and country levels *(2)*. The GTFCC brings together organizations working across multiple sectors and serves as a coordination platform to support countries in the implementation of the Global Roadmap on ending cholera *(3)*. The Roadmap is underpinned by early detection and quick response to contain outbreaks; a targeted multi-sectoral approach to prevent cholera recurrence; and an effective mechanism of coordination for technical support, advocacy, resource mobilization, and partnership at local and global levels. A key role of the GTFCC is to promote and support the implementation of the Ending Cholera – A Global Roadmap to 2030 at country level by providing the advocacy, coordination, policy guidance and technical assistance necessary for countries to develop National Cholera Plans (NCPs) and implement them effectively. By implementing the strategy between now and 2030, the GTFCC partners will support countries to try to reduce cholera deaths by 90%.

The GTFCC convenes multi-sectoral partners. In particular for countries, the work includes (i) tool development and technical guidance which the GTFCC Secretariat helps to coordinate and GTFCC technical working groups develop; (ii) support to the implementation of these tools and their translation into activities (CSP support[22] in a small number countries but not extensively in Kenya, and technical assistance provided by partners) and (iii) the independent review panel (IRP) has reviewed NCPs in a small number of countries, including Kenya.

Kenya has benefited from active support from the GTFCC for a range of activities. This includes:

- Support from the GTFCC Secretariat, US CDC (GTFCC Partner) financing technical assistance through Washington State University and independent review panel (IRP) to develop and review the Kenya National Multisectoral Cholera Elimination Plan (NMCEP);
- Support for the first hotspot mapping though the GTFCC Epidemiology Focal Point of the Epidemiology Working Group (WG);
- Support to implement the Priority Areas for Multi-sectoral Interventions (PAMI) process with technical assistance from the GTFCC Epidemiology Working Group (WG) focal point, in collaboration with Washington State University and the US CDC;
- Support from the GTFCC oral cholera vaccine (OCV) WG, GTFCC Secretariat and US CDC/ Washington State University to apply for OCV support and prepare and deliver two rounds of reactive OCV campaigns; and
- Participation of Kenya's Ministry of Health, Ministry of Water, Sanitation and Irrigation Services (MoW) and national stakeholders in GTFCC Annual General Assemblies.

[22] The CSP was established in 2020 and leads the multi-sectoral support that the GTFCC provides to countries for the implementation of their NCPs. The CSP supports the short, medium and long-term deployment of GTFCC multi-sectoral expertise in countries. Five 'primary operational countries' have received substantial support: Bangladesh, Democratic Republic of Congo (DRC), Mozambique, Nigeria and Zambia. In addition, another four countries have received ad-hoc technical support.

2. Key findings

2.1 Relevance

Q1: To what extent is the Roadmap relevant given the changing environment (e.g. epidemiological, political, climate and risk profiles)? To what extent have measures been taken to ensure continuous adaptation of the Roadmap in line with latest international best practices and guidelines, and emerging needs at the country level?

Q2: To what extent is the design of the GTFCC adequate to support the objectives of the Roadmap?

Relevance of Roadmap given the changing environment

The Global Roadmap is highly relevant and aligned with the country needs in terms of its ambitions and content. A number of national stakeholders interviewed confirmed the relevance of the Roadmap as a key reference tool to inform government planning at the country level, as articulated in the 2022-2030 NMCEP. The Kenya NMCEP provides a comprehensive plan of action to control and eliminate cholera in the country by 2030. This document includes clear reference to the Global Roadmap and describes a national approach for cholera control and elimination articulated around six measures: (i) Leadership and coordination, (ii) Case management and infection prevention and control (IPC), (iii) Surveillance and reporting, (iv) Water, Sanitation, and Hygiene (WASH), (v) Risk communication and community engagement (RCCE), and (vi) OCV. These are closely aligned with the strategic multi-sectoral interventions recommended in the Global Roadmap[23] to enable integrated and comprehensive approaches both within and outside of the health sector.

The Roadmap also highlights various global risks factors that are likely to increase the risk of cholera in the coming years such as climate change and urbanisation, as well as emphasising the need for cross-border coordination and surveillance in high-risk areas such as refugee camps. These are challenges that are clearly identified in the NMCEP and highlighted by all stakeholders as main risks factors for cholera outbreaks in Kenya. However, it is worth noting that stakeholders highlighted the contrast between the global Roadmap ambitions and available resources in countries, including Kenya. This particularly relates to prevention activities given the competing health and development needs in country as detailed in section 2.4.

Design of the GTFCC to support objectives of the Roadmap

Relatively few national stakeholders were fully aware of the GTFCC internal structures and objectives (although some were aware of the support received through these structures). However, of those that were aware, or had engaged with the GTFCC, the majority expressed that the GTFCC structures and objectives are appropriate to support the objectives of the Roadmap and its operationalisation at country level. Many national level stakeholders and most county level stakeholders in Kenya were not fully aware of the GTFCC

[23] The Roadmap strategic multi-sectoral interventions include (i) Leadership and Coordination, (ii) Water, Sanitation and Hygiene, (iii) Surveillance and Reporting, (iv) Use of Oral Cholera Vaccine (OCV), (v) Health Care System Strengthening, (vi) Community Engagement. GTFCC (2017). Ending Cholera: A Global Roadmap to 2030.

objectives, its internal structures or the extent of its activities. Feedback gathered from engaged stakeholders indicated that the objectives[24] and activities of the taskforce are appropriate in terms of facilitating implementation of the Global Roadmap at country level. In particular, the GTFCC role in (i) supporting the design and implementation of global strategies, (ii) providing a forum for technical exchange, coordination, and cooperation on cholera-related activities and (iii) supporting advocacy and resource mobilization to increase the visibility of cholera as an important global public health problem, were often cited as critical areas, with a lesser emphasis on the support provided for the development of a research agenda. However, in practice, the level of implementation and extent to which these objectives and related activities have been implemented in the country varied, as further explored in section 2.3 and 2.4. With regards to the structures of the GTFCC, stakeholders that were engaged with the GTFCC were able to comment mostly on the support received from various members of the GTFCC through its Secretariat, IRP, WGs (mostly the OCV WG), which are discussed under section 2.3 and 2.4., rather than being able to comment on the structures themselves (i.e., in terms of their purpose, composition, roles or responsibilities).

One aspect highlighted by a few stakeholders is the expected benefits that a dedicated GTFCC presence in country (e.g., through the CSP) could yield for the country if this were to be provided. In particular, some stakeholders highlighted that a GTFCC country and/ or regional presence could potentially be beneficial to enhance coordination at the national level between partners and national actors and in supporting intergovernmental coordination (discussed in the following section).

Technical assistance from GTFCC Secretariat, WGs and through support from partners has been appreciated. As noted in Section 1, Kenya has received support from the GTFCC in a number of areas. This support has been much appreciated by country stakeholders interviewed for the aspects that it has been provided for. This includes technical support from Washington State University for at least four years (funded by US CDC) for a number of areas such as PAMIs and development of the NMCEP.

2.2 Coherence

Q3: To what extent has the GTFCC, through its governance structures and mechanisms, promoted complementarity, synergy and integration between different members' interventions at the global and the country level? What is the added value of GTFCC members acting together?

National coordination is generally a strength during outbreaks but is lacking to drive efforts on preparedness and prevention. In addition, the multiple taskforces present in Kenya risk duplication of work. National coordination is currently facilitated through national taskforces (led by the Ministry of Health) and is described in the NMCEP. These national platforms include both government stakeholders and some key partners. However, some stakeholders noted these platforms were mostly active during outbreaks and thus

[24] The objectives of the taskforce are to (i) support the design and implementation of global strategies to contribute to cholera prevention and control globally; (ii) provide a forum for technical exchange, coordination, and cooperation on cholera-related activities to strengthen countries' capacity to prevent and control cholera; (iii) support the development of a research agenda with special emphasis on evaluating innovative approaches to cholera prevention and control in affected countries; and (iv) increase the visibility of cholera as an important global public health problem and conducting advocacy and resource mobilization activities to support cholera prevention and control at national, regional, and global levels.

coordination was more of a reactive nature, with more limited engagement in between outbreaks to support preparedness and prevention.

In addition to the national platforms, WHO and UNICEF country teams have also led efforts to strengthen coordination between partners with a WHO led taskforce that brings together most health and humanitarian/ emergency partners and donors (e.g., UNICEF, UN agencies, Kenya Red Cross, MSF, USAID, US CDC, etc.) and a UNICEF-led taskforce coordinating efforts from WASH partners. These platforms have been highlighted as particularly beneficial especially in the absence of a health cluster to steer and drive coordination during outbreak periods as one stakeholder noted, "In the absence of a Health Cluster in the country, the taskforce set up by WHO was critical to coordinate players on the health side" and another stakeholder said, "The WASH forum was instrumental for coordination, resource planning, and knowledge sharing during the outbreak". These taskforces have reportedly enabled more synergetic partner responses and complemented existing national coordination mechanisms. Ministries and partners representation on national and partners taskforces were also facilitated to promote knowledge sharing and coordination across coordination mechanisms. Pre-existing collaboration between the national and county authorities with partners was noted as highly beneficial to facilitate response coordination and implementation of activities.

Given the many coordination platforms, there are potential risks for duplication of work given most stakeholders are part of multiple platforms. In addition, stakeholders unanimously agreed that there is a gap in coordination outside of outbreaks to drive efforts on preparedness and prevention interventions across partners and national stakeholders.

Regional coordination on cholera control and prevention is considered to be an area requiring further attention. A potential area for improvement noted by stakeholders (and suggested by some as an area where GTFCC support would be welcome) is regional coordination on cholera control and prevention - especially with regards to cross-border transmission - recognised as important for Kenya's cholera response. As one stakeholder said, *"Cross border intervention and coordination is critical to really support cholera control and enable elimination".* Stakeholders have reported seeing the tangible impact on the efficiency of current interventions due to the lack of strong intergovernmental and cross-border coordination for cholera interventions such as during OCV campaign implementation (further details provided in section 2.4). Several existing regional platforms have been highlighted by stakeholders as potential fora to facilitate regional engagement and coordination on cholera, including the AFRO and EMRO WHO Regional Offices, Africa CDC, Nile Basin Initiative (NBI), the Intergovernmental Authority on Development (IGAD) in Eastern Africa, the Lake Victoria Basin Commission (LVBC), amongst others. However, engagement in these platforms has been limited by various issues. For example, stakeholders shared that whilst the WHO regional office was well placed to provide critical cross-border coordination support, the delineation between WHO EMRO and AFRO poses challenges to enable effective information sharing and coordination with some neighbouring countries (e.g. Somalia is covered by WHO EMRO whilst Kenya is covered by WHO AFRO). However, some stakeholders highlighted that in the absence of a dedicated focal point to drive engagement on cholera across these platforms, it was likely to be deprioritized especially outside of multi-country outbreak periods due to the high number of existing competing priorities and lack of dedicated capacity to focus on cholera in these platforms.

2.3 Efficiency

Q4: To what extent are the GTFCC operational structures set up efficiently to support the objectives of the Roadmap?

Q5: How efficiently has the Roadmap been implemented by the GTFCC in terms of optimizing human and financial resource allocation to support countries in a changing cholera landscape?

There was minimal feedback pertaining directly to the design or functioning of the internal structures of the GTFCC, most likely due to a lack of awareness on their operational model, aside from the General assembly, which is considered to be a very useful platform to enable cross-country learning and high-level engagement on cholera. National stakeholders who attended the General Assembly commented on the usefulness of this forum especially for experience sharing and lesson learning between countries. They shared the utility of learning from other countries on the challenges and successes they face to identify common gaps and potential best practices both from countries in similar and different contexts. It is worth noting that from the Government of Kenya, representatives from both the Ministry of Health and the Ministry of Water, Sanitation, and Irrigation Services have attended the GTFCC General Assembly, and see it as a benefit to strengthen commitment at the highest levels of authority in the country from both sectors.

Stakeholders also highlighted some aspects of the General Assembly that could be strengthened:

- There are challenges with the timeliness of General Assembly reports which are often delayed and disseminated well after the event, potentially missing a window of opportunity and momentum created by the General Assembly event to drive action at national level.
- The format of dissemination could be improved, as it is currently done mostly by publishing reports on the GTFCC website, which does not facilitate efficient in-country dissemination. Some suggested that a formal dissemination process for countries' participants could be helpful e.g., through an online meeting where country stakeholders could ask follow-up questions.
- The use and feedback of country reporting at the General Assembly could be improved. Currently, countries are asked to compile a report with details of progress on key indicators at the country level, which is considered to be a lengthy and demanding process at country level (e.g., comprehensive data collection across indicators, coordination and consultation with country level stakeholders). Reports across countries are then compiled and analysed by the GTFCC Secretariat, before sharing high level global trends and key country details as part of the Secretariat report to the General Assembly. However, country stakeholders shared receiving very limited feedback once the report has been shared with the Secretariat which they view as a missed opportunity.[25,26]

[25] Examples of feedback suggested to be useful include comments on progress made and any needs and gaps identified, sharing of trend analysis both for the country itself as well as cross countries at regional and global level. They also suggested that the use of a visual online dashboard providing country, regional and global level data and trend analysis would be highly beneficial to provide easy access to cholera data and foster better accountability across countries.

[26] Currently, the GTFCC and WHO cholera program team compile monthly situation reports (sitreps) that provide key information on the global cholera landscape (that month), as well as epidemiological and operation information on cholera (e.g., total number of cases and deaths, number and location of countries that have reported cholera, information on the OCV and vaccination rate globally, etc.). However, the format and content of sitreps does not enable an overview of country progress overtime and is mostly focused on outbreak information.

2.4 Effectiveness

Q 6: What results have been achieved by the GTFCC partnership in the implementation of the Roadmap at the country level?

Q 7: Which factors have influenced the implementation of the Roadmap to date? What opportunities could be tapped into for better results?

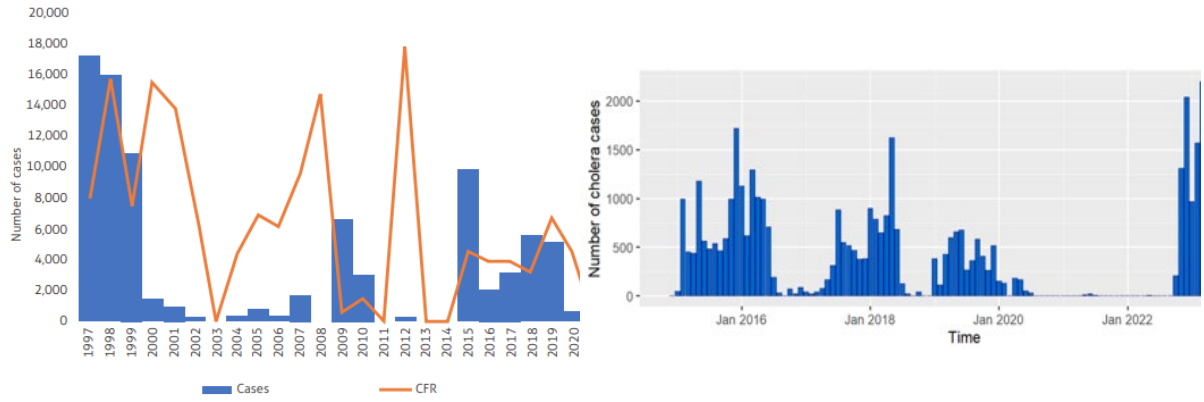
Early detection and response to contain outbreaks

Cholera remains a disease of major public health concern in the country with large-scale outbreaks occurring since 2014, most recently between 2022-2024. Kenya is considered a cholera-endemic country and has experienced cyclical reoccurrence of large-scale outbreaks (1997-1999, 2007-2010, and recently between 2015- 2019 and 2022-2024 as show on figure 5 below) since the disease was first reported in the country in 1971. As of February 2024, the country reported 12,521 cases from the most recent outbreak which occurred across 28 of the 47 counties, with a high case fatality rate of 1.7% (beyond the 1% CFR acceptable threshold defined by WHO). This still represents an improvement from historical outbreaks as recent studies estimated a CFR of 3.9% for outbreaks that have occurred during the period between 1997 to 2010 (totalling ~68,522 clinical cases and 2641 deaths). The risk of cholera outbreak remains high at national and regional levels with 7 (out of 47) counties and 25 (out of 290) sub-counties mapped as high priority based on high incidence and high persistence of cholera. About 10% of the Kenyan population (4.89 million) is living in these 30-combination high-priority sub-counties.

Table 8: Trend in outbreaks in the country

Period	Number of cases	Number of deaths	Case fatality rate (CFR)
1997-1999	26,901 cases	1362 deaths	5.1% CFR
2007-2009	16,616 cases	454 deaths	2.7% CFR
2022-2024	12,521 cases	206 deaths	1.7. % CFR

Figure 5: Epicurve – cholera outbreaks in Kenya between 1997-2021



The capacity in country to respond to outbreaks has increased over recent years as illustrated by the last outbreak response in which Kenya was able to leverage existing response systems and resources. Through an After-Action Review (AAR) conducted following the national response to the cholera outbreak, the Ministry of Health and stakeholders were able to document a number of pre-existing capacities and resources that were in place prior to the cholera outbreak across key pillars of the response (surveillance, case management, ICP, WASH, laboratory, OCV) and contributed to strengthen the emergency response. This included existing plans and policies to guide and inform activities, available resources such as trained human resources and healthcare workforce and active Community Health Promoters (CHPs), existing health systems such as reporting systems and referral systems, available infrastructure for service delivery and case management such as designated cholera treatment centres, equipped healthcare facilities for referral of complicated cases - ICUs, preparedness activities e.g., cholera hotspots mapping, water quality surveillance, availability of emergency financial resources (e.g., for surveillance) and existing national and subnational coordination mechanisms, Public Health Emergency Operation Centres (PHEOCs) as well as technical and coordination committees.

Stakeholders interviewed also highlighted key progress in the country response mechanism and activities notably in terms of coordination between players to enable faster data sharing and joint approach for responding to outbreaks, which has enhanced response effectiveness. This includes coordination between partners and government as well as across partners and between ministries such as the Ministry of Health and MoW. The surveillance pillar was also highlighted as an area of good progress, notably in the area of port health, where country capacity has increased with the expansion the Port-Health technical capacity within the Ministry of Health "from a unit to a division of health department" and the introduction of new surveillance efforts, a progress largely attributable to the recent COVID-19 pandemic according to some stakeholders. Water quality surveillance and the use of surveillance data has also been facilitated by the existence of Kenya Health Information System (KHIS) reporting system, and further enhanced by the implementation of Indicator Based Surveillance (IBS) and Event Based Surveillance (EBS) in both community and health facility settings (that had been expanded in response to the COVID-19 pandemic).

Technical and implementing partners play a critical role in supporting the country and strengthening their capacities for preparedness, early detection, and response to outbreaks, including the most recent one. Key areas of support provided by partners include case management and service delivery (e.g., with partners such as MSF), implementation of WASH activities (e.g., key support from UNICEF), Risk Communication and Community Engagement (RCCE) activities (e.g., by WHO, IOM, AMREF, Kenya Red Cross), capacity building of healthcare workforce and human resources, delivery of essential commodities such as emergency and cholera kits, rapid diagnostic tests (RDTs), and WASH supplies. Stakeholders interviewed also highlighted the essential role of partners to facilitate, and participate in coordination efforts during outbreaks and emphasised the "*deliberate efforts to ensure open collaboration and sharing of information this time*" which led to significant improvement during this last response compared to 2020. As highlighted in Section 2.2., coordination was especially strengthened by partners such as WHO and UNICEF who were able to facilitate coordination between partners (on the health and WASH side respectively) by setting up additional taskforces. The availability of guidelines and tools from the GTFCC was also cited as highly useful especially in areas such as surveillance and IPC/ WASH.

The implementation of a reactive OCV vaccination campaign, as part of a multifaceted response, was a key success factor in the last response to effectively interrupt transmission of the disease and control the outbreak. As part of the response, the country was approved for OCV in 2022 from the International Coordination Group (ICG) and was able to implement a reactive vaccination campaign (though a single dose strategy) for the first time. In the February 2023 campaign, 2,033,999 people were immunised and in the

August 2023 campaign, 1,675,043 people were immunised to help the country curb the outbreak.[27] Stakeholders also commented on the efficiency and effectiveness of the reactive OCV vaccination campaign, which was delivered as part of a multifaceted response, with the support of all key partners in countries as well as through cross-sectoral coordination between relevant government ministries.

Stakeholders interviewed highlighted the active role of partners to enable these vaccination campaigns, including from the GTFCC which was said to have played a critical role in this endeavour. In-country stakeholders highlighted the active support they received from the GTFCC through the OCV WG (focal point) to prepare and deliver these campaigns by coordinating frequent engagement where WHO and national colleagues were able to participate, maintaining good communication with the WHO country team throughout the process, helping to review and strengthen the country OCV application and supporting capacity building of national actors to deliver the campaign. Stakeholders also highlighted the impact of concerted and coordinated efforts among in country-partners which were able to leverage their respective capacities to support the planning and delivery of the campaign (e.g. UN and other partners supported the government based on their comparative advantage, such as UNHCR who facilitated entry points to informal settlement populations).

These OCV campaigns were also key examples of successful cross-sectoral coordination between relevant government ministries at national and county level which were able to coordinate cross-sectoral interventions and integrate other response activities in this campaign. For example, the Ministry of Water, Sanitation and Irrigation Services (at national and county levels) was actively engaged in the planning and delivery of the campaign to integrate WASH activities such WASH sensitisation, RCCE, and awareness raising during vaccination activities. Health promotion departments at national and county facilitated a multipronged promotion campaign by using community health promoters (CHPs) and champions in communities (e.g., community leaders, schools, women groups) as well as leveraging social media e.g., through WhatsApp groups, to encourage vaccination uptake, alongside other risk communication messaging.

As a result of these efforts, the campaigns were successfully implemented in eight high burden counties.[28] Post-vaccination coverage surveys reported high vaccination uptake (99.2% for the February campaign and 91.8% for the August campaign).[29,30] Beyond curving the outbreak, stakeholders emphasised the window of opportunity provided by this campaign to increase cholera control measures and preventative interventions and accelerate efforts to implement the 2022-2030 NMCEP to avoid further catastrophic outbreak in the country.

However, stakeholders also highlighted several issues and gaps within Kenya's cholera response that limit the effectiveness of cholera control measures and preventative interventions. This includes:

- The persistence of cross-border transmission exacerbated by large movement of people due to conflicts, movement of nomadic pastoralist communities, cross-border trade, and insufficient cross-border coordination between partners.
- Cross-county transmission which accelerates transmission during outbreaks between neighbouring counties and disease spread between urban and rural areas.

[27] Kenya Ministry of Health (2024) and WHO Kenya. Reactive Oral Cholera Vaccine Campaign Report (Kenya), February 2023

[28] (Garissa (Dadaab Refugee Camps), Homabay (Suba South) Wajir North, Nairobi (Embakasi Central & Kamukunji), Kajiado East & Marsabit (Moyale) and identified security confinements and learning Institutions in Machakos County (i.e. Prisons and schools in Machakos)

[29]Kenya Ministry of Health (2023), Post Oral Cholera Vaccination Coverage Survey – August 2023

[30] Kenya Ministry of Health, Directorate of Public Health Division of Disease Surveillance and Response, Oral Cholera Post-vaccination – Campaign Survey Report

- Poor surveillance and access to health services in informal settlements and camps such as Kakuma and Dadaab that offer fertile ground for mass contamination and fast spread of the disease.
- The deployment of rapid response teams (RRTs) to support counties has also been cited as a key challenge which causes delays between the disease onset and initial case reporting and implementation of the response.
- The subnational/ county capacity for laboratory diagnosis of cholera is inadequate according to stakeholders and as reported in the recent outbreak AAR, notably due to a lack of well-defined sample referral systems within the counties and national level for collecting, transporting and shipping outbreak samples to the national laboratory, unclear responsibilities between laboratory and surveillance offices, lack of adequate transportation capacity to facilitate transport from peripheral sites, lack of cholera guidelines and inadequate training of lab personnel leading to incorrect sampling and results, compounded by a shortage of laboratory staff due to staff turnover and budget constraints as well as a lack of laboratory supplies (e.g. cholera testing kits and PCR test).
- Despite the progress made so far in the surveillance pillar, data quality and completeness (e.g. epidemiologic data) continue to be an issue with suboptimal data collection practices, lack of standardisation, and difference in availability of data between counties. Stakeholders also flagged challenges in coordination between the national and county level government hindered in part by inherent challenges in the current devolution system[31] as well as limited capacity by national actors in some counties (e.g., competing priorities for disease control such as Marsabit County which had both cholera and malaria outbreaks concurrently and limited capacity to effectively respond to both diseases).

Prevention of disease occurrence through targeted multi-sectoral interventions in cholera hotspots

Stakeholders highlighted the development of the 2022-2030 Kenya National Multisectoral Cholera Elimination Plan (NMCEP) as a key success to enable a strategic and multisectoral approach to cholera elimination, although implementation remains a key issue. The NMCEP is a multisectoral and multiyear plan which offers a clear roadmap to implement priority cholera control and preventative interventions with the objective to eliminate cholera in the country by 2030. The plan benefits from high-level endorsement in the national government and has been co-signed by the Ministry of Health and the Ministry of Water, Sanitation, and Irrigation. The plan formulates government ambition for eliminating cholera through government approach and a well-coordinated multi-sectoral endeavour that emphasizes continuous prevention effort beyond the traditional focus on outbreak response only. Stakeholders lauded the comprehensiveness of the plan, in terms of its content which provides a clear situation analysis of the cholera landscape in the country with key risks factors and identified hotspots, as well as outlining key activities across all strategic pillars of cholera control and prevention. The plan also identifies and strengthens the linkages between government entities and key partners and outlines the areas, roles, and responsibilities where each actor can contribute and offer significant added value depending on their mandate. Efforts will focus on cholera high risk areas that include those commonly affected by floods and drought, low-income urban areas, refugee camps, and cross border interventions. The NMCEP also includes a monitoring plan that outlines indicators, targets (against baselines), and responsibilities for tracking progress across each pillar, provides tools to conduct rapid

[31] Under the devolved government, mandate and authority for health service delivery, planning, management and budgeting was transferred to county governments while the national government retained policy and regulatory functions.

assessments on preparedness and response activities across the six pillar areas at county/ sub-county levels, and estimates the financial costs required to implement some (though not all) activities. The support of the GTFCC was also flagged as instrumental in developing this new plan as reported in the sections above, and a review of the IRP assessment reports provides evidence of feedback that were provided to strengthen the technical and operational content of this plan.

However, whilst the development of a comprehensive strategic plan for cholera elimination is a positive result on its own, stakeholders emphasised the importance of implementing that plan and flagged the potential challenges that may hinder this implementation. These include:

- Dissemination: A first challenge lies in the lack of dissemination of this plan at national, subnational level, and across stakeholders. Several in-country partners and county stakeholders interviewed were not aware of the existence of the NMCEP or its content, due in part to the fact that the plan had been endorsed but not yet launched at national level. In the absence of a formal launch and active dissemination of this plan, the extent to which other relevant national plans (e.g., from the WASH sector) and county level strategic plans are aligned to the NMCEP is unclear. For example, the Kenya Rural Sanitation and Hygiene Roadmap (2023-2030), another comprehensive national strategy from the Ministry of Health that outlines national priorities for WASH in rural areas of the country, makes no refence to the NMCEP or cholera.[32]
- Prioritization and stakeholder engagement: Stakeholders highlighted missed opportunities to integrate cholera as a key priority in relevant partners strategic plans and align efforts across stakeholders and between sectors (e.g., promoting the prioritization of cholera hotspots for WASH interventions). Some reported that they were not involved in developing the plan or had only informally come across at a later stage. As such, whilst stakeholders considered that most partners interventions are somewhat aligned to what is proposed in the NMCEP, they shared that an earlier involvement at design stage would provide an opportunity for strong endorsement of the NMCEP across all partners and intentional alignment of their activities and priorities with the proposed approach in the NMCEP.
- Monitoring: Whilst the NMCEP contains an M&E plan, stakeholders highlighted that monitoring of progress across all pillars remains a key issue. The lack of dissemination of the current plan and lack of joint monitoring and evaluation framework agreed across all sectors and partners, prevents comprehensive visibility on ongoing activities that contribute to this plan and hinders continuous assessment and adaptation where needed. As such, whilst the NMCEP is already being implemented as interventions are ongoing in the country, there is no clear picture on the progress achieved to date and areas of challenges.
- Funding: Effective implementation of this plan is limited by a lack of a full costing for the plan (as the NMCEP only includes costs for some interventions) and lack of clear modalities for sustainably financing the plan especially the long-term prevention and WASH components. There was no official figure found on the current level of funding of the NMCEP and estimated gap in funding. However, insufficient funding has been highlighted as a key weakness in the SWOT analysis presented in the NMCEP across all pillars and stakeholders unanimously recognised the high dependence on donor financing for cholera interventions (for outbreaks response and long-term interventions). This represents a major challenge to the implementation of the plan and sustainability of cholera interventions in the country. Stakeholders flagged the importance of strengthening advocacy and

[32] Noting however that the 2023-2030 Costed Kenya Rural Sanitation and Hygiene Roadmap makes reference to the prevalence of waterborne diseases and diarrhoeal diseases more generally as well as referencing the 2014–2030 Kenya Health Policy

fundraising efforts at the top national leadership level of Government Ministries and partners to ensure effective financing and implementation of the NMCEP.

- Interlinkage of plans: It is also worth noting that this new 2022-2030 NMCEP comes after a number of previous national cholera plans including the 2008, 2009 and 2010 yearly cholera response plans and most recently a Multi-sectoral Cholera Prevention and Control Plan 2011-2016. Whilst no formal evaluation was found to provide a clear picture on the extent to which these previous plans had been implemented, some sources documented key challenges in their implementation included a lack of dissemination between national and sub-national level, sub-optimal multisectoral coordination, lack of funding and persisting gaps in the monitoring of these. Similar challenges have been reported with regards to the NMCEP and the new plan does not yet integrate learnings from earlier plans or include mitigation elements to address these challenges

The identification of new PAMIs provides an opportunity to enhance strategic action for cholera prevention and response, and optimise resource allocation towards priority areas, but will require ownership and consensus across sectors. The GTFCC was able to support the Government of Kenya to implement a PAMIs assessment in 2024 and enable the implementation of targeted approach to effectively control and eliminate cholera in the most at-risk areas. This new mapping provides an updated situation analysis of areas where cultural, environmental, and socioeconomic conditions facilitate the occurrence and transmission of disease and will now replace the current hotpots included in the NMCEP. This new assessment was based on (i) a comprehensive analysis of epidemiological data across the previous six years (Jan 2018 - Dec 2023); (ii) key indicators such as incidence, mortality, persistence of the disease, testing coverage; (iii) geographical, contextual factors; (iv) vulnerability indicators such as access to water and sanitation services, population density, presence of at-risk populations (refugees, fishing community, and mining populations) and (v) areas subject to extreme climate events, and areas bordering identified cholera hotspots in a neighbouring country etc. Stakeholders were highly positive about the availability of this new PAMIs assessment, which in their opinion offers a more comprehensive approach to identify high risk areas compared to the previous approach. As one stakeholder said, "*The previous hotspots only used epidemiologic and WASH data. The new PAMIs now have more comprehensive risk indicators including contextual factors which helps enable better use of multisectoral interventions*."

However, stakeholders highlighted the importance of disseminating the new PAMIs across stakeholders and ensuring partners and actors in other sectors are aligning their interventions accordingly. At the time of conducting this case study, the new PAMIs had not yet been disseminated and were still due to be updated in the NMCEP. As a result, many partners were not aware of these new PAMIs, which prevented their ability to align their activities accordingly. In addition, partners flagged the need to align the PAMIs approach with other existing methodologies especially for WASH interventions, which focuses on priority areas with highest rates of open defecation. Currently, the 15 priority counties with highest rates of open defecation and prioritized for WASH investments are mostly aligned with the priority areas for cholera interventions identified through the PAMIs. However, stakeholders highlight the risk that priority areas may diverge if methodologies are not aligned, especially for long term WASH actors that may be less engaged in health forums. As one stakeholder noted, *"PAMIs need to be brought to WASH sector and align with their priority areas so they can also target these interventions, for both WASH in the water sector and WASH in health sector."*

Slow progress in WASH remains a key issue overall despite recent progress in WASH in the country. The government of Kenya has made sanitation and hand hygiene a development priority, integral to the Kenya Vision 2030, the country's long-term development plan. Thanks to this political will and increased efforts in this area, key WASH indicators have been improving in the country. Between 2010 and 2022, open defecation

was reported to have declined from 12.8% to 6.5% at national level and approximately 60% of Kenyans have access to safe drinking water.

However, stakeholders emphasised the need to accelerate WASH investments and interventions, as significant challenges remain. In 2022, 63.5% of the population still did not have access to basic sanitation and approximately 17 million people still require assistance to access safe drinking water and sanitation services. Stakeholders also noted high disparities between progress in rural and urban areas. Open defecation is practiced more in rural areas than urban areas, and over 44% of Kenyans living in rural areas do not have any handwashing facility on premises. Funding for WASH also remains a major issue. The government reported that only 16% of total investments needed to implement the Costed Kenya Rural Sanitation and Hygiene Roadmap have been made against the KHS256 billion (US$2.23 billion) required. Despite efforts to scale up RCCE activities and sensitise the population towards healthier WASH practices, challenges in access to safe water and sanitation leads to households reverting to non-safe practices following outbreaks such as open defecation, drinking untreated water, not practicing handwashing, indiscriminate waste dumping etc. Stakeholders flagged the need to increase domestic capacity and resources for water testing, quality control and treatment, and ensure WASH investments are continuous beyond outbreak response interventions for sustainable prevention of cholera. The role of the private sector has been highlighted as particularly key in this area and stakeholders emphasised the need to boost private sector participation through Public-Private Partnership (PPP) as well as better involvement of private actors in cholera planning to align WASH interventions.

Effective mechanism of coordination for technical support, resource mobilization, and partnership

The majority of stakeholders who were aware of the GTFCC shared positive feedback in terms of its support through the CSP, IRP, OCV WG, and Secretariat for coordination in country and consolidation of national capacity to implement key interventions. Kenya has received support from the GTFCC in the past four years, including:

- Technical support by the CSP to implement a PAMIs analysis. Stakeholders shared that this support provided through a dedicated consultant assigned to the country for this exercise, brought a much needed additional technical and administrative capacity for conducting the PAMIs, in particular to facilitate data collection at national and subnational level, data analysis and interpretation of results, and validation across stakeholders. The new PAMIs are due to be integrated into the NMCEP implementation.
- Technical support by the IRP for the NMCEP review. This support was said to have been timely and helpful, especially to strengthen the NMCEP alignment with the Global Roadmap. The new Kenya NMCEP for 2022-2030 was subsequently approved by the GTFCC. Whilst the IRP review in itself provided some benefits to strengthen the country plans content and alignment with the Roadmap, the extent to which a formal GTFCC endorsement at the end of this process provided tangible added value to the country was unclear. A small number of stakeholders fed back that they see limited added value of this endorsement, which does not come with tangible incentive mechanisms compared to other GTFCC tools such as the PAMIs which is required before being approved for OCV support.[33]

[33] Stakeholders reported that the acceptance and review of countries OCV request to the ICG is conditioned to satisfactory presentation of evidence that a PAMIs exercise has been conducted at country level to inform OCV campaign implementation, which has been a strong incentive promoting the uptake of PAMIs.

- The Secretariat is supporting the country, especially in terms of monitoring outbreaks. They supported coordination during the IRP review process of the NMCEP, which stakeholders consider enabled an efficient review process, notably through the biweekly meetings coordinated by the Secretariat (which included members of the GTFCC, WHO country office, WSU, and ministry staff) and regular check-ins to identify additional needs for further support. As one stakeholder said, *"The Secretariat really helped to push the NMCEP review process, especially during the Covid period."*
- The support provided by the OCV WG was said to have been instrumental to enable the country to submit their request for emergency OCV and receive vaccines for the first time. Stakeholders commented on the timeliness and usefulness of their engagement with the GTFCC OCV WG, which enabled their application to be processed efficiently and aided the country to contain and curb their last major outbreak.
- Beyond direct technical support, many national stakeholders also reported using GTFCC website and app to access available tools and guidance. The app in particular has enabled access to GTFCC resources to stakeholders across the country including at county level, complementing the more traditional technical assistance delivered through direct support mostly at national level.

Factors influencing implementation of the Roadmap

Open defecation, high population density, cross-border movements of persons, transmission in crowded settings amongst refugees and internally displaced persons as well as during mass gathering events, and changes in rainfall patterns have been flagged as key risk factors for cholera in the country. The recent cholera outbreak in the country, linked to mass gathering activities in urban settings, like weddings, highlighted the need to strengthen food safety as well as bringing stakeholders' attention to the risk of cholera outbreak in urban settings beyond rural areas. The lack of access to safe water and appropriate sanitation continues to hinder efforts to reduce harmful practices such as open defecation and increases the risk of water contamination and cholera incidence especially in the poorest populations. Extreme climatic conditions and adverse weather events such as flooding and prolonged drought periods have also contributed to exacerbate cholera outbreaks in the country. In addition, stakeholders pointed that the recent cholera outbreak occurred in the context of increased risk factors for cholera including subregional conflicts, insecurity in the Horn of Africa, complex humanitarian emergencies and associated rise in refugees, and overcrowding in refugee camps. Population density, exacerbated by unplanned urban development and the growth of informal settlements with poor access to safe water and sanitation infrastructure increases the risk of cholera in the country. This is further compounded by population movements within the country (e.g., between counties) as well as between neighbouring countries, including nomadic pastoralist communities and people movement due to trading activities (e.g., truck drivers).

Inadequate financial resources and sub-optimal domestic capacity continue to be a critical challenge hindering effective cholera prevention, readiness, preparedness and response.

At the same time, a number of enabling factors contributed to supporting country progress on cholera control. The majority of stakeholders highlighted the strong national engagement in the last outbreak and the endorsement of the NMCEP at the highest levels of national ministries as key factors that have contributed to recent progress in the fight against cholera in the country. The devolution model of governance also provide both benefits, e.g., in decentralising decision making for health, promoting county's ownership of cholera interventions and better contextualisation of national plans at priorities depending on county's needs, as well as challenges for cholera control, e.g., potential gaps in coordination between national and county level, risk of

delay in outbreak notification and response initiation. In addition to this, strong political engagement and support from technical and implementing partners, including the GTFCC through ways mentioned above, have been instrumental in responding to outbreaks and the progress in preventative measures. Whilst the impact of COVID-19 has been cited as a challenge, including in the disruption of routine services and added strain on limited government capacity, it has also enabled the country to strengthen a number of preparedness and response systems, including port health and surveillance systems which have benefited cholera response.

2.5 Sustainability

Q 8: What steps has the GTFCC taken to ensure the sustainability of its interventions under the Roadmap?

Ensuring sustainability continues to be a challenge overall. A critical challenge to the sustainability of cholera interventions remains a high level of dependency on unpredictable and decreasing donor funding. This emphasises the need to identify more sustainable sources of funds, especially for preventative interventions, including domestic resources to fund the NMCEP and cholera activities overall. Stakeholders also reiterated that strategic investment in long term WASH in PAMIs is necessary to prevent cholera reoccurrence in a sustainable way and accelerate progress towards elimination. On the other hand, one good example in relation to sustainability that stakeholders highlighted is the commended use of community health promoters and health promoters as an essential practice to sustain interventions such as RCCE and behaviour change in communities beyond outbreak responses.

2.6 Gender, equity and human rights (crosscutting)

Q 9: To what extent has the Roadmap included GER concerns? To what extent have implementation activities factored equity considerations at the global and country level?

The use of disaggregated data from the Kenya HIS data and collaboration with key partners, such as the UNHCR and IOM, have helped enhance gender, equity and human rights consideration in cholera interventions. The Kenyan Health Information System has been instrumental in guiding implementation activities by providing vital sub-county population data, including specific insights from UNHCR regarding refugees and asylum-seekers. Collaboration with partners like UNHCR and IOM is essential for reaching underserved populations, including refugees, IDPs, and residents of informal settlements. However, challenges persist in data reporting and quality, particularly in the completeness and disaggregation of data for vulnerable groups. Stakeholders have shared that better data analysis, integrating disaggregated reporting by gender and age, and enabling better monitoring of affected demographics are crucial to inform decision making and enhance equity.

While Kenya's NMCEP does not directly engage with issues of gender equality, it includes people with disabilities as part of its WASH objectives. Stakeholders noted the need to integrate considerations of gender equity and sustainability into planning documents, ensuring that interventions are inclusive, such as accommodating the needs of disabled individuals in water access solutions. Overall, while current interventions largely focus on the general population, incorporating a deeper understanding of the unique challenges faced by marginalized groups, is essential for achieving progress in cholera control.

Conclusion

This mid-term evaluation case study has found that Kenya has benefited from strong support from the Secretariat, CSP, and long-term support from US CDC through Washington State University for technical assistance. This has all been seen as valuable support by the country and supported development of the NMCEP, undertaking of hotspot mapping and the more recent PAMI assessment and implementation of the OCV campaign.

The case study emphasizes the importance of the Kenya NMCEP, which aligns with the GTFCC's Global Roadmap, targeting cholera hotspots through a multi-sectoral approach. The NMCEP has led to improved response mechanisms during outbreaks, enhanced surveillance, and better coordination among national and international stakeholders. The country has seen successes in reducing cholera-related deaths through coordinated efforts, including reactive OCV campaigns and partnerships with agencies like UNICEF, WHO, and local government.

However, key obstacles have also been identified that hinder the full realisation of cholera elimination. These include limited funding, fragmented coordination outside of outbreaks, and gaps in long-term WASH interventions, particularly in rural and high-risk areas. While the NMCEP is a strong strategic framework, its implementation remains inconsistent, particularly due to challenges in funding, stakeholder alignment, and cross-border coordination that exacerbate risks of cholera transmission.

Sustainability remains a significant challenge, with cholera prevention efforts being heavily reliant on donor funding. The case study suggests a need for stronger domestic investment, better dissemination of strategic plans like the NMCEP, and continuous capacity building at both national and county levels. Lastly, the integration of gender equity and human rights considerations into cholera interventions is essential to ensure that marginalized populations, including refugees and residents of informal settlements, are adequately supported.

While Kenya has made commendable progress in cholera control, sustained efforts, increased funding, and more robust coordination mechanisms are necessary to eliminate cholera by 2030, as outlined in the NMCEP. The continued support from the GTFCC, alongside stronger domestic commitment, will be important in addressing these challenges and achieving long-term cholera prevention.

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Consultee list

The case study was informed through consultations and focus group discussions with the following entities stakeholders:

Stakeholder group	Organization (# of consultees)
Government - national level	Ministry of Health (3)
	Ministry of Health / WASH (1)
	Ministry of Water and Sanitation (3)
Government - county level	Kajiado County and Kajiado-East sub-county (14)
	County MoW (2)
Partners	US CDC / Kenya country office (1)
	IOM (2)
	MSF (1)
	KEMRI (1)
	Kenya Red Cross (1)
	UNICEF / WASH (1)
	UNICEF / Health Emergency (1)
	UNHCR (1)
	USAID (1)
	Washington State University (1)
	WHO / Epidemic Preparedness and Response (2)
	WHO / Public Health (2)
	WHO / Laboratory (1)
	WHO / RCCE (1)

Country case study Nepal

This Nepal country case study supports the Mid-term Evaluation of the Global Task Force on Cholera Control (GTFCC). Following background information and country context (Section 1), country-level findings are presented for each of the evaluation criteria (Section 2): relevance (Section 2.1), coherence (Section 2.2), efficiency (Section 2.3), effectiveness (Section 2.4), sustainability (Section 2.5) and gender, equity and human rights (Section 2.6). A final conclusions section based on these findings from Nepal follows (Section 3).

1. Introduction, background and country context

1.1 Introduction

This case study is one of six case studies which have the purpose to generate evidence for evaluation questions set out in the evaluation framework and be an important evidence base for findings in the main evaluation report. This includes questions relating to (i) the work of the GTFCC and (ii) implementation of the cholera Roadmap from a country perspective.

Countries were selected to allow for diverse representation across key criteria for the evaluation and permit a deeper assessment of successes, challenges and lessons pertaining to the work of the GTFCC and the Roadmap. For Nepal, this included: (i) being on the Roadmap priority list; (ii) being a country that has received support from the GTFCC and is not a country support platform (CSP) supported country and (iii) has received support to develop Priority Areas for Multisectoral Interventions (PAMIs) and have a draft National Cholera Plan (NCP).

1.2 Methods

Data collection methods for this case study included a review of key documentation and focus group discussions (FGDs) and stakeholder interviews. Key informants were purposefully selected to take part in interviews and FGDs. They were selected to ensure there was a mix of stakeholders from government including different national level ministries (e.g. health and water), representatives from different GTFCC partners (e.g. WHO, UNICEF, IFRC), and those who could speak to different pillars of the cholera Roadmap (e.g. laboratory, surveillance, oral cholera vaccine (OCV), WASH etc). Key informant interviews (KIIs) and FGDs were conducted remotely using a semi-structured interview guide. In total, 13 KIIs were conducted with informants based in Kathmandu, India, Bangladesh (regional stakeholders) and one in the USA. Data from KIIs and FGDs were triangulated with other sources of evidence to develop the findings for this case study.

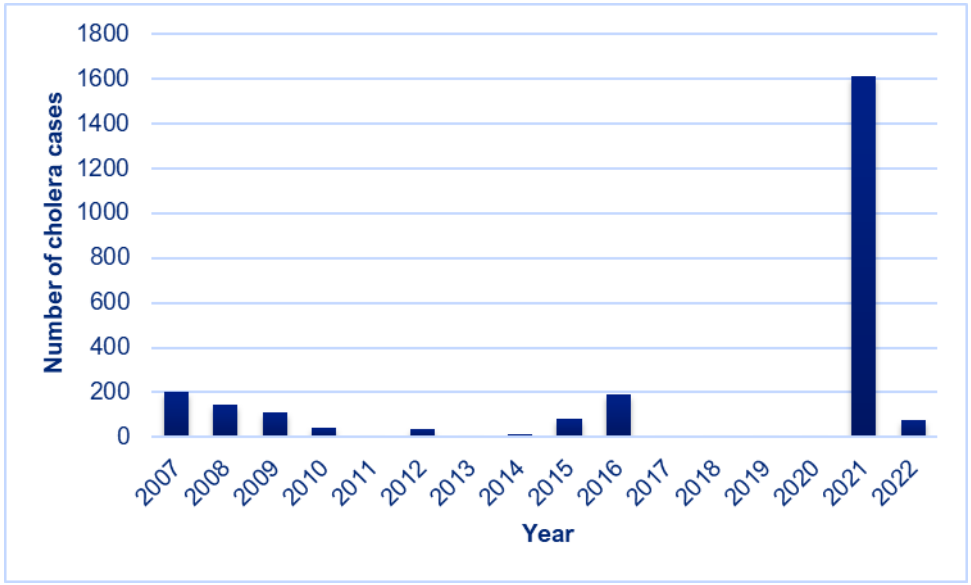
Limitations include the limited number of key informants in part due to interviews being conducted remotely, and in part due to the limited availability of key stakeholders during the timeframe for the evaluation. There were also some data limitations including in particular the lack of specific data for gender and equity related to cholera beyond geographic differences in incidence and persistence of cholera in the draft PAMI report and gender-related WASH data.

1.3 Key country characteristics and cholera context

Nepal is a landlocked country located in South Asia, with China to the north and India to the south, east and west. Nepal is a low-middle income country, with over 79% of its 29.2 million population based in rural areas, though the country is considered to be rapidly urbanising.

Nepal has periodic epidemics of communicable diseases, epizootics, and natural calamities such as floods, landslides, and earthquakes. Its vulnerability is accentuated by its unique geographical landscape and topography which causes climatic variations which harbour disease vectors differently, and has resulted in variable infrastructure which can affect accessibility of people and goods. Nepal is endemic for cholera, with ongoing regularity of, and potential for, large outbreaks. It is estimated that over 18 million people, more than 60% of the Nepalese population, are at risk of cholera. The average incidence rate of cholera is 1.64 per 1,000 and an estimated 30,000 cases annually, with a case fatality rate of 3%. Cholera is typically detected each year from the beginning of the monsoon season (May to September), usually in the Kathmandu Valley, which includes Kathmandu, Lalitpur, and Bhaktapur districts, though outbreaks can be seen across the country, which also complicates the prediction of outbreak locations. The draft PAMI report reports 21,029 suspected cholera cases from 2019-2023 with variability seen in cholera incidence between provinces, months and across years. As of 29th of September 2024, there were 95 reported cases of cholera in Nepal. In 2023, six autochthonous cases were reported for cholera in Nepal. The number of cholera cases in Nepal over the years are presented in Figure 6.[34]

Figure 6:Cholera cases in Nepal (2007-2022)



Different factors contribute to the high risk of cholera in Nepal. These include limited access to clean, safe drinking water, inadequate sanitation and hygiene, poor wastewater management and sewerage infrastructure, seasonal flooding caused by monsoon rains, population movement and overcrowding, health infrastructure gaps, and insufficient public awareness.[35] According to the MICS 2019 survey and in line with

[34] Cholera cases in 2021 were high due to an outbreak in Kapilvastu District, a border region with India. This region is highly vulnerable to outbreaks due to the porous border and poor WASH conditions.
[35] Dr Rajesh S. Pandav, WHO Representative: Nepal. 9th GTFCC Annual Meeting, 27-28-29 June 2022

WHO and UNICEF Joint Monitoring Programme data, almost all households have access to basic water services (94%) but only four in five Nepali households have access to safe drinking water in sufficient quantities. More than 80% of Nepali households have drinking water with moderate to very high levels of E. Coli contamination (>10 cfu/ 100 ml). Two in five (39%) households reportedly do not have access to safely managed sanitation with 21% still unable to access basic sanitation services at all. Open defecation is still practiced in some areas.[36] In addition, flooding and landslides during the rainy season can lead to breakdowns of already fragile water and sanitation infrastructure. The migration pattern from mountainous and hilly regions to the flat plains of Terai, which has accelerated in recent decades owing to various environmental, social and economic drivers, also exacerbates the risk of cholera as this unplanned population movement exerts additional strain on the already fragile healthcare and water sanitation and hygiene (WASH) infrastructure in urban and Terai regions. In recent years, cholera cases have also been reported during the winter season, potentially exacerbated by the effects of climate change. The Government of Nepal (GoN) spends a little over 4% of its GDP on healthcare, with most of its healthcare expenses allocated to treatment. Overall, Nepal's public health infrastructure is considered underdeveloped and stretched in its capacity to meet the population's healthcare needs.

1.4 Governance structures for cholera management

Nepal became a federal republic following the implementation of the new constitution in 2015. The new federal structure has three levels of governance: a federal government at the central level; seven provincial governments, 753 local municipalities, including six metropolises, 11 sub-metropolises, 276 municipalities and 460 *gaunpalikas* (rural municipalities), each with their own executive body and administrative powers. The Epidemiology and Disease Control Division (EDCD), under the Department of Health Services (DoHS), one of three departments within the Ministry of Health and Population, is primarily responsible for the management of cholera and acute gastroenteritis (AGE), along with other infectious diseases, spanning the implementation of public health policies, coordination of surveillance, control and preventive activities (such as vaccination), as well as responses to outbreaks. Owing to the decentralised structure, the provincial level Ministry for Social Development or Ministry of Health (the name can differ by province), have greater accountability in terms of actual implementation of health policies, budgeting, and monitoring and evaluation of health programs. The Department of Water Supply and Sewerage Management (DWSSM) under the Ministry of Water Supply (MoWS) is responsible for planning, implementation, operation, repair, and maintenance of water supply and sanitation systems throughout the country, and is the lead implementing agency of the WASH sector. As with all ministries in Nepal, the MoWS also operates through the same decentralised structure.

In 2017, the Ministry of Health and Population endorsed a “National Preparedness and Response Plan for Acute Gastroenteritis/ Cholera Outbreaks” to guide planning and response for cholera preparedness and control in Nepal, to span the period July 2017 to July 2022. The plan aimed to improve the health of citizens by achieving several key goals: reducing cholera incidence, preventing cholera spread, reducing cholera attributed mortality, establishing coordinated and collaborative response to outbreaks, and implementing a rapid response mechanism. A subsequent plan for the control and elimination of cholera is in development (see below).

[36] Dr Rajesh S. Pandav, WHO Representative: Nepal. 9th GTFCC Annual Meeting, 27-28-29 June 2022

1.5 Object of the evaluation and summary of GTFCC support to Nepal

The GTFCC is a partnership of approximately 50 institutions to coordinate activities for cholera control at global, regional, and country levels *(2)*. The GTFCC brings together organizations working across multiple sectors and serves as a coordination platform to support countries in the implementation of the Global Roadmap on ending cholera *(3)*. The Roadmap is underpinned by early detection and quick response to contain outbreaks; a targeted multi-sectoral approach to prevent cholera recurrence; and an effective mechanism of coordination for technical support, advocacy, resource mobilization, and partnership at local and global levels. A key role of the GTFCC is to promote and support the implementation of the Ending Cholera – A Global Roadmap to 2030 at country level by providing the advocacy, coordination, policy guidance and technical assistance necessary for countries to develop National Cholera Plans (NCPs) and implement them effectively. By implementing the strategy between now and 2030, the GTFCC partners will support countries to try to reduce cholera deaths by 90%.

The GTFCC convenes multi-sectoral partners. In particular for countries, the work includes (i) tool development and technical guidance which the GTFCC Secretariat helps to coordinate and GTFCC technical working groups develop; (ii) support to the implementation of these tools and their translation into activities (CSP support[37] in a small number countries and technical assistance provided by partners) and (iii) the independent review panel (IRP) has reviewed NCPs in a small number of countries, and will soon be reviewing in relation to Nepal (see below).

Nepal is in early stages of formal engagement with the GTFCC, though Nepal has been informally engaged with the GTFCC for several years, having participated in General Assemblies, working sessions, annual meetings, and many of the technical working group activities. It is understood that this collaboration has led to some exchanges around PAMIs identification, surveillance system and response to cholera outbreaks. This is in addition to routine interactions between WHO Cholera Programme and the Ministry of Health and Population in relation to annual cholera and case fatality data (required by all member states), advocacy for and technical support to launches of cholera vaccine campaigns (involving in particular WHO and the Bill and Melinda Gates Foundation (BMGF)), and financial support from GTFCC to Ministry of Health and Population technical staff to enable engagement in regional and international dialogues on cholera.[38]

During the General Assembly in 2023, representatives of Nepal authorities expressed willingness to develop a NCP, and options were discussed with the GTFCC. In 2023, Nepal was identified by GTFCC, among several other countries, as a potential country to be supported by the GTFCC operational arm, the CSP, in its expansion phase. Through 2024, Nepal has received technical and financial support[39] from GTFCC in two key areas, both channelled through the International Federation of Red Cross & Red Crescent (IFRC), the nominated representative of the GTFCC CSP (which is seen as the GTFCC focal person according to country informants):

- Support in the implementation of the Priority Areas for Multi-sectoral Interventions (PAMI) process, commissioned by the DoHS, and conducted during April-June 2024. The aim of the PAMI was to

[37] The CSP was established in 2020 and leads the multi-sectoral support that the GTFCC provides to countries for the implementation of their NCPs. The CSP supports the short, medium and long-term deployment of GTFCC multi-sectoral expertise in countries. Five 'primary operational countries' have received substantial support: Bangladesh, Democratic Republic of Congo (DRC), Mozambique, Nigeria and Zambia. In addition, another four countries have received ad-hoc technical support.
[38] Specific details of the volume of financial support are unavailable.
[39] Specific details of the volume of financial support are unavailable.

compile and synthesise evidence on cholera incidence and burden in Nepal; review cultural, environmental, and socio-economic conditions that facilitate disease transmission; and assess recent cholera control and preventive efforts, as a basis for identifying disease 'hotspots' and developing the new NCP. The PAMI is currently in the final approval processes within the Ministry of Health and Population. Once approved, it will be shared with the GTFCC for final approval.[40]

- Support in the drafting of the NCP, based largely on the draft PAMI process, with the goal of reducing morbidity and mortality due to cholera by 90% by 2030, in line with GTFCC control and elimination targets. The first phase will cover a period of four years (2025 – 2028) with a focus on enhancing control measures, including preventive vaccination in 2026-2028 in PAMI districts. The second phase will cover a period of two years (2029 – 2030) with a focus on initiating activities to eliminate cholera. The Plan provides guidance on a multi-sectoral approach to combatting cholera through addressing and strengthening six measures (leader and coordination, surveillance and reporting, case management, oral cholera vaccine, water and sanitation, and community engagement) and emphasises the support needed from government and partners to increase support for cholera control. The NCP will also complement the government's other efforts to attain the SDGs, specifically as outlined in the 16th National Development Plan (2024-2028), Nepal Health Sector Strategic Plan (2023 – 2030) and Nepal Water Supply Sanitation and Hygiene Sector Development Plan (2016 -2030). The Nepal Health Sector Strategic Plan (2016-2030) is aimed to ensure the health rights of all citizens in Nepal and specifically highlights the multisectoral collaboration and health in all policies as a guiding principle in line with the NCP's emphasis in multisector action on cholera. Furthermore, the Nepal Water Supply Sanitation and Hygiene Sector Development Plan 2016-2030 outlines progressive realisation of safely managed services, acknowledging the need to move beyond basic services and support reliable, accessible and functional WASH services for all, a necessity highlighted in the draft NCP. The NCP, when finalised, will also be anchored to the National Public Health Services Act, 2075 (2018). The NCP is currently in final draft and there is hope that it will be approved by the GoN and then finally approved by the GTFCC to enable its launch by the end of 2024.[41]

Nepal is now considered by country informants as being in the early stages of becoming a 'CSP country'. At the time of drafting this case study, the technical support from the CSP appears to be becoming more formalised with an official GTFCC mission held in country during the week of 11 November 2024. A GTFCC symposium will also be hosted in Nepal during the 17th Asian Conference on Diarrhoeal Disease and Nutrition (ASCODD), 8-10 December 2024, which will likely further boost engagement and planning between GTFCC and country authorities. A series of working sessions and strategic meetings with national authorities are also expected to be held with the GTFCC Secretariat/ WHO Cholera Programme along with the CSP representative (IFRC) in the coming months.

[40] While still in draft, this document was available to the evaluators to inform this review.
[41] While still in draft, this document was available to the evaluators to inform this review.

2. Key findings

2.1 Relevance

Q1: To what extent is the Roadmap relevant given the changing environment (e.g. epidemiological, political, climate and risk profiles)? To what extent have measures been taken to ensure continuous adaptation of the Roadmap in line with latest international best practices and guidelines, and emerging needs at the country level?

Q2: To what extent is the design of the GTFCC adequate to support the objectives of the Roadmap?

Relevance of the Roadmap given the changing environment

Country and regional stakeholders aware of the Roadmap consider it to be highly relevant to country needs, though there are concerns that the Roadmap's elimination targets may be too ambitious. While many stakeholders were unfamiliar with the Roadmap, on its review during interviews, the dominant perspective from KIs was that the Roadmap was comprehensive and relevant and also considered the shifts in the cholera control and elimination landscape. There was recognition that the Roadmap to some extent is theoretical, hence the need for country specific NCPs. There is validation in the relevance of the Roadmap through its recent use as the core framework for the development of Nepal's NCP, which is aligned with Roadmap scope and goals.

At the same time, it was noted by some stakeholders that the Roadmap is very ambitious, and while there is appreciation of the need for 'stretch targets', there was concern that, while progress is being made in relation to cholera control, elimination targets in particular may be unachievable in the medium term. For example, one KI stated that "*in Nepal, can we eliminate cholera in Nepal by 2030? Can we do it even by 2040? I am not confident on that. When a disease is in the community, you can control it but to eliminate it? It takes a long time*." Stakeholders also mentioned some global shifts which are exacerbating cholera risk and whether these should be better reflected through more realistic elimination targets which may also encourage a broader and more focused engagement effort because they may be seen as 'more achievable'. Specifically noted were climatic factors, given they will likely increase cholera incidence and broaden geographical scope of areas at risk (i.e. as one KI said, "*you are having floods where there were no floods*"), the threat of anti-microbial resistance (AMR) which can pose a significant threat to managing cholera, and the rise in conflicts which complicate both outbreak control and preventive efforts.

There was also some confusion around the GTFCC's country-led strategy which is focused on the reduction of cholera deaths by 90% by 2030, and why there is less emphasis on cases, the primary metric tracked in countries. Many stakeholders also mentioned the use of helpful templates and tools provided by GTFCC to guide the development of the NCP. However, one stakeholder noted that GTFCC guidance on outbreak response seems more reflective of humanitarian contexts involving sporadic outbreaks and the role of cholera treatment centres, which does not relate well to the Nepali context where cholera is endemic, and there are often small pockets of cases across several areas managed by the routine health system.

Design of the GTFCC to support objectives of the Roadmap

GTFCC objectives and activities are overall seen as appropriate for country needs. All stakeholders reported satisfaction with country engagement via the IFRC in relation to the PAMI process and the development of the NCP. Focus is now shifting to the support the GTFCC will be able to provide in terms of advocacy, resource mobilization, and support in encouraging and enabling multi-sectoral engagement and collaboration, once the NCP is approved. As one stakeholder conveyed, "*with the history of low political commitment to cholera in our region, it will be incredibly challenging. We have some of the best brains working at GTFCC and the right technical know-how, but it is where rubber meets the road that is hard*."

There was positive recognition that GTFCC's support is to enhance what is being done at country level and is seen as boosting government accountability, focus, and responsiveness to the idea of working at a multisectoral level, given "*multisector work is challenging, so if there are clear cut guidelines like a Roadmap, it is easier to work with key stakeholders*." It was noted by several informants that a dominant challenge for cholera prevention and control is WASH and that more examples and guidance in terms of how GTFCC has mobilized and engaged sectors beyond health, including across response, preparedness and prevention phases and through effective operational platforms, would be helpful.

There is also recognition across stakeholders that the support to be provided by the CSP needs to be ultimately streamlined into national mechanisms. While this is seemingly the overall aim, there is concern that a drive by an 'external programme' may compromise country ownership and raise the need later for an exit strategy, thereby potentially affecting sustainability of progress towards cholera elimination. That said, Nepal's transition to a CSP country is seen by KIs as likely to boost the commitment of technical expertise, and enhance donor commitments and encourage ongoing partner support, which are all welcomed and needed, provided efforts are streamlined and integrated according to national cross-cutting priorities. Stakeholders also currently have a sense that the CSP is available to provide support more with the planning side of cholera control than in relation to acute events, where the responsibility lies with WHO country or regional offices, through which support may come through channels other than the GTFCC. In the case of outbreaks and need for surge response, multiple stakeholders suggested that additional support and linkage between WHO and the GTFCC CSP may be useful, potentially suggesting some confusion around the linkage between the WHO cholera program, the GTFCC and other WHO support mechanisms which could relate to cholera (i.e. the WHO-hosted South East Asia Regional Health Emergency Fund (SEARHEF)).

More broadly, regarding the design of the GTFCC structures, it was raised whether there is sufficient country representation on the global GTFCC Steering Committee. It was observed that membership is dominated by agencies, with less country representation, and predominantly from the health sector, while other sectors such as WASH, community engagement or food hygiene, have less of a presence. It was also suggested that TWG representation was 'technical skills and experience focused' rather than 'country represented' which may be a missed opportunity for valuable input.

2.2 Coherence

Q3: To what extent has the GTFCC, through its governance structures and mechanisms, promoted complementarity, synergy and integration between different members' interventions at the global and the country level? What is the added value of GTFCC members acting together?

Most country level stakeholders are not generally aware of global level coordination efforts under the GTFCC and how they relate to Nepal. Recent GTFCC support has given impetus to more effective coordination efforts in country, though some challenges remain. Coordination structures for cholera in Nepal have been in place for some time and were nominally active under the previous Plan, though they have been reenergised and restructured through the recent PAMI and NCP development processes. This has also enabled the engagement of a wider partnership. The Director General of the DoHS chairs the Steering Committee (SC) for Enteric Diseases, which includes cholera. The Member-Secretary is the Director of EDCD, with other members including representatives from other ministries and agencies, including MoWS, Ministry of Education Science and Technology (MoEST), the Department of Food Technology and Quality Control (DFTQC) under the Ministry of Agriculture and Livestock Development (MoALD), and the Ministry of Finance (MoF). The SC has guided the PAMI and development of the NCP to date and will likely continue to do so after its approval, focusing on the overall coordination of implementation of activities and monitoring of progress. The SC is now supported by six technical working groups (TWGs) led by government, with themes enabling alignment with pillars under the Roadmap: leadership and coordination, surveillance and reporting, oral cholera vaccine, case management, risk communication and community engagement, and WASH. The TWGs are led by government and relevant partners including WHO, UNICEF, International Vaccine Institute's Enhancing Cholera in Nepal (ECHO-N), National Public Health Laboratory, other government and bilateral agencies (i.e. JICA), as well as various local and international NGOs which work on areas such as health education, community outreach, emergency response and WASH (such as WaterAid). When a disease outbreak occurs, the GoN also proactively seeks support from the global community, including WHO (via SEARHEF), and UNICEF regional office, as well as others depending on the need and engagement emphases at the time. This has been the case with recent outbreaks. the time. This has been the case with recent outbreaks.

The TWG meetings have been supported by IFRC, with funding from GTFCC. To inform the PAMI and development of the NCP, several consultations were held with the TWGs to understand the status of implementation, strengths, weaknesses, opportunities, and threats (SWOT) in the respective pillars for cholera control, and to discuss the scope and detail of specific activities to be included in the NCP, which will also ultimately contribute to the Global Roadmap 2030.

There are hopes that formally becoming a CSP country will further boost coordination efforts in country to facilitate effective implementation of the NCP. Many stakeholders noted that the previous Plan did not necessarily provide a useful framework or impetus for engagement, both within government, as well as across external partners, with efforts being largely responsive and focused on outbreaks. That the development of the new NCP has been more consultative is expected to help maintain commitment and engagement of stakeholders. However, there are some key challenges to overcome:

- Once the NCP is approved, there will a need for a concerted leadership effort to "*keep the profile of cholera in the eyes of the stakeholders*" as one stakeholder stated, given both government departments and partners are not accustomed to considering cholera as a priority, required to make solid gains towards elimination as opposed to "*something we live with*" as another stakeholder said.
- How effective coordination of partnership activity will be maintained under the NCP is yet to be seen. There is a need for better definition of roles across partners in line with proposed activities under the NCP, and linkage to wider systems strengthening efforts which may extend beyond the scope of the NCP. How complementarity of activity in both technical and geographic areas across partners will be encouraged and supported is yet to be ironed out. Overall, there is concern that the key/ core partners led by the EDCD will hold operational responsibility for Plan implementation and other

stakeholders' focus will wane once the focus of Plan finalisation has passed. Stakeholders note that upfront financial costings within the Plan and commitments across stakeholders will be key but this step has not yet been made.

- Traditionally, non-health partners have been less engaged in cholera control efforts in Nepal than health-specific partners. To enable key progress against the new NCP, a shift will be needed in their prioritization of cholera control activities The WASH components of cholera control are recognised to be challenging as they require the engagement of a range of sub-sectors, such as infrastructure upgradation and water quality management. The WASH stakeholders engaged to date have also largely focussed on response efforts, rather than longer-term, preventive efforts.
- While engagement under the TWGs has so far been encouraging, there are complicated dynamics in some areas owing to the different entry points of multiple government ministries, with more progress to be made in effective multi-sectoral working. Activity under surveillance and WASH especially has reportedly remained "*traditionally one-sector driven so far*", implying multi-sectoral coordination efforts have not yet become routinised.
- National coordination is considered by many stakeholders interviewed as "*quite effective*" during outbreaks, but that same coordination is not in place to drive prevention and preparedness efforts. Similarly, national level coordination is seen as more effective than sub-national and local level coordination across response, preparedness, and prevention efforts. There is also not yet a culture of collectively applying lessons and insight/ data generated from outbreak and response phases into prevention and preparedness planning and delivery. This is complicated by the need to boost cross-sectoral working efforts.
- Community engagement efforts, also key for effective surveillance and preventive activity, were highlighted by some interviewees as needing ongoing support to ensure efforts are of quality and aligned, though engagement channels are extensive under the decentralised system. It was suggested that this could be primarily provided through Female Community Health Volunteer networks, a long-standing network of volunteers supporting community health programs in Nepal.
- There were concerns highlighted with 'overlaps' in planning cycles, particularly WHO planning cycles. For example, WHO has country support plans spanning five-year periods, whereas regional offices conduct planning on a biennial basis. Misalignment was also reported between WHO planning cycles at country and regional levels, and planning cycles at a global level for the WHO cholera programme and GTFCC. Managing the various planning cycles was noted to misalign with CSP planning which could potentially lead to a lack of synergy in review and revision points against the NCP. There are concerns that this could complicate engagement with WHO at various levels and therefore, GTFCC/CSP, in relation to assessment of country progress against the Roadmap.
- How in-country efforts link to regional cholera control efforts, both in terms of direct engagement with other countries (especially India and Bangladesh which also have comparatively high cholera burdens), as well as cross-border regional efforts, also needs clarification. There is uncertainty around who this clarification needs to be led by, whether it is WHO regional office or the GTFCC. There has been no support request so far to the GTFCC in this regard, given the NCP is still being finalised, but country authorities may likely discuss the need for more regional collaboration in relation to cholera control with GTFCC in the coming months.

The role that GTFCC can play in addressing coordination challenges and in boosting advocacy and resource mobilization efforts aligned to the Roadmap appears to be unclear to most country informants. While there is an expectation that the GTFCC's involvement will provide good impetus for addressing these issues, the specific role that GTFCC can play in doing so, and how this will align with existing support from i.e. WHO and

UNICEF country offices, is less clear to in-country stakeholders. WHO and UNICEF's specific roles in the GTFCC at the country level are still unclear to most informants, especially given the GTFCC is seen to be led by IRFC regionally. Some specific technical assistance suggestions were made by KIs which are included in Section 2.4. (Axis 3). It is also hoped that the Plan will boost advocacy efforts with government and partners in country (including at the sub-national level), with the aim of boosting commitment and engagement, as well as resource mobilization efforts. It was suggested that it would be useful if the GTFCC could also guide the development of a streamlining mechanism to strengthen engagement with regional entities, as well as regional cross-sectoral working.

2.3 Efficiency

Q4: *To what extent are the GTFCC operational structures set up efficiently to support the objectives of the Roadmap?*

Q5: *How efficiently has the Roadmap been implemented by the GTFCC in terms of optimizing human and financial resource allocation to support countries in a changing cholera landscape?*

Given Nepal is in early stages of formal engagement with the GTFCC and in applying the Roadmap to routine cholera control efforts, reflections on the efficiency of the governance and operating structures of the GTFCC were minimal. There is overall limited awareness of specific GTFCC operational structures among country stakeholders. While there is hope that Nepal could become a CSP country (amongst those familiar with the mechanism), there remains a lack of certainty around the role the CSP can play and opportunities for Nepal's future engagement with the GTFCC. Insights and reflections were focused largely on the CSP given that it is the current focus and engagement mechanism for Nepal. Overall, there appears to be appreciation of the CSP and the technical support available as needed through the platform, although for some stakeholders, reflections were based on assumptions and expectations of support available via the CSP rather than on actual experience.

Some stakeholders raised awareness of resource mobilization challenges by GTFCC at the global level, although there remains hope and expectation around the value of GTFCC in being able to generate useful and needed human and financial resources for Nepal once it formally becomes a CSP country. The processes through which this may be eventualised and the scale of opportunity remain unclear, however, as outlined in Section 2.2. above.

In general, there were a few key areas of uncertainty raised across in-country stakeholders in relation to operational aspects of the GTFCC:

- Given resource limitations and an uncertain pipeline, it was noted that the GTFCC is often not able to commit resources in advance, which may challenge the supportive role it can play, specifically a planned provision of technical, human, or financial resources to support effective roll out of the NCP.
- The extent to which the GTFCC is globally, nationally and locally focused/ orientated, and how that informs or guides country engagement, was unclear to many. For example, stakeholders said, "*GTFCC needs to think globally and act locally. What works well in the context and how can we support the countries with those challenges*?" Many stakeholders were of the impression that it would be good

for the GTFCC to prioritize efforts in guiding engagement within countries, even though national settings may vary widely.

- The collaboration between the GTFCC Secretariat and other internal structures and WHO regional and country offices was unclear to several stakeholders. It was not clear how the role of WHO at both the country and regional level might shift if, and when, Nepal becomes a CSP country. This was raised as a question for clarification by the GTFCC, including relating to the initiation of requests for commodities, such as Oral Cholera Vaccines (OCVs) and rapid diagnostic tests (RDTs).
- Uncertainty around the potential scope for adjustment and flexibility in the use/application of GTFCC guidelines and tools was raised. One stakeholder reflected that some of the GTFCC tools are "*very perfect standard*", which either required adjustment in country to fit routine, operational systems, or did not have the inbuilt flexibility to enable contextual adjustment; another stakeholder also raised the Excel sheets for PAMI analysis as an example of this. It was also noted that once tools were requested from GTFCC to support the PAMI and NCP development, they reportedly came late. There was also mention of the need for a WASH costing tool which is understood to be forthcoming by the GTFCC.

2.4 Effectiveness

Q 6: What results have been achieved by the GTFCC partnership in the implementation of the Roadmap at the country level?

Q 7: Which factors have influenced the implementation of the Roadmap to date? What opportunities could be tapped into for better results?

In this section, evidence is presented for progress towards the three Roadmap axes and factors that have influenced implementation of the Roadmap are considered. It is recognised that this is challenging though given (i) the GTFCC internal structures, such as the Secretariat, have not been that involved in Nepal so far, and (ii) the lack of knowledge on the GTFCC among country informants, as has been discussed above.

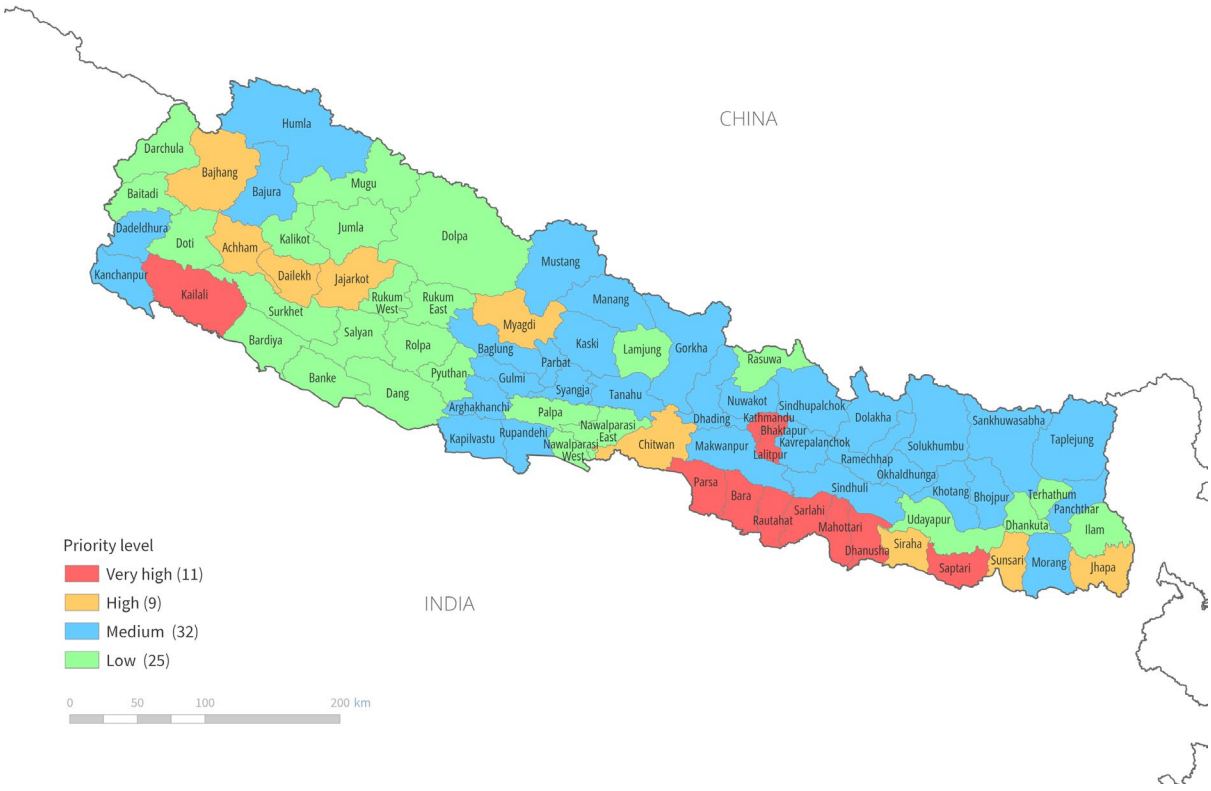
Early detection and response to contain outbreaks

Owing to its endemicity, Nepal is accustomed to annual cholera outbreaks, with the recent PAMI enabling an important and further focusing of future response efforts. As outlined in Section 1, Nepal is accustomed to yearly outbreaks of cholera, and the response system is well established. Stakeholders discussed key areas of progress which have aided early detection and outbreak response, including enhanced case detection through the roll out of RDTs and improvements to the laboratory network, and effective case management guided by a comprehensive case management protocol. Furthermore, the recently conducted PAMI has instigated the prioritization and targeting of districts classified as 'high-priority', thereby enabling outbreak response and containment efforts to become more focused.

The PAMI process involved some adjustment to the GTFCC toolkit to suit the local availability of data and engagement processes. The PAMI drew on various data sets, including (1) historical outbreak data, specifically the Early Warning, Alert, and Response (EWARS) data on prior cholera outbreaks across the country, including laboratory-confirmed outbreaks since 2009; (2) ECHO-N surveillance data, though coverage did not span all at-

risk areas, and (3) media monitoring data, including notifications of suspected or confirmed cholera outbreaks in the national media using the Epidemic Intelligence from Open Sources (EIOS) system. The data validation process also incorporated local contextual knowledge, including factors that influence vulnerability to cholera transmission, in particular WASH related infrastructure and practices, to ensure the lists of districts proposed as high-priority accurately reflected the on ground conditions. Some limitations to the data used for the PAMI were highlighted during interviews, including the absence of granular WASH data at the municipal level and the lack of national wide case data. While the impact of data limitations is unclear, future PAMI analysis once more detailed data on cases and WASH are available, may enable prioritization of districts more appropriately. The PAMI process highlighted that among the 77 districts assessed, 20 (26%) were identified as PAMI, which accounted for 71.4% of all cholera cases and 46.8% of the total population of Nepal. Of these, 11 districts were classified as very high-risk and 9 as high-risk for cholera incidence and outbreaks. The GTFCC has also recommended regular reviews of PAMI through analysis of surveillance data and contextual factors to ensure interventions remain adaptive to the evolving cholera landscape and to ongoing guidance aligned with the NCP once approved. Figure 7 provides the map of Nepali districts by priority index for cholera control.

Figure 7: Map of Nepali districts by priority index for cholera control[42]



Specifically, the intention according to the DoHS/ EDCD is that the PAMI will enable (1) more effective early detection and response to enable authorities to promptly implement containment measures; (2) more effective resource allocation to ensure funding and personnel are directed towards areas most susceptible to

[42] Available from Epidemiology and Disease Control Division Department of Health Services, Ministry of Health and Population, Nepal, 2024 and noted in IFRC. Identifying Priority Areas for Multisectoral Interventions for Cholera Control (DRAFT). 2024.

cholera outbreaks; and (3) strengthened data collection and analysis through a deeper understanding of the local cholera epidemiology and contextual outbreak-contributing factors, which also guides ongoing surveillance and monitoring initiatives. This knowledge enhances the effectiveness and efficiency of prevention and control efforts, covered in the following Section.

Surveillance systems are periodically operational, predominantly during outbreaks and strengthening efforts are underway, though data on cholera cases and deaths are still far from representative of on-ground realities. Several public health surveillance systems operate in Nepal, though EWARS, laboratory-based surveillance, and the routine Integrated Health Monitoring Information System (IHIMS) are the three main systems that monitor cholera incidence and outbreaks at the national level. Stakeholders reported that surveillance guidelines and case definitions are well up to date, having drawn on technical guidance from the GTFCC. The EWARS is a hospital-based sentinel surveillance system with 118 hospitals reporting weekly into the system, spanning cases and deaths of six priority diseases/ syndromes, including cholera. However, stakeholders emphasised that the reporting only includes inpatient cases with community cases omitted, and the scope is currently misaligned to the at-risk districts identified through the PAMI, though this is expected to be addressed once the PAMI and NCP have been approved. Event-based surveillance, a proactive approach to monitoring outbreaks which involves gathering information from various sources, including news reports, social media, health facilities, and community reports, is nominally in place but the system is not fully routinised or supported. In addition to challenges in acquiring sensitive incidence data, stakeholders discussed the lack of cholera mortality data, owing to a weak cause of death data system. For example, as one KI said, "*There are a few provinces with detailed data but generally it is not there. It is very difficult to generalise for the entire country*." The introduction of RDTs is expected to help with case detection and reporting which may also enable a more comprehensive case mapping effort during future outbreaks (reserves of these kits are now maintained at the provincial level for outbreak response efforts).

Surge response systems are in place and have strengthened over time, though timeliness and multi-sectoral coordination could be boosted. Data challenges also naturally affect surge response planning and activation. In response mode, once a cholera case is confirmed through a positive RDT, EDCD is triggered automatically to initiate a review and coordination effort. However, in practice, the speed of the initial response is usually much slower than intended. As one stakeholder conveyed, "*the government is awake when a case is confirmed, but you need to look beyond. The first case is kept secret and then rushed once a few more come in*". Cholera can also entail trade and travel embargoes, carrying significant societal and economic impacts, which can also contribute to reluctance for fast action. Despite the known cholera risk from natural disasters, in particular flooding, these events also don't appear to raise alarm to instigate cholera assessment (or preventive) efforts. There is some suggestion that the lack of impetus to respond with urgency reflects a lack of confidence in case detection, which could be aided by the more widespread use of RDTs.

The need to strengthen surge capacity through a more effective multisectoral coordination effort was also raised by many stakeholders. This has reportedly gotten better over time and is reportedly more effective than under prevention and preparedness modes, but there are still some misalignments during response. For example, as one KI said, "*when a response is happening, technical experts from other sectors, people from WASH and food safety, as well as public health inspectors, need to align in the response. We don't see this happening much - most burden still sits with health.*" However, there is some evidence of effective joint WASH and health efforts implemented in the Kathmandu valley in response to the 2015 earthquake and for the few years afterwards in anticipation of potential further outbreaks. Rapid response was conducted to include sentinel surveillance (case detection), with UNICEF coordinating health, WASH and education sectors with local government. Reports highlight positive efforts in relation to capacity development in systems strengthening to improve coordination for WASH sectors; training on cholera for both WASH and health key stakeholders at

local levels, such as village health workers, water service providers and user groups; door to door WASH and hygiene promotion awareness campaigns; community-led water quality testing; and the conduct of child-centred risk mapping.

Federalisation was also raised as a key challenge in outbreak response, given the lack of framework or guidance on how local levels can effectively perform their response responsibilities, though ToRs and SOPs are reportedly in development. While the Public Health Service Act states that local municipalities can declare and respond to local outbreaks, insufficient resource mobilization and capacity at local levels, and the lack of clarity of roles which has also complicated the cross-sectoral coordination system, can cause critical response delays. NGOs are playing an enhanced role at local levels to boost the data collection and monitoring efforts across sectors in support of local government, which also presents a quality and coordination challenge, according to some stakeholders.

Prevention of disease occurrence through targeted multi-sectoral interventions in cholera hotspots

Multi-sectoral planning and engagement in relation to cholera prevention and preparedness is not yet formalised or entrenched at either national or local levels. Nominally, cholera prevention and control is specified as a multi-sectoral effort, with overall technical guidance from the Ministry of Health and Population and involving other ministerial level departments, spanning WASH, food safety, risk communication, and community engagement. This coordination effort is intended to span national to local levels, though in practice, is still less formalised and entrenched, including in relation to response efforts. As conveyed by one stakeholder, "*my learning is that we do have good coordination across sectors but we can't look beyond response – once we are done, you forget the whole thing – we need to strive beyond response*."

A good level of cross-sectoral representation has been encouraged through the NCP which, despite its multi-sectoral orientation, is still seen very much seen as a 'Health Plan' under the EDCD. Additional coordination efforts are needed with WASH actors and with different entities responsible for different aspects: for example, the Ministry of Health and Population collects monitoring data and tracks progress on sanitation and is responsible for surveillance of water quality, whereas water quality is identified as a specific cross sector responsibility and activity. The Ministry of Education, Science and Technology (MoEST) promotes sanitation in schools and Ministry of Federal Affairs and General Administration is responsible for local governance and for planning rural WASH projects. Similar to the challenges posed by decentralisation in relation to outbreak response, this shift in 2015 also somewhat changed roles and responsibilities for planning prevention and preparedness efforts. Collaboration between the Ministry of Health and Population and MoWS is reportedly working to boost WASH at health facilities which is seen as a mutual priority, but there has been slower progress in other coordination areas at local levels. The MoWS does also not have formal representation at the municipality level, and it was also noted that, in the prevention space, continual staff turnover is a challenge which hinders institutional memory carry-over at both national and local levels.

However, the recent NCP development process has enabled the consideration of a comprehensive Roadmap for the first time and has facilitated the active engagement across stakeholder groups and sectors which will take time and effort to operationalise. The previous Plan reportedly had plans by pillar which guided more of a 'learning by doing' approach with low accountability attached. As previously mentioned, the Nepal NCP will be anchored to the Public Health Service Act, 2075 (2018) as opposed to being a Department level plan, which is

expected to boost commitment and accountability, as the Act is driven by law. The PAMI will also be key for guiding and prioritising coordinated efforts in identified hotspot areas.

Recent progress has been made in the implementation of prevention and long-term control interventions. There is consensus across stakeholders that lack of adequate WASH remains the most critical risk factor for cholera, which is also the most complex component to address. The approval of the PAMI is expected to facilitate the concentration of preventive efforts in high-risk areas, such as advocating for good hygiene practices, strengthening water and sanitation infrastructure, ensuring access to safe water and sanitation facilities, and conducting targeted OCV campaigns. Improved data on incidence, vulnerability factors, and the effectiveness of specific interventions will also continue to inform the development of new or adapted interventions to suit local contexts. OCV campaigns are seen as key priority in high-risk districts in the coming years. One stakeholder even reported that, "*a key motivation for the development of the NCP was the potential for sustained commitment to the roll out of OCVs, given if you have a Plan, the country can go for vaccines*". More emphasis is also expected to be given to public health campaigns, stressing the importance of hygiene, safe water, and sanitation practices to prevent cholera, to be rolled out in communities, schools, and through media channels before the monsoon season, particularly in priority areas.

There was consensus across stakeholders that WASH remains the most critical risk factor for cholera, but is also the most complicated component to address, owing to a range of factors. The government tends to focus funding heavily on water supply solely (45% of resource allocation), water and sanitation combined (40%), and standalone sanitation (12%). The availability of comprehensive WASH data with which to plan and guide efforts is not optimal in Nepal. For example, district level data on the proportions of households with handwashing stations and with access to safe drinking water is not readily available, and the data available on open defecation reportedly far underestimates the extent of the practice. One stakeholder emphasised that, "*we are not getting detailed localised data and big surveys are not reflective of reality on the ground. We need more detailed WASH baseline assessment*." The rollout of GIS-based WASH data planning and management called NWASH is being implemented with over 300 local municipal areas currently engaged. This data will provide household level data and support sharpening prioritization of WASH efforts and highlight potential cholera risks. Existing WASH infrastructure is vulnerable during heavy rains and floods with further investment required to improve wastewater management system resilience and sustainability. In addition, stakeholders engaged in cholera response and planning are predominantly those involved in WASH emergencies rather than those with responsibilities for longer-term WASH planning, and infrastructure development and upgrades, limiting the ability to bring together WASH actors across the prevention, preparedness and response cascade.

There is a national WASH Sector Development Plan (2016-2030) that outlines a strategy, policy and regulatory framework and roles and responsibilities for WASH, although it does not explicitly mention cholera. The varied linkage between, and identified responsibilities across, health and other sectors as outlined above also appear to confuse roles, thereby potentially also limiting impetus for action. Stakeholders commented that more advocacy and engagement work was needed to boost the prioritization of cholera within the WASH sector, with efforts focused on the hotspots areas.

Effective mechanism of coordination

Recent efforts under the PAMI and development of the NCP have given focus towards boosting relevant coordination structures in the country, despite is a continued need to strengthen partner coordination and engagement, resource mobilization efforts, and advocacy initiatives, particularly beyond the central level. As outlined in Section 2.2., there are hopes that becoming a CSP country will boost effective coordination in country and facilitate resource mobilization and advocacy efforts from sources both inside and outside the

country for effective implementation of the NCP. However, the specific processes to enable this as well as the extent of actual opportunity remain unclear to country stakeholders based on their levels of insight and the guidance available to them. Some specific points that were raised include:

- **Technical assistance (TA).** Stakeholders agreed that NCP implementation should very much be led by countries, with TA sourced primarily from partners active in-country, but also from GTFCC if available and as needed. Some specific technical assistance suggestions were made by stakeholders, which included: (1) the provision of more examples of effective WASH engagement, and the governance and coordination systems which could effectively facilitate this; (2) guidance in conducting and applying findings from after-action reviews (AARs) to support a more data driven approach to preparedness and surge response planning; (3) support in the development of a dashboard to enable the conduct and regular updating of a stakeholder mapping.
- **Resource mobilization and advocacy efforts.** Stakeholders in-country are keen to explore options for GTFCC's support to increase financial resources to implement the NCP, and advocacy efforts towards that end. It is hoped that more support from GTFCC through the CSP may attract more support from other donors, with the World Bank, Asia Development Bank, USAID, and the Gates Foundation mentioned specifically. It was acknowledged that prevention and preparedness efforts are not only costly but harder to generate funds for, and that there is a need for dedicated resources for both responses and preparedness/ prevention efforts. One stakeholder commented that, "*the benefit of GTFCC in country is to facilitate those missing links*". It was recognised that the GTFCC has played a key role, primarily through engagement efforts surrounding the PAMI and NCP development, in advocating for the prioritization of cholera control and elimination efforts at the national level in Nepal, though efforts need to be sustained, "*given it is never enough for a neglected disease like cholera*". The sub-national level has been given little focus, and the "*advocacy at higher levels hasn't trickled down to local levels*". As outlined previously though, while the focus of the GTFCC is routinely the national level, there remains some uncertainty about whether, or how, the GTFCC could potentially play at sub-national levels, particularly during the context of an outbreak.
- **Research.** It was noted that the current GTFCC NCP template does not feature research, but there is interest in conducting relevant research in country with the overall aim informing the pathway towards elimination.

Influencing factors

A number of factors have been identified as key in influencing the extent of progress in relation to cholera control in recent years. These include political prioritization post outbreak event, climate change affecting patterns and vulnerability, variable quality and availability of surveillance data, consistency of partner and sector engagement across sectors, prioritization of WASH efforts and alignment with the health sector, sub-national level capacity and clarity on roles, prioritization of community engagement efforts, and extent of application of learning post outbreak. Ongoing political challenges including openness to reporting cholera cases given potential societal and economic consequences, challenges remaining with porous borders, and a lack of regional coordination emphasis towards progressing cholera elimination efforts, may also continue to impede progress if not given focus.

2.5 Sustainability

Q 8: What steps has the GTFCC taken to ensure the sustainability of its interventions under the Roadmap?

Country stakeholders consider sustainability to be key, though few deliberate steps have been taken so far to enhance sustainability of efforts. There was broad recognition that NCP implementation and CSP support must foster country ownership and acknowledge contextual needs while maintaining adherence to global guidance. An active NCP that fosters government leadership while providing ongoing support with both responsive and long-term intentions was considered critical. Sustained advocacy was also thought to be important. Two key advocacy areas commonly highlighted were: (1) advocacy to high level government officials to maintain cholera as a priority issue; and, (2) advocacy to increase and maintain domestic and international financing for NCP implementation. Frequent turnover of key government officials was seen to jeopardise sustainability, and it was suggested by one stakeholder that the GTFCC could consider its role to include briefing new government stakeholders on cholera to help sustain continuity of institutional memory.

Gaps in multisectoral coordination, particularly across the spectrum of prevention, preparedness and response, were seen to threaten sustainability, including by the government. While coordination mechanisms were utilised for cholera responses, roles and responsibilities for longer term prevention and preparedness efforts remain weak, especially with those responsible for WASH, and at subnational levels. Strengthening multi-sector coordination will be needed at all levels to foster sustainability of cholera action. One specific element to mandate this coordination is anchoring of the NCP to the Public Health Services Act, 2075 (2018). This was seen as a positive achievement in the NCP development process that may enable the strengthening of sustainable coordination and ongoing accountability.

2.6 Gender, equity and human rights (crosscutting)

Q 9: To what extent has the Roadmap included GER concerns? To what extent have implementation activities factored equity considerations at the global and country level?

Country stakeholders had no insights into the extent to which the Roadmap considers Gender, Equity and Human Rights (GER) and a review of the draft NCP indicated that GER is insufficiently addressed so far. No systematic disaggregated data for gender for cholera was identified throughout the review. However, analysis of the 2021 outbreak in Kapilvastu District indicated that women and children are disproportionately affected, with women and children aged 5-14 years representing 55% and 32% of cases, respectively. The draft PAMI analysis highlights geographical variation in cholera incidence and persistence, however, inadequate surveillance is noted to limit the accuracy of data currently available. Supporting government plans, such as the Nepal Water Supply, Sanitation and Hygiene Sector Development Plan (2016-2030), articulate specific actions and financing to address marginalised and vulnerable groups. In relation to whether the PAMI and NCP have considered GER, stakeholders noted that there is a Gender Equity Disability and Social Inclusion (GEDSI) strategy in country which NCP activity will be aligned to, though more thinking needs to be done to embed planning**.** The Constitution of Nepal has specific guarantees for all citizens to uphold human rights, including for health and WASH, and to ensure freedom of all citizens from social discrimination. Given the constitutional nature of the recognitions of rights and social discrimination, it was highlighted by several respondents that

this means GER would, in principle, be recognised in the NCP, its Steering Committee's operations and adhered to in any roll out. However, those that had sighted the NCP drafts, acknowledge that GER was not comprehensively or systematically covered in the NCP, which was also verified by this case study.

One respondent, who was familiar with broader GTFCC processes, felt the GTFCC could likely support Nepal's efforts on embedding GER into their routine work given the GTFCC's work in this area. Several respondents could highlight where cholera, and in particular relating to WASH responses, had considered GER needs and where vulnerabilities exist or remain. Beyond the NCP, WASH policies do have some provisions for GER that acknowledge the need for local and community engagement to effectively address GER. The federalized system may provide an opportunity for strengthening GER given the local nature of responses and through the engagement of village health workers, a recognised and valued health work force in Nepal.

As outlined in Section 2.4., the PAMI analysis was limited by the lack of granular data at the district level, especially for WASH. Limits on accuracy, comprehensiveness and granularity of WASH data was acknowledged by several respondents though the shift to GIS data collection systems could potentially address this in the future. A lack of quality data from local levels may further limit the ability for targeted GER strategies and targets in both the NCP and its implementation.

3. Conclusion

The mid-term evaluation of the GTFCC in Nepal highlighted that although the country is early in its transition to becoming a CSP country, recent efforts supported by GTFCC, specifically the PAMI analysis and development of the draft NCP, are seen as pivotal in positioning Nepal for its next phase of cholera control and elimination. The Roadmap is seen as useful, comprehensive, and relevant, though there are concerns that its elimination targets may be too ambitious when applied to Nepal, given the endemic nature of the disease and persistent yearly outbreaks.

Nepal has made important progress in recent years in strengthening its cholera response and control efforts. Surveillance systems are improving though they reportedly do not yet reflect the actual cholera cases detection and early warnings and deaths, and the rise in use of RDTs is expected to improve case detection. Surge response systems are in place and have strengthened over time, though timeliness and multi-sectoral coordination need more focus. While activity in response mode is seen to be stronger as compared to the preparedness and prevention modes, progress has also been made in the implementation of prevention and long-term control interventions. WASH efforts however remain a key gap, owing in large part to the engagement and coordination complexities between health and WASH, including both emergency WASH and longer-term systems focussed WASH and the limitations of WASH data. Recent GTFCC support has given impetus to more effective coordination efforts in country, though some challenges remain, including the engagement of non-health actors, and at the local levels owing to the decentralization shift.

Going forward, the PAMI analysis, once approved, will be key in enabling the concentration of efforts and resources for both preparedness and prevention efforts in high-risk areas. The GTFCC has recently engaged with Nepal to bolster political support to prioritization of cholera. Expectations are high for GTFCC's ongoing support through the CSP platform, specifically opportunities for support advocacy and resource mobilization efforts, as well as targeted areas of technical support to enable effective implementation of the approved NCP. More clarity in the role that GTFCC can play through the CSP, including in coordination with WHO at country and regional levels, will be useful.

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Consultee list

Stakeholder group	Organization (# of consultees)
Government national level	Ministry of Health / Policy, Planning & Monitoring (1)
	Ministry of Health / Epidemiology and Disease Control (1)
	Ministry of Water Supply (1)
Country partners	World Health Organization (1)
	UNICEF / WASH (1)
	UNICEF / Immunisation (1)
	IFRC (2)
	Group for technical assistance (2)
Regional partners	IFRC (1)
	WHO – SEARO (2)

Country case study Nigeria

This Nigeria country case study supports the Mid-term Evaluation of the Global Task Force on Cholera Control (GTFCC). Following country background information and context (Section 1), country-level findings are presented for each of the evaluation areas (Section 2): Relevance (Section 2.1), coherence (Section 2.2), efficiency (Section 2.3), effectiveness (Section 2.4), sustainability (Section 2.5) and gender, equity and human rights (Section 2.6). A final conclusions section based on these findings from Nigeria follows (Section 3).

1. Introduction, background and country context

1.1 Introduction

This case study is one of six case studies which have the purpose to generate evidence for evaluation questions set out in the evaluation framework and be an evidence base for findings in the main evaluation report. This includes questions relating to (i) the work of the GTFCC and (ii) implementation of the cholera Roadmap from a country perspective.

Countries were selected to allow for diverse representation across key criteria for the evaluation and permit a deeper assessment of successes, challenges and lessons pertaining to the work of the GTFCC and the Roadmap. For Nigeria, this included: (i) being on the Roadmap priority list; (ii) being a country support platform (CSP) supported country; (iii) having a draft National Cholera Plan (NCP) and (iv) being a country in a fragile context.

1.2 Methods

Data collection methods for this case study included a review of key documentation and focus group discussions (FGDs) and stakeholder interviews. Key informants were purposefully selected to take part in interviews and FGDs. They were selected to ensure there was a mix of stakeholders from government including different national level ministries (e.g. Ministry of Health, Ministry of Environment, and Ministry of Water Resources and Sanitation), representatives from different GTFCC partners (e.g. WHO, UNICEF, IFRC, MSF), and those who could speak to different pillars of the cholera Roadmap (e.g. laboratory, surveillance, oral cholera vaccine (OCV), water, sanitation and hygiene (WASH) etc). Key informant interviews (KIIs) and FGDs were conducted using a semi-structured interview guide. In total, KIIs and FGDs were conducted with 30 consultees. The majority of interviews were conducted in-person, with a minority conducted virtually to accommodate stakeholders based outside the capital city or otherwise unavailable to attend in-person. Data from KIIs and FGDs were analysed alongside documents to develop the findings for this case study.

Limitations included limited availability of certain key stakeholders identified for interview during the timeframe of the case study. Where possible, the evaluation team responded by setting up alternate interviews with individuals within the same or similar organizations. Additionally, at times, interviewees only had limited information on key aspects relating to the GTFCC.

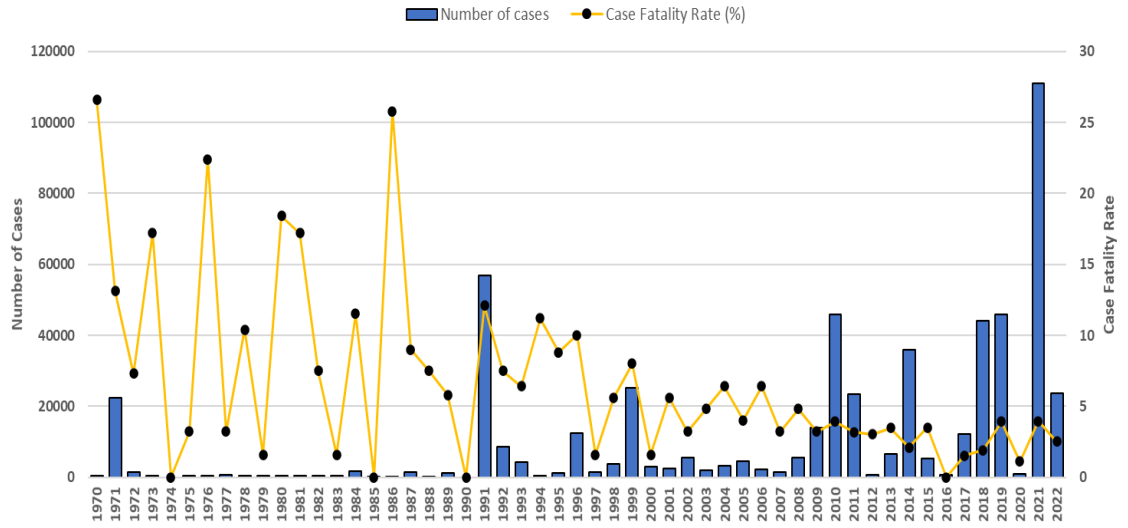
1.3 Key country characteristics and cholera context

Located in West Africa, Nigeria sits between the Sahel in its north and the Gulf of Guinea on the Atlantic Ocean along its southern coast. It shares borders with Benin, Cameroon, Chad, and Niger. With an estimated population of 236.7 million in 2024 and a growth rate of approximately 2.52%, Nigeria is the sixth most populous country in the world. Classified by the World Bank as a lower-middle income country, Nigeria's 2023 GDP per capita was estimated at US$ 1,621. Administratively, it is divided into 36 states and 1 Federal Capital Territory (FCT), which hosts the capital city, Abuja. These states and the FCT are further divided into 774 Local Government Areas (LGAs).

Nigeria's healthcare system is provided through a mix of public and private services. Within the public sector, management of the healthcare system is spread across the three tiers of government. The Federal Government oversees tertiary healthcare centres, immunisation programs, and national regulation, while state governments administer secondary healthcare facilities, and local governments manage primary healthcare centres. Despite this structure, the healthcare sector faces significant challenges, including underdeveloped infrastructure, a high rate of medical tourism, and a shortfall of skilled healthcare workers due to emigration. In 2024, only 5% of the national budget was allocated to health, significantly below the 15% target of the 2001 Abuja Declaration. Furthermore, with 76.2% of health expenditure coming from out-of-pocket payments in 2023, universal access to healthcare remains a critical issue. While the National Health Insurance Scheme (NHIS), established in 1999 and launched in 2005, aimed to provide universal coverage for all Nigerians by 2015, only approximately 5% of Nigerians were enrolled in the scheme as of 2022. This limited enrolment contributes to the reliance of out-of-pocket payments, which accounted for over 75% of total healthcare expenditure in 2023.

Cholera continues to pose a significant public health burden in Nigeria, with recurring outbreaks disproportionately impacting vulnerable communities, including low-income populations, in rural and peri-urban areas, internally displaced persons (IDPs), and communities affected by conflict or natural disasters. Since the country's first reported incidence in 1970, the disease has been endemic, with major outbreaks following in 1991, 2010, 2018, 2021, and 2024. Figure 8 below provides the annual number of cholera cases in Nigeria between 1970 and 2022. While the number of reported cases follows a pattern of periodic spikes, there has been a positive decline in case fatality rates between 1970 and 2022. Between June 2023 and June 2024, Nigeria recorded 2,261 cases of cholera with a case fatality rate of 3.8%.

Figure 8: Annual number of cholera cases and fatality rate between 1970 – 2022



Cholera outbreaks in Nigeria are predominantly driven by limited access to safe drinking water, adequate water sanitation and hygiene infrastructure, and healthcare services. Other factors such as poverty, conflict, and natural disasters (e.g., floods), also play a key role in the recurrence of cholera. Conditions in internally displaced persons (IDP) camps, such as overcrowding and limited sanitation increase vulnerability, further exacerbate the spread of the disease.

1.4 Object of the evaluation and summary of GTFCC support to Nigeria

The GTFCC is a partnership of approximately 50 institutions to coordinate activities for cholera control at global, regional, and country levels. The GTFCC brings together organizations working across multiple sectors and serves as a coordination platform to support countries in the implementation of the Global Roadmap on ending cholera. The Roadmap is underpinned by early detection and quick response to contain outbreaks; a targeted multi-sectoral approach to prevent cholera recurrence; and an effective mechanism of coordination for technical support, advocacy, resource mobilization, and partnership at local and global levels. A key role of the GTFCC is to promote and support the implementation of the Ending Cholera – A Global Roadmap to 2030 at country level by providing the advocacy, coordination, policy guidance and technical assistance necessary for countries to develop National Cholera Plans (NCPs) and implement them effectively. By implementing the strategy between now and 2030, the GTFCC partners will support countries to try to reduce cholera deaths by 90%.

The GTFCC convenes multi-sectoral partners. In particular for countries, the work includes (i) tool development and technical guidance which the GTFCC Secretariat helps to coordinate and GTFCC technical working groups develop; (ii) support to the implementation of these tools and their translation into activities (CSP support in a small number countries including Nigeria and technical assistance provided by partners) and (iii) the independent review panel (IRP) has reviewed NCPs in a small number of countries, and is expected to soon be reviewing in relation to Nigeria (see below).

Nigeria was one of the first four countries to benefit from the establishment of the GTFCC's Country Support Platform's (CSP) in-country presence in 2021. The Nigeria Centre for Disease Control and Prevention (NCDC) has been a key partner for the CSP, playing a central role in the country's cholera response and supporting the

development of Nigeria's National Strategic Plan of Action on Cholera Control (NSPACC) 2024–2028. In 2022, the former NCDC director represented Nigeria's Ministry of Health at the World Health Assembly cholera side event held by the GTFCC. The position of NCDC Director is politically appointed, and in February 2024, a new director was appointed by the Office of the Presidency of Nigeria.

Support provided by the CSP to strengthen Nigeria's cholera prevention and response efforts include:

- CSP, in collaboration with the WHO, supported and organised workshops to facilitate the development of a national cholera diagnostic guideline and a national cholera case management guideline.
- The CSP successfully provided technical support for Nigeria's application to Gavi to secure Rapid Diagnostic Tests (RDT) kits for cholera.
- The CSP, in collaboration with the WHO Regional Office for Africa (AFRO), supported workshops in November 2024 to facilitate the mapping of Priority Areas for Multisectoral Intervention (PAMIs), representing an update to the hotspot mapping exercise conducted in 2019, in order to align with the latest GTFCC guidance.
- CSP has supported the development of a new national cholera plan, the NSPACC 2024-2028. The draft document is currently awaiting feedback from the IRP, with a target launch for December 2024.
- CSP supported preparation of OCV requests

In addition, Nigeria has received support/ engaged with the GTFCC in the following ways:

- Multiple stakeholders from Nigerian government agencies and ministries have participated in GTFCC annual meetings and are involved in the GTFCC working groups and Independent Review Panel (IRP).
- In May 2024, Nigeria submitted their draft NCP for review by the IRP but as of October 2024, feedback from the IRP had not been provided on it.
- The Nigerian government has received direct support from GTFCC partners (e.g. WHO, UNICEF, MSF, amongst others).

2. Key findings

2.1 Relevance

Q1: To what extent is the Roadmap relevant given the changing environment (e.g. epidemiological, political, climate and risk profiles)? To what extent have measures been taken to ensure continuous adaptation of the Roadmap in line with latest international best practices and guidelines, and emerging needs at the country level?

Q2: To what extent is the design of the GTFCC adequate to support the objectives of the Roadmap?

Relevance of the Roadmap given the changing environment

The Global Roadmap is highly relevant to Nigeria's health and policy landscape, particularly as the country continues to face persistent cholera outbreaks. This relevance is evident in Nigeria's draft NSPACC for 2024-2028, which serves as an adaptation of the Global Roadmap, aligning its global framework with the Nigerian context. The NSPACC was developed by the NCDC, the Ministry of Health, Ministry of Water Resources and

Sanitation, and the Ministry of Environment in collaboration with multiple partners and support from the CSP. Stakeholders directly involved in NSPACC's development acknowledged the Roadmap's value in the development of Nigeria's cholera control plan recognising its clear framework for a multisectoral approach to cholera prevention and control. The adaptability of the Roadmap underscores its relevance, as it provides a strong foundation while enabling country-specific modifications to meet Nigeria's specific needs. This flexibility is reflected in the NSPACC's structure, which adapted the Global Roadmap's five pillars (Surveillance and Reporting, Healthcare System Strengthening, OCV, WASH, and Community Engagement)[43] to cover the following nine technical thematic areas: Leadership and coordination, Surveillance and Epidemiology, Laboratory, Case Management (Health Care System), Risk Communication and Community Engagement (RCCE), WASH and Solid Waste Management, OCV, Logistics, and Research. Stakeholders stated these additional pillars were introduced into the draft NSPACC to provide dedicated workstreams towards these key areas. The expanded framework highlights how the Global Roadmap's guidance serves as a baseline that countries can adapt to enhance relevance and comprehensiveness in their specific contexts. The new draft NSPACC represents Nigeria's second national cholera plan, building on an earlier national plan that was developed in 2018 based on hotspot mapping conducted between 2013-2017. This updated version reflects recent guidelines and demonstrates an expanded coalition of stakeholders involved, broadening the primarily health-focused approach of the first plan.

The Global Roadmap is relevant to Nigeria's health and policy landscape, as demonstrated by its adaptation as a framework in the development of the NSPACC 2024-2028. However, despite this alignment, the majority of stakeholders interviewed indicated no or limited awareness of the Global Roadmap itself, including stakeholders from national government agencies, ministries, and international technical partners. While the Roadmap's inherent relevance is evident due to Nigeria's ongoing cholera endemicity and the adaptable framework it provides, there remains a need for increased advocacy and engagement to translate the Roadmap and the NSPACC from strategic guidance and planning efforts into implementation. Stakeholders reported that further engagement is required with funders and funding channels on both the government side and among international partners operating in Nigeria to facilitate implementation.

Design of the GTFCC to support objectives of the Roadmap

The engagement of key country-level stakeholders involved in Nigeria's cholera response efforts with the GTFCC's operational structures varied significantly.

The GTFCC operates through the following structures: the GTFCC Secretariat, the Steering Committee, the IRP, the GTFCC Technical Working Groups (OCV, WASH, Epidemiology, Laboratory, and Case Management), and the CSP *(2)*.[44] It also has an annual General Assembly. Stakeholders who had engaged with the GTFCC directly, through the General Assembly, membership of the IRP or Working Groups, or attendance of in-country workshops hosted by the CSP, had a good knowledge of the GTFCC, were well engaged overall, and reported that the activities supported by the GTFCC were beneficial. However, several key stakeholders, including major funding channels at both the domestic and international levels, expressed having limited or no awareness of

[43] The GTFCC's Interim Guiding Document to Support Countries for the Development of their National Cholera Plan lists the five pillars outlined above, while the GTFCC's Cholera Roadmap Research Agenda presents a slightly different set of five pillars: OCV, WASH, Surveillance, Community Engagement, and Case Management.
[44] The GTFCC Steering Committee provides global strategic direction, the IRP conducts transparent reviews of NCPs for endorsement, the Secretariat ensures coordination between the WHO cholera program and the CSP, the Working Groups establish norms and standards for cholera control, and the CSP delivers country-level support through technical assistance, advocacy, capacity building, and implementation of research projects.

the GTFCC, the CSP, or the ongoing development of Nigeria's draft NSPACC, despite the CSP's in-country presence. Such lack of awareness among critical stakeholders represents a significant gap, as their engagement is essential for mobilising resources and supporting the implementation of the costed draft NSPACC. The majority of stakeholders involved in the development of the NSPACC highlighted that securing funding for its implementation will be a major challenge. Addressing the limited awareness of the GTFCC and the NSPACC among key funding channels, both within the Nigerian government and among international partners, will be crucial to mobilising the necessary resources to implement the plan.

2.2 Coherence

Q3: *To what extent has the GTFCC, through its governance structures and mechanisms, promoted complementarity, synergy and integration between different members' interventions at the global and the country level? What is the added value of GTFCC members acting together?*

While a significant number of stakeholders interviewed had limited awareness of the global and in-country coordination efforts facilitated by the GTFCC, those who were informed described it as successful. The annual GTFFC General Assemblies were praised as valuable opportunities for cross-country and cross-sector technical exchange, fostering collaboration, and sharing innovations that enhance cholera response strategies. In particular, the majority of stakeholders who had attended assembly meetings stated that informal discussions between country representatives provided opportunities to share challenges and successful ways of working. However, stakeholders also consistently remarked that from their perspective, such meetings would be more productive if they were held in cholera endemic countries as it would provide an opportunity to engage with political officials whose support is required for the implementation of cholera prevention and response strategies. The GTFCC's global WGs were viewed as instrumental in developing guidance that could be applied at the country level, helping to shape both policy and practices in cholera control efforts in Nigeria. Critically, stakeholders highlighted the GTFCC's role in raising the global profile of cholera, describing the platform as very important for giving cholera "*global voice*".

National coordination for cholera response in Nigeria has benefited significantly from the CSP, which stakeholders widely praised for serving as a critical bridge between the GTFCC and the country. The CSP has acted as a catalyst in the continuous development and improvement of Nigeria's cholera response particularly through its ability to convene multi-sectoral stakeholders, as reported by interviewees, and ensure collaboration among key government ministries such as the Ministries of Health and Social Welfare, Water Resources and Sanitation, and Environment, alongside international technical partners. Stakeholders interviewed stated that agencies that are crucial to providing a coordinated response against cholera, such as the Nigeria Centre for Disease Control (NCDC) and the National Primary Healthcare Development Agency (NPHCDA), similarly benefit from the coordinating activities of the CSP as it facilitates their engagement with external partners.

A clear example of this coordination is seen in the development of Nigeria's NSPACC. Nigeria previously developed a national cholera plan in 2018, before the CSP's involvement. Between 2022 and 2024, with the CSP's support, a new draft national cholera plan, the NSPACC 2024-2028, has been developed, incorporating the latest GTFCC guidance, such as the Interim guiding document to support countries for the development of their national cholera plan, and expanding the base of involved stakeholders to ensure a robust and balanced plan. Stakeholders described the new draft NCP as a major improvement on the previous iteration, as it was

developed in collaboration with ministries and agencies beyond the health sector such as the Ministries of Water Resources and Sanitation and Environment. This exemplifies how well the CSP approach to national coordination aligns with Nigeria's needs and context. By building upon the previous NCP, according to KIIs, the CSP has maintained continuity, leveraging the experience of key stakeholders and institutions involved in the development of the 2018 plan. Expanding the stakeholder base for the new NSPACC ensures that a broader array of actors is now engaged in a coordinated response, fostering collaboration, and reducing the risk of siloed efforts in cholera response. In particular, according to KIIs, the new draft NSPACC benefits from significantly expanded stakeholder engagement at the state level, greater involvement from non-health federal ministries, such as the Ministries of Water Resources and Sanitation, and Environment, and increased collaboration with NGOs as they were engaged in the drafting stage.

Despite notable progress, some key funding channels/partners within the government and international technical partners operating in Nigeria reported limited awareness of the GTFCC, the CSP, and the draft NSPACC. This lack of awareness among crucial stakeholders poses risks of duplicative actions and siloed responses. For instance, a major health focused government funding channel indicated that they were in the process of finalising their health sector strategy document, which would serve as a guide to health funding nationwide across disease areas, yet had no knowledge of, or engagement with, the draft, costed NSPACC. Consultations also revealed that a key stakeholder, operating in the health sector, was developing a working group for communicable diseases across Nigeria. While this working group would operate with a much broader scope than any of the national level cholera working groups, this may still lead to a duplication of functions as both systems would operate in parallel without coordination. This highlights a critical gap in awareness and integration across health strategies that could hinder a cohesive, multisectoral cholera response in Nigeria.

Stakeholders noted that although regional coordination is essential in cholera response, as the disease easily crosses borders, there has been limited progress in implementing a coordinated regional approach. Porous borders and a lack of political will to support cross-country coordination have been documented as significant challenges to achieving regional coordination. Stakeholders interviewed stated that the GTFCC, as a global platform, could play a significant role in supporting the development of a regional response among the countries it interfaces with, or through engagement with international partners such as the Africa CDC.

2.3 Efficiency

Q4: *To what extent are the GTFCC operational structures set up efficiently to support the objectives of the Roadmap?*

Q5: *How efficiently has the Roadmap been implemented by the GTFCC in terms of optimizing human and financial resource allocation to support countries in a changing cholera landscape?*

The efficiency of the GTFCC's support to Nigeria has been strengthened by the catalytic role of the CSP. The CSP has played a key supporting role in expanding the scope of the national technical working groups, which includes key non-health components, such as WASH, risk communication, and community engagement, that are critical for an effective cholera response. Stakeholders widely praised the CSP's ability to engage these non-health actors and foster multisectoral collaboration. This approach has been pivotal in the development of Nigeria's draft national cholera plan, ensuring inclusivity and technical depth. Multiple stakeholders

emphasised that the CSP's coordination facilitated a robust planning process that might not have been achieved without its involvement. Furthermore, the CSP's support was also instrumental in accessing the OCV stockpile, allowing for rapid and targeted responses. This coordination and logistical support underscore the GTFCC's efficient use of resources where the CSP's facilitative role has added substantial value to national cholera control initiatives. By operating outside of government ministries, the CSP is able to circumvent bureaucratic constraints and protocol, enabling more direct cross-ministry engagement and fostering timely collaboration across key partners. By operating externally, the CSP can streamline inter-ministerial coordination, mitigating procedural delays.

However, stakeholders also identified areas where the CSP's efficiency could be enhanced. The CSP manager position involves a significant element of political engagement and relationship cultivation, which is impacted by the frequent turnover of key political appointees, such as ministers and the director generals of agencies, as well as mandatory retirements of senior civil servants. Stakeholders stated that this turnover in government leadership has led to delays in the development of the draft NSPACC. Given this context of turnover among key government partners, stability of the CSP manager position becomes even more critical to ensuring continuity in cholera prevention and response efforts. However, since the CSP's inception in Nigeria in 2021, there have been three CSP managers, with the position currently being re-advertised, as the incumbent manages the role alongside another position within the IFRC. The majority of stakeholders agreed that greater stability in the position of the CSP manager could be beneficial moving forward. However, stakeholders were split on the impact of the changeover in CSP managers. Some cited that the CSP had handled the handovers well, minimising friction, while others noted that the political and relationship-based nature of the role meant that previous changeovers resulted in the need to spend time redeveloping relationships. Additionally, the CSP operates as a single-person team managing extensive responsibilities and stakeholders recommended expanding the CSP in order to more efficiently meet the broad needs of Nigeria's cholera response.

Delays within the IRP presents a significant obstacle to efficiency.

Nigeria's draft NCP, submitted to the IRP in May 2024, remains under review as of November 2024, well beyond the anticipated 6-week review timeline. This delay has prompted stakeholders to consider launching the NCP as a 'living document' without the IRP's review and implementing feedback after the launch. However, this could limit the extent to which potentially valuable feedback from the IRP can be implemented after the launch. The IRP and Secretariat's limited communication regarding the delay has compounded these issues, creating uncertainty around expected timelines for the document's launch. Multiple stakeholders cited the delay as a cause of frustration and posed that it could eventually lead to a loss of momentum in support for the NCP and GTFCC.

2.4 Effectiveness

Q 6: What results have been achieved by the GTFCC partnership in the implementation of the Roadmap at the country level?

Q 7: Which factors have influenced the implementation of the Roadmap to date? What opportunities could be tapped into for better results?

In this section, we consider each Roadmap axis in turn: (i) outbreak response, (ii) prevention and (iii) coordination mechanisms.

Early detection and response to contain outbreaks

Cholera has remained a significant public health challenge in Nigeria, with periodic outbreaks reported across the country. Between January 2022 and September 2024, Nigeria recorded 38,283 suspected cholera cases, with a high case fatality rate (CFR) of 2.7%, and suspected cases across all 36 states and FCT in the country. The WHO states that with proper treatment, the CFR for cholera should remain below 1%, thus raising concerns regarding the CFR. Table 9 provides an annual breakdown of suspected cases over the period.

Table 9: Suspected cholera cases and deaths between 2022 and 2024

Year	Number of suspected cholera cases	Number of suspected cholera deaths	CFR
2022	23,763	592	2.5%
2023	3,683	128	3.5%
2024	10,837	359	3.3%
Total	**38,283**	**1,016**	**2.7%**

The capacity of the Federal Government to respond to outbreaks has increased in recent years due in part to improved coordination mechanisms. In 2017, Nigeria established the National Cholera Technical Working Group (TWG) to coordinate cholera response activities. The TWG is hosted at the NCDC in collaboration with the Federal Ministry of Health, Federal Ministry of Water Resources and Sanitation, the Federal Ministry of Environment, and the NPHCDA. There is ongoing surveillance in all states through the routine Integrated Disease Surveillance and Response (IDSR) and Event Base Surveillance (ESB). National Rapid Response Teams (NRRTs) are deployed as part of the outbreak response to support states in reporting cholera cases. There is also ongoing support to expand state-level laboratory testing capacity for cholera, which is currently limited to the NCDC National Reference Laboratory in Abuja and the Central Public Health Laboratory in Lagos. However, with support from the CSP, Nigeria successfully received approval for its request for cholera RDT kits from Gavi, which can further aid detection at the state level.

Key stakeholders noted that despite advancements facilitated by the GTFCC and its CSP, particularly in supporting the strengthening cholera response mechanisms, two key challenges persist in enhancing Nigeria's capacity for cholera detection and response. These challenges highlight areas where the GTFCC's support could be further leveraged to address systemic barriers and improve overall outcomes. The first challenge is political: stakeholders pointed out that for federal and international support to be mobilized for a state experiencing a cholera outbreak, the state must first acknowledge and declare it. There has at times been some reluctance to declare outbreaks, which is tied to the stigma associated with cholera, particularly as it relates to perceptions of development and hygiene standards. As a result, political officials face a disincentive to report outbreaks, especially if they are recurrent. This challenge is further complicated by the fact that cholera primarily affects low-income communities with limited political influence, lowering the perceived political cost of overlooking outbreaks. Stakeholders observed that overcoming this bottleneck would significantly improve the effectiveness of Nigeria's cholera response. In response, federal agencies and the CSP have adopted a proactive approach, engaging with state governments in cholera awareness efforts to reduce delays in outbreak declarations. Another limiting factor cited by stakeholders is the delay in transporting samples to laboratories equipped to identify the cholera pathogen: transporting samples often results in degraded samples, that may no longer be viable for accurate detection, leading to missed cases and further hampering response efforts.

International partners play a significant role in supporting Nigeria's cholera response through contributions to case management, capacity development and the delivery of essential commodities. Organizations such as WHO, Gavi, UNICEF, MSF, and Africa CDC are actively involved in these efforts. However, multiple stakeholders interviewed from key international and technical partners reported limited knowledge of or engagement with the GTFCC, the CSP, or involvement in the development of the draft NSPACC. This represents an area for improvement. Strengthening coordination and collaboration with these stakeholders could enhance the effective implementation of the country's cholera control strategy. Notably, the World Bank, a

major funding partner for WASH initiatives in Nigeria, was identified as a key organization that has yet to be engaged in these efforts. Targeted engagement with the World Bank and other partners could significantly bolster WASH initiatives and contribute to a more comprehensive cholera response.

The implementation of a reactive OCV vaccination campaign has been a success in recent responses but in some instances the vaccines have not been used as initially planned. In 2024, Nigeria received 4.4 million doses of OCV, approved by the ICG, to support vaccination campaigns. The doses were initially planned for use in Lagos state which was experiencing a cholera outbreak, but the doses were ultimately redirected to states in the North East, North West, and South East geopolitical zones after Nigeria successfully secured ICG approval to redeploy the shipment due to the containment of the Lagos outbreak. However, feedback from multiple stakeholders indicated that a key reason the vaccines were not deployed as planned was due to vaccine hesitancy, suggesting a lack of coordination between federal and state governments in their approach towards cholera control and response, as the application for OCV would have been developed and submitted by federal bodies, while other levels reportedly resisted their use. One stakeholder pointed out that the substantial amount of vaccines allocated towards the Lagos outbreak represented approximately 70% of the available global stockpile at the time, therefore this delay in deployment and utilisation may have represented a major opportunity cost to other communities facing cholera outbreaks. Both the CSP and other key government agencies involved in Nigeria's cholera response acknowledged the issue of vaccine hesitancy among state governments and have sought to engage proactively with states reporting cases, providing sensitisation and support to mitigate this challenge.

Prevention of disease occurrence through targeted multi-sectoral interventions in cholera hotspots

Two major developments in Nigeria's cholera prevention landscape are currently underway, yet to be launched and completed. The first is the Priority Areas for Multi-sectoral Intervention (PAMI) mapping, for which the CSP was planning to organise a workshop for in November 2024. Although, Nigeria previously conducted hotspot mapping, the updated PAMI mapping will align with the latest GTFCC guidance and is expected to be a more comprehensive exercise. Stakeholders expressed significant enthusiasm for this initiative, as it will involve a broader range of stakeholders beyond just the health sector, including the Federal Ministry of Water Resources and Sanitation and Environment strengthening the mapping process and increasing the accuracy of risk identification across the country. Furthermore, the PAMI mapping closely aligns with the objectives of the draft NSPACC, which was expected to launch in 2024.

Stakeholders have noted the development of Nigeria's NSPACC as a pivotal step towards a strategic and structured approach to cholera elimination. This multi-sectoral and multi-year plan is designed to prioritize cholera control interventions across sectors, particularly health, water, sanitation, and hygiene, with targeted efforts in high-risk states and LGAs. Moving away from a solely reactive approach, the plan emphasises sustained cholera prevention, aligning with WHO's vision for lasting cholera control.

The plan leverages WASH initiatives to address critical environmental and hygiene-related risk factors. The plan includes ambitious targets of achieving 80% access to safe drinking water and 60% sanitation coverage in priority hotspot areas by 2027. By enhancing access to safe water, expanding sanitation infrastructure, and promoting improved hygiene practices, this strategy seeks to reduce cholera transmission risks through comprehensive environmental and behavioural interventions.

Effective mechanism of coordination for technical support, resource mobilization, and partnership

While the GTFCC's support has facilitated progress toward a structured cholera response in Nigeria, the effectiveness of these efforts cannot yet be fully assessed as the draft NSPACC has not been implemented. Notable reported achievements include the development of a comprehensive NSPACC, supported by the GTFCC's technical guidance and the CSP's coordination, which together facilitated an adaptable context-specific framework for cholera control. Stakeholders highlighted that without the CSP's support, the NCP would likely have focused more narrowly on outbreak response rather than adopting a broader cholera control strategy. Furthermore, the CSP played a critical role in ensuring high-quality stakeholder engagement, bringing together across from various sectors even amid government transitions, and guiding the submission of the NSPACC to the IRP. While the process has taken longer than anticipated, stakeholders agreed that the enhanced quality of the document reflects the value add of CSP involvement.

Additionally, PAMI workshops were scheduled for November 2024, with the aim of implementing targeted interventions in cholera hotspots. However, as the NSPACC has not yet been formally launched and the identification of PAMIs remained in the planning stages at the time of this evaluation, both the stakeholders interviewed and the evaluating team for this case study cannot comment on the direct outcomes of these developments on cholera prevention and control.

Workshops and annual meetings are considered by stakeholders to be very useful. Engagement with technical guidance has been limited amongst stakeholders but when it has been utilised (e.g. the app), it has been much appreciated by stakeholders. Stakeholders identified the annual meetings and workshops as highly productive platforms for knowledge exchange and cross-sector dialogue. The GTFCC-related meetings held in Kenya in October 2024 by the GTFCC OCV Working Group and a separate research-focused meeting hosted by GTFCC partner, the Wellcome Trust, were attended by representatives from the NCDC and the CSP. Stakeholders cited that holding the meetings in a cholera affected country was a positive development. The majority of stakeholders consistently remarked that it would be beneficial to host gatherings in countries affected by cholera as opposed to countries in the Global North as such events raise the profile of cholera and present opportunities for engagement with high-ranking political office holders. Furthermore, stakeholders involved in developing Nigeria's draft NCP acknowledged the GTFCC's guidance as valuable, particularly in aligning the plan with international best practices.

However, direct engagement with the Global Roadmap and GTFCC technical guidance documents was generally limited among stakeholders interviewed, even among those with technical roles. This may be due in part to the fact that cholera is one of a number of diseases among stakeholders' profiles of work.

On the other hand, the GTFCC app, a mobile application developed by the GTFCC which proved technical information and guidance for cholera, has been considered useful. It was cited as a practical tool for managing resources at the state level during outbreaks, including supporting needs assessment and resource management during cholera outbreaks. Multiple interviewees stated that they were introduced to the app at a regional cholera readiness meeting in Ghana hosted by the WHO and other partners. Introducing stakeholders to the app in conjunction with an in-person event may have contributed to the level of successful engagement of stakeholders with the app. One stakeholder noted that upon their return from the meeting, they recommended the app to their colleagues as a useful source up-to-date technical guidance resource. However, one WASH stakeholder mentioned that the app's WASH content lacked adequate depth prompting them to rely on it primarily as a resource to learn about other pillars of cholera response. The app's popularity, alongside WHO AFRO's production of concise summaries of GTFCC guidelines, suggests a demand for more accessible, consumable resources.

Coordination between national partners has been enhanced, but further integration between national and subnational levels is needed for effective cholera response. Nigeria's Cholera Technical Working Group enables multi-sectoral coordination, bringing together representatives from the Ministry of Health, the Ministry of Water Resources and Sanitation, the Ministry of Environment and other stakeholders. This collaboration facilitates information sharing, expedites response planning, and enables consistent alignment across sectors. However, stakeholders noted that more cohesive integration between national and subnational levels is essential to ensure timely and effective implementation. In addition, the majority of stakeholders noted that while the GTFCC has made significant contributions to health responses for cholera, there is an opportunity to place greater emphasis on other critical pillar such as WASH, to achieve a more balanced approach in cholera control.

Funding advocacy and resource mobilization efforts related to cholera have been perceived by the majority of stakeholders as areas where the GTFCC and the in-country CSP could provide greater support. Stakeholders interviewed recognised the importance of advocacy and resource mobilization in addressing the significant challenges affecting Nigeria's cholera response. While acknowledging that the GTFCC is not a funding organization, several stakeholders suggested that it could enhance its advocacy efforts at both the global and country level to draw greater attention and resources towards cholera control. For example, the GTFCC could target funding partners outside of the health sector, operating in areas of development or humanitarian support. One suggestion frequently raised was for the GTFCC to move events away from the Global North and host them within cholera-affected countries. Stakeholders noted that holding these events within endemic regions could foster high-level political engagement in host countries while simultaneously alleviating visa-related barriers associated with travel to the Global North.

Influencing factors

Open defecation, high population density, and cross-border movements are the primary risk factors for cholera transmission in Nigeria. As of 2024, open defecation remains widespread in rural areas and high population density in urban centres exacerbates cholera risk by facilitating rapid transmission. Additionally, Nigeria's extensive borders with neighbouring countries pose challenges for controlling cross-border transmission, as population movements and trade routes can introduce cholera cases from neighbouring regions.

Climate-related events, including flooding, contribute to the persistence of cholera in Nigeria. Flooding, especially during the rainy season, increases the risk of cholera outbreaks by contaminating water sources and overwhelming the inadequate sanitation infrastructure. The presence of seasonal nomadic communities, who move between states, also contributes to the spread of cholera in rural and peri-urban areas.

2.5 Sustainability

Q 8: What steps has the GTFCC taken to ensure the sustainability of its interventions under the Roadmap?

Stakeholders expressed optimism regarding the institutional sustainability of Nigeria's draft NCP, noting that if it is successfully housed within the Office of the Vice Presidency under the Office of SDGs, it could provide a stable long-term platform to anchor the initiative. Key stakeholders expressed that their aim is to place the NCP under the accountability of the Office of the Vice Presidency, as it would grant the NCP a greater

platform cross-sectoral impact than if the NCP was exclusively housed under a single, vertically focused ministry. This strategic placement would afford the NCP substantial visibility and coordination support across sectors, as cholera control requires multisectoral engagement beyond the health sector alone. However, as the NCP is yet to be launched, the durability of this institutional support and its ability to withstand political shifts or administrative turnover remains untested. Several stakeholders cited past challenges in institutionalising health plans due to frequent changes in government officials, making the need for a resilient placement of the NCP within a high-level office all the more crucial.

Financing of the cholera response remains a very significant barrier to sustainability and no donor engagement strategy has been established yet. On financial sustainability, while the draft NCP's costing represents a positive step towards operationalisation, stakeholders interviewed noted a lack of targeted engagement with key funders such as the World Bank and bilateral partners, which are critical for mobilising long-term investment. This gap extends to limited dialogue with international WASH donors and multilateral agencies operating in Nigeria, who could play a pivotal role in addressing the financial requirements for cholera prevention and control. Multiple stakeholders expressed that without a structured donor engagement strategy to secure these essential partnerships, the government's reliance on external funding sources remains uncertain.

2.6 Gender, equity and human rights (crosscutting)

Q 9: To what extent has the Roadmap included GER concerns? To what extent have implementation activities factored equity considerations at the global and country level?

Cholera response efforts in Nigeria focus on economically marginalised communities/areas and there are efforts to collect disaggregated gender and age data, but additional efforts are needed to address other GER dimensions. The Roadmap reflects an awareness of socioeconomic inequities related to cholera, emphasising the vulnerability of impoverished communities and proposing interventions, such as OCV and WASH campaigns, in priority areas. However, the Roadmap engages more directly with economic inequities than with other GER dimensions. In Nigeria, cholera epidemiology reports, developed by the NCDC, consistently disaggregate outbreak data by age, gender and geographic distribution enabling monitoring of outbreak trends across these different groups. However, these reports do not include disaggregated data on other vulnerable populations such as people with disabilities or IDPs. There are approximately 3.4 million IDPs in Nigeria, these individuals face an increased risk to cholera due to the suboptimal WASH services available in IDP camps. The draft NSPACC acknowledges health and access to water and sanitation as fundamental human rights. However, beyond this, there is limited reference to other GER principles such as gender equity or disability inclusion within the document.

The prevalence of cholera in Nigeria underscores socioeconomic inequities, disproportionately impacting economically marginalised communities, especially those in areas with limited infrastructure and resources. Moreover, those most affected, typically low-income populations with limited political influence, are easily overlooked, exacerbating the cycle of neglect and vulnerability.

3. Conclusion

The GTFCC, especially through the CSP (and to a smaller extent the WGs), has helped facilitate Nigeria's cholera prevention and response efforts through supporting the development of the draft NSPACC, facilitating coordination, and supporting capacity building initiatives such as workshops. These efforts underscore the GTFCC's value in providing technical guidance and fostering multisectoral collaboration. The draft NSPACC, informed by the Global Roadmap, represents a positive development of adapting international good guidance to suit the specific country context of Nigeria.

The Global Roadmap remains relevant to Nigeria's health and policy landscape, as demonstrated by its integration into the NSPACC 2024 – 2028. The nine thematic areas covered by the NSPACC represent an adaptation of the five pillars in the Global Roadmap. This alignment represents the Roadmap's continue applicability in Nigeria's evolving cholera context. However, despite this strong relevance, awareness of the Roadmap remains limited among key national and international stakeholders active in Nigeria.

The GTFCC, in large part through the CSP, has played a crucial role in strengthening national coordination for cholera control in Nigeria. The CSP has facilitated collaboration among key ministries, government agencies, international technical partners, ensuring that the NSPACC reflects a broader, multi-sectoral approach. Furthermore, the GTFCC's General Assembly and global Working Groups have been valuable in promoting cross-country knowledge exchange, though stakeholders noted that holding such meetings in cholera-endemic countries could improve engagement with political decision-makers.

The GTFCC's operational structures, particularly the CSP, have helped to facilitate multi-sectoral coordination, supporting technical guideline development, and applications for critical resources such as RDTs. The CSP's ability to navigate bureaucratic constraints has been particularly valuable in accelerating cholera response planning and efforts and strengthening collaboration across government entities.

However, there are still opportunities for enhanced efficiency in terms of support from the GTFCC. Delays in receiving feedback from the IRP on the draft NSPACC, have impacted the launch of the national cholera plan. The CSP itself operates as a single-person team with the large mandate of supporting cholera prevention and response efforts in a country of over two-hundred million people. While expanding the CSP would require a funding commitment, the expansion could enable greater technical support, and further improve coordination and engagement with key stakeholders.

The support from the GTFCC and partners has contributed to progress in Nigeria's cholera response, particularly through strengthening outbreak detection and response mechanisms, and technical guidance. However, challenges remain in fully translating strategic planning into effective cholera response and prevention implementation. Political reluctance to declare cholera outbreaks at the state level has limited or delayed response efforts in the past. Limited state-level diagnostic capacities and delays in sample transport further impact early detection. Additionally, some key donors and technical partners are not yet engaged, limiting the ability to mobilize resources.

The NSPACC represents a key step towards institutionalising Nigeria's cholera response beyond the remit of any single ministry, with plans to anchor it under the Office of the Vice Presidency to ensure high-level political commitment and cross-sectional coordination. This positioning could provide the long-term stability needed to sustain cholera prevention and response efforts. Additionally, the multi-sectoral approach embedded in the NSPACC reflects a shift toward a more integrated and sustainable strategy, leveraging WASH interventions and community engagement to reduce cholera transmission risks over time.

However, financial sustainability remains a challenge. Without long-term financial commitments, the implementation of the cholera prevention measures, particularly WASH infrastructural investments, remain uncertain.

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Consultee list

This case study was informed through consultations and focus group discussions with the following stakeholders:

Stakeholder group	Organization (# of consultees)
Government – National Level	Nigeria Centre for Disease Control (NCDC) (3)
	Federal Ministry of Environment (1)
	Federal Ministry of Water Resources and Sanitation (1)
	Federal Ministry of Health and Social Welfare (1)
	National Primary Healthcare Development Agency (NPHCDA) (1)
	Sector Wide Approach (SWAp) Coordination Office (1)
Non-Governmental Organizations (NGOs)	Resolve to Save Lives (1)
	CASFOD (1)
	Lafiya Program (1)
	Break Through Action (1)
Research and Academia	National Institute for Pharmaceutical Research and Development (1)
	University of Benin (1)
GTFCC Country Support Platform	IFRC (1)
Technical Partners and Donors	WHO / Health Operations (3)
	WHO / Health Information Management (1)
	WHO / Risk Communication and Infodemic (1)
	WHO / Country Preparedness and International Health Regulations (1)
	WHO / Public Health and Environment (1)
	WHO / Vaccine Preventable Diseases (1)
	UNICEF / HIV/AIDS (1)
	UNICEF / NCDC (1)
	UNICEF / Emergency (1)
	Africa CDC (1)
	Médecins Sans Frontières (1)
	World Bank / Supply and Sanitation (2)

Country case study Somalia

This Somalia country case study supports the Mid-term Evaluation of the Global Task Force on Cholera Control (GTFCC). Following country background information and context (Section 1), country-level findings are presented for each of the evaluation areas (Section 2): Relevance (Section 2.1), coherence (Section 2.2), efficiency (Section 2.3), effectiveness (Section 2.4), sustainability (Section 2.5) and gender, equity and human rights (Section 2.6). A final conclusions section based on these findings from Somalia follows (Section 3).

1. Introduction, background and country context

1.1 Introduction

This case study is one of six case studies which have the purpose to generate evidence for evaluation questions set out in the evaluation framework and be an evidence base for findings in the main evaluation report. This includes questions relating to (i) the work of the GTFCC and (ii) implementation of the cholera Roadmap from a country perspective.

Countries were selected to allow for diverse representation across key criteria for the evaluation and permit a deeper assessment of successes, challenges and lessons pertaining to the work of the GTFCC and the Roadmap. For Somalia, this included: (i) being on the Roadmap priority list; (ii) being a country that has not received country support platform (CSP) support; (iii) having a National Cholera Plan (NCP) and (iv) being a country in a fragile context.

1.2 Methods

Data collection methods for this case study included a review of key documentation and focus group discussions (FGDs) and stakeholder interviews held. Key informants were purposefully selected to take part in interviews and FGDs. They were selected with the aim to get a mix of stakeholders from government including different national level ministries (Ministry of Health and Human Services, Ministry of Energy and Water Resources), representatives from different GTFCC partners (WHO, UNICEF), and those who could speak to different pillars of the cholera Roadmap (e.g. laboratory, surveillance, oral cholera vaccine (OCV), water, sanitation and hygiene (WASH) etc). Key informant interviews (KIIs) were conducted using a semi-structured interview guide. In total, KIIs were conducted with only six interviewees through a mix of in-person and remote interviews. Data from KIIs were analysed alongside documents to develop the findings for this case study.

Limitations: It was only feasible for the evaluation team to conduct a small number of interviews for this case study owing in part to logistical challenges in the complex situation, including constraints in accessing stakeholders and collecting data within the timeframe available for the evaluation. Where possible, the evaluation team responded by setting up alternate interviews with individuals within the same or similar organizations, and the WHO Country Office supported mitigation efforts by facilitating some remote

consultations. Additionally, at times, interviewees only had limited information and documentation on key aspects relating to the GTFCC.

1.3 Key country characteristics and cholera context

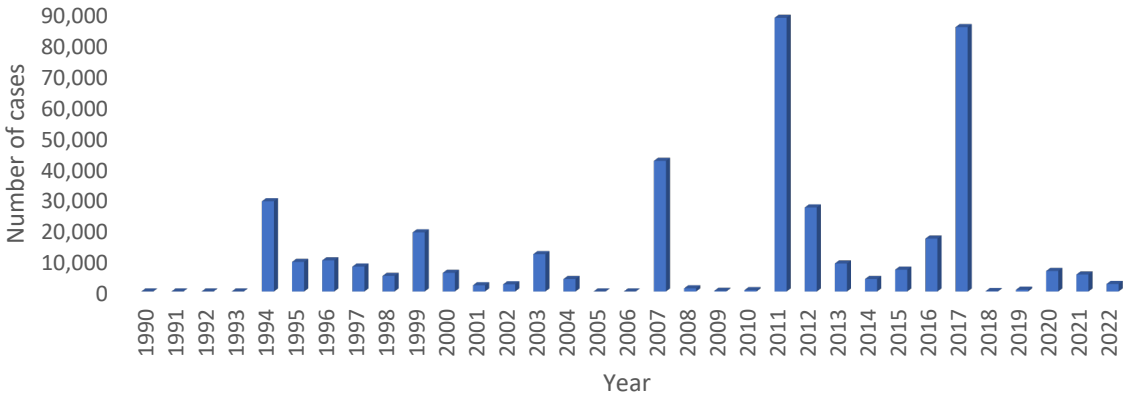
Somalia, located in the Horn of Africa, is bordered by Ethiopia to the west, Djibouti to the northwest, Kenya to the southwest, the Gulf of Aden to the north, and the Indian Ocean to the east. With the longest coastline on mainland Africa, Somalia has an estimated population of 19.2 million, of which 2.6 million reside in the country's capital, Mogadishu. Approximately 85% of the population is ethnically Somali, and the official languages are Somali and Arabic. Governance in Somalia is based on a federal system, composed of two levels of government, the federal government and the six Federal Member States (FMS) of Jubaland, South West State, Galmudug, Hirshabelle, Puntland, and Somaliland, as well as the Benadir Regional Administration which encompasses the federal capital of Mogadishu.

Somalia faces complex developmental challenges. Periods of conflict, political instability, climate shocks, including recurrent droughts, floods and locust infestations have compounded poverty, food insecurity, and displacement. These challenges have contributed to low economic growth, with real GDP growth averaging 2.1% annually from 2019 to 2023 and negative real GDP per capita growth (-0.7%) over the same period. As of 2024, Somalia ranks 193rd on the United Nations Human Development Index and is identified as the most fragile state according to the Fragile States Index, reflecting the significant challenges the country continues to face.

Somalia's healthcare system is characterised by a combination of public, private, and humanitarian services, with significant reliance on external partners such as international organizations and NGOs. The public healthcare system is overseen by the Federal Ministry of Health at the national level, while the states manage healthcare delivery at regional and local levels. However, governance remains fragmented, and coordination between federal and regional authorities is limited. The Somali healthcare system faces significant challenges, including underdeveloped infrastructure, a shortage of trained healthcare workers, and insecurity which limits access to services in conflict-affected areas. Healthcare delivery is further constrained by low public spending on health which was estimated at 2.62% of GDP in 2022. As a result, out-of-pocket expenditure made up 42.14% of healthcare expenditure in Somalia in 2022.

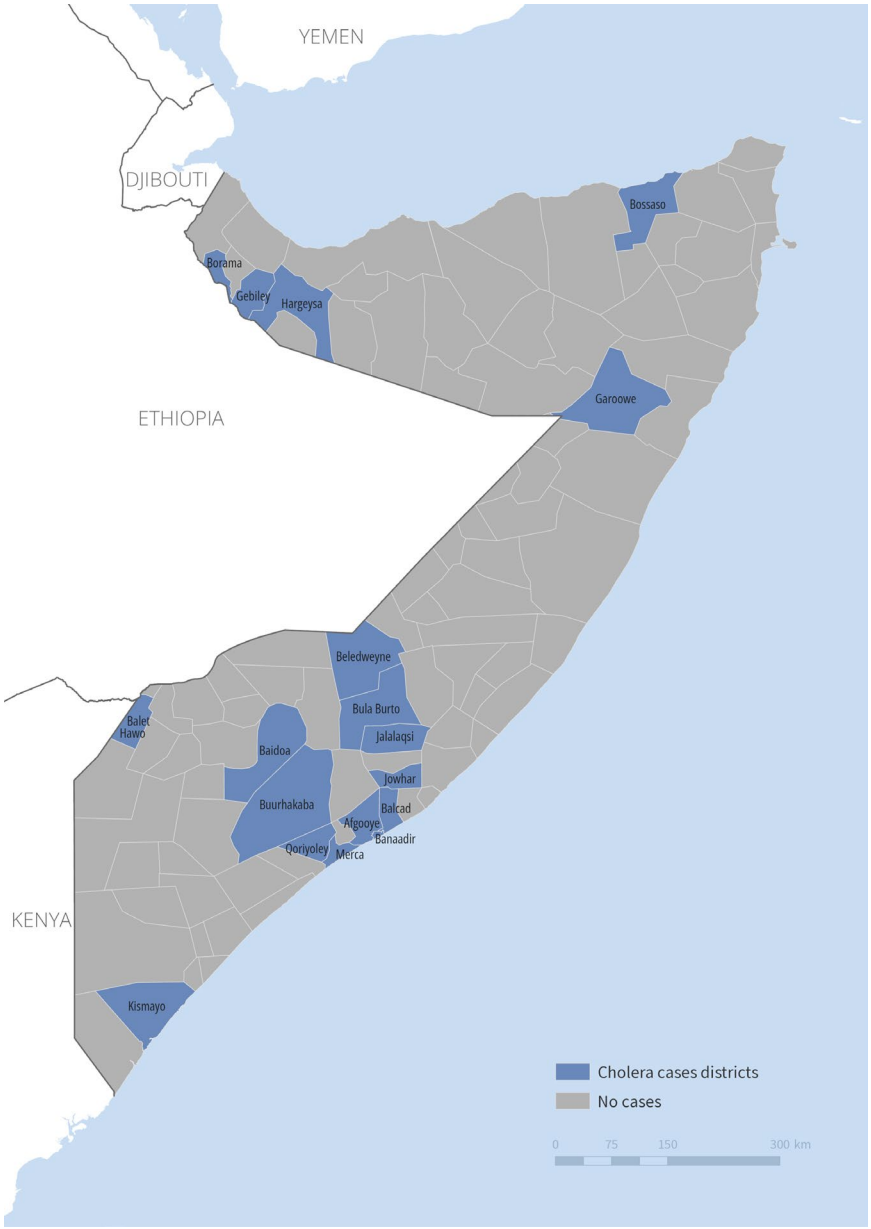
Cholera has been a persistent public health challenge in Somalia for decades, with the disease becoming endemic in many regions. The disease was first reported in Somalia in 1970 but the first major cholera outbreak in Somalia occurred in the early 1990s during the country's civil war, a period marked by widespread displacement and the collapse of essential services. Since then, cholera outbreaks have been recurrent, driven by poor WASH infrastructure, conflict-induced displacement, and cyclical climate shocks such as droughts and floods. The 2017 outbreak marked a turning point, as the cholera epidemic moved to endemic transmission and became uninterrupted, particularly in central and southern regions of Somalia where vulnerabilities remain most acute. Over the years, persistent lack of access to safe drinking water, overcrowding in internally displaced persons (IDP) camps, and food insecurity have exacerbated the disease's spread, particularly among children under five who remain disproportionately affected. Figure 9 below demonstrates the annualised trend in cholera cases in Somalia between 1990 and 2022, which features cyclical major outbreaks.

Figure 9: Annual number of cholera cases between 1990 – 2022



As of 2024, cholera transmission in Somalia has expanded geographically with outbreaks now being reported beyond traditional hotspots to regions in Somaliland and Puntland. In the first half of 2024 alone, Somalia recorded 16,927 cholera and Acute Watery Diarrhoea (AWD) cases, with children under five accounting for 60% of infections. The cumulative death toll stood at 136, largely driven by malnutrition rates exceeding emergency thresholds. The 2024 Gu rainy season (April – June) exacerbated the situation, as flooding damaged WASH infrastructure, further increasing the risk of cholera transmission in affected areas. Figure 10 below shows cholera cases by districts in Somalia as of March 2022.

Figure 10:Cholera cases (as of March 2024) in Somalia by district



1.4 Object of the evaluation and summary of GTFCC support to Somalia

The GTFCC and Roadmap

The GTFCC is a partnership of approximately 50 institutions to coordinate activities for cholera control at global, regional, and country levels*(2)* . The GTFCC brings together organizations working across multiple sectors and serves as a coordination platform to support countries in the implementation of the Global Roadmap on ending cholera *(3)*. The Global Roadmap Strategy (Ending Cholera – A Global Roadmap to 2030), was issued in 2017, The Roadmap provides the global strategy for cholera control at the country level and outlines a path towards a world in which cholera is no longer a threat to public health *(3)*. The Roadmap is underpinned by early detection and quick response to contain outbreaks; a targeted multi-sectoral approach

to prevent cholera recurrence; and a mechanism of coordination for technical support, advocacy, resource mobilization, and partnership at local and global levels. A key role of the GTFCC is to promote and support the implementation of the Ending Cholera – A Global Roadmap to 2030 at country level by providing the advocacy, coordination, policy guidance and technical assistance for countries to develop National Cholera Plans (NCPs) and implement them. By implementing the strategy between now and 2030, the GTFCC partners aim at supporting countries to try to reduce cholera deaths by 90%.

In particular for countries, the work of the GTFCC includes (i) tool development and technical guidance which the GTFCC Secretariat helps to coordinate and GTFCC technical working groups develop; (ii) support to the implementation of these tools and their translation into activities (Country Support Platform (CSP) support[45] in a small number countries (but not Somalia), and technical assistance provided by partners) and (iii) the independent review panel (IRP) that reviews NCPs for select countries (Somalia was not included in this exercise).

The GFTCC and Roadmap in Somalia

Somalia is a key country for the work of the GTFCC in achieving the Roadmap goal of eliminating cholera as public health threat by 2030 due to its endemic cholera status and recurrent outbreaks. Somalia's engagement with the GTFCC has been primarily facilitated through the WHO and its country office with targeted technical support to strengthen cholera prevention, preparedness, and response. Somalia's Ministry of Health has participated in GTFCC General Annual Meetings since 2023. Somalia's engagement/ interaction with the GTFCC includes:

- In September 2023, Somalia's Federal Ministry of Health, WHO, UNICEF, the Health Cluster, and WASH Cluster merged existing Technical Working Groups into a unified National Task Force on acute watery diarrhoea (AWD) and cholera, focussing on the GTFCC's five pillars of surveillance and reporting, healthcare system strengthening, OCV, WASH, and community engagement.
- Somalia's Cholera Preparedness and Response plan (2024 – 2028) was developed by the Ministry of Health with support from the WHO, the Health and WASH Clusters, and in alignment with GTFCC guidelines. As part of this long-term strategy, a short-term Six-Month Cholera Multi-Sectoral Operational Plan (December 2023 – May 2024) was developed in response to the heightened risk of cholera surges due to flooding. The six-month operational plan was derived from the five-year plan.
- Between 2017 and 2019, 1.8 million doses of OCV were administered in OCV campaigns, which included targeting high risk areas with support financial and technical support from GTFCC partners including WHO, UNICEF and Gavi.
- As reported by KIIs, in October 2024, a Somalia mission by the WHO Cholera Program Team Lead and the Coordinator/ Focal Point of the GTFCC Secretariat led to the adoption of key decisions by national authorities, including: initiating the process of identifying Priority Areas for Multisectoral Intervention (PAMIs) with support from the WHO and the GTFCC Epidemiology Working Group Focal Point and revising the national cholera plan to incorporate the PAMIs that will be identified.

[45] The CSP was established in 2020 and leads the multi-sectoral support that the GTFCC provides to countries for the implementation of their NCPs. The CSP supports the short, medium and long-term deployment of GTFCC multi-sectoral expertise in countries. Five 'primary operational countries' have received substantial support: Bangladesh, Democratic Republic of Congo (DRC), Mozambique, Nigeria and Zambia. In addition, another four countries have received ad-hoc technical support.

2. Key findings

2.1 Relevance

Q1: To what extent is the Roadmap relevant given the changing environment (e.g. epidemiological, political, climate and risk profiles)? To what extent have measures been taken to ensure continuous adaptation of the Roadmap in line with latest international best practices and guidelines, and emerging needs at the country level?

Q2: To what extent is the design of the GTFCC adequate to support the objectives of the Roadmap?

Relevance of Roadmap given the changing environment

The Global Roadmap remains highly relevant to Somalia, offering a framework for addressing the country's endemicity amid a complex and evolving landscape. Stakeholders interviewed affirmed that the Roadmap's objectives and strategic pillars respond to the complex drivers of cholera transmission, including poor WASH infrastructure, food insecurity and recurrent climate shocks. The revised Cholera Preparedness and Response Plan for Somalia 2024 – 2028 and Somalia's Six-Month Cholera Multi-sectoral Operational Plan were developed in alignment with the Global Roadmap and GTFCC guidance.

Some issues with translating the global Roadmap to implementation in Somalia were noted during stakeholder interviews:

- While the Roadmap promotes a balance between outbreak response and prevention, stakeholders emphasised that Somalia's cholera interventions remain heavily outbreak response driven due to the persistent humanitarian context. Key stakeholders stated that the current strategies lack sufficient integration with long-term health system strengthening or structural WASH improvements, which are critical for sustained cholera prevention.
- Engagement with the Roadmap has been limited beyond federal actors, with subnational stakeholders often unaware of its objectives and the tools it provides. This lack of awareness among subnational stakeholders highlights a gap in effective engagement with the subnational and local levels of governance (discussed below).

Despite these limitations, the Roadmap's relevance remains clear in Somalia, where the conditions driving cholera transmission (climate variability, displacement, and malnutrition) align closely with the Roadmap's focus on addressing the root causes of cholera. Stakeholders stressed the need to accelerate hotspot mapping, also in line with the Roadmap. Interviewees consider that the implementation of the Roadmap can provide a critical foundation for achieving sustained progress in Somalia's fight against cholera with further adaptation and targeted implementation of the NCP.

Design of the GTFCC to support objectives of the Roadmap

Somalia has had relatively limited engagement with the GTFCC internal structures with support being provided primarily through WHO as a key GTFCC partner. This approach to providing support has generally worked well in Somalia.

The GTFCC operates through several key structures, including the Secretariat, the Steering Committee, the Independent Review Panel (IRP), the Technical Working Groups (TWGs), which focus on OCV, WASH, Epidemiology, Laboratory, and Case Management, and the CSP.[46]

Somalia's engagement with the GTFCC internal structures has primarily been through the WHO country office (and regional office to a lesser degree) and the GTFCC Secretariat. Stakeholders noted the support from WHO for assistance for activities such as the development of Somalia's Cholera Preparedness and Response Plan (2024–2028) and request for support around aspects like PAMI identification. Somalia does not have access to a formalised in-country support structure such as the GTFCC's CSP which provides support to some GTFCC countries and stakeholders expressed a desire for this support.

The WHO country office and the WHO regional office staff have provided direct technical assistance and importantly, strategically requested support from the GTFCC Secretariat and WHO Cholera Program on some key areas of assistance for the country (e.g. PAMIs). The WHO is recognised for playing a critical role in linking support between the GTFCC internal structures (e.g. Secretariat, Working Groups) and Somali stakeholders.

More broadly, the GTFCC has also supported cholera prevention and response efforts in Somalia through its provision of technical guidance documents, support for targeted OCV campaigns, and participation of country representatives from Somalia in the task force's Annual General Meetings. However, overall engagement remains at the Federal Government with limited awareness of the GTFCC's operational structures, particularly at the subnational level. The stakeholders interviewed highlighted that more direct engagement with state level actors (directly or indirectly) would be beneficial to ensure GTFCC tools and guidelines are effectively adapted to local contexts.

2.2 Coherence

Q3: To what extent has the GTFCC, through its governance structures and mechanisms, promoted complementarity, synergy and integration between different members' interventions at the global and the country level? What is the added value of GTFCC members acting together?

Coordination has been enhanced through establishment of the National Task Force, but multisector collaboration and alignment between federal and state level government remains a challenge. Due to the endemicity of cholera in Somalia, multiple different technical working groups and task forces were established across government and international stakeholders in previous years. In September 2023, a meeting between the Federal Ministry of Health and Human Services, WHO, UNICEF, Health cluster and WASH cluster, led to a decision to merge the existing technical working groups and task forces into a National Task Force on AWD/ Cholera which would focus on the GTFCC's five pillars (surveillance and reporting, healthcare system strengthening, OCV, WASH, and community engagement). According to stakeholders interviewed, this multisector and multi-stakeholder platform has provided a structured mechanism for aligning activities with the global Roadmap and enhancing collaboration among stakeholders.

[46] The Steering Committee provides overall strategic guidance, while the IRP is responsible for transparent reviews and endorsement of National Cholera Plans (NCPs). The Secretariat plays a central role in coordinating efforts between the WHO cholera programme and the CSP. The TWGs develop technical standards, guidelines, and best practices for cholera control, and the CSP supports countries directly by offering technical assistance, capacity building, advocacy, and implementation support for research initiatives.

However, despite the presence of this task force, stakeholders interviewed consistently highlighted weaknesses in achieving multisector collaboration, particularly between the health and WASH sectors. Engagement with ministries outside the health sector at the federal level remains limited, and coordination gaps persist at the state and district levels, where implementation occurs. WASH partners highlighted delays in data sharing and collaboration, which hinder the integrated approach outlined in the Roadmap.

2.3 Efficiency

Q4: To what extent are the GTFCC operational structures set up efficiently to support the objectives of the Roadmap?

Q5: How efficiently has the Roadmap been implemented by the GTFCC in terms of optimizing human and financial resource allocation to support countries in a changing cholera landscape?

The way in which WHO has supported the country's cholera interventions appears to be an efficient way for the country to receive support. However, significant challenges remain to deliver the cholera response more efficiently.

GTFCC's guidance and technical resources, primarily channelled through WHO, have supported the country's cholera interventions. This has ensured efficient provision of support, especially given the WHO staff's knowledge of the available GTFCC resources. However, **stakeholder feedback revealed mixed perceptions of the efficiency of cholera response overall and the implementation of the Roadmap in Somalia,** specifically:

- A key issue identified by the stakeholders interviewed was the over-reliance on emergency response activities, with limited focus on preparedness and capacity building, particularly at the subnational level. Technical support from WHO, such as assistance with vaccine deployment and operational guidance, has been crucial; however, stakeholders highlighted that knowledge sharing and capacity-building efforts are not provided frequently enough to keep pace with the country's evolving needs.
- Resource allocation challenges were raised by interviewees. Cholera treatment centres (CTCs) are sometimes underutilised, with some facilities maintaining large staffing rosters despite low patient loads. These inefficiencies are compounded by inconsistent funding mechanisms, which hinder the ability of local actors to address cholera outbreaks effectively. Additionally, inefficiencies in surveillance and reporting systems were noted, particularly the lack of differentiation between AWD and cholera in case data, which can lead to an inflation in reported case numbers.

While WHO's longstanding operational presence in Somalia enables it to provide valuable logistical and technical support, stakeholders noted that the broader cholera response system does not sufficiently integrate long-term strategies for health system strengthening. Efforts remain heavily focused on short-term emergency measures rather than addressing systemic inefficiencies in WASH infrastructure, surveillance, and local capacity building. The WASH Cluster in Somalia is comprised of over 180 local NGOs, government agencies and international organizations including: the Ministry of Health, UNICEF, the UN Refugee Agency (UNHCR), Polish Humanitarian Action (PAH), the Ministry of Energy and Water Resources, OCHA, the International Organization for Migration (IOM), and multiple others.

2.4 Effectiveness

Q 6: What results have been achieved by the GTFCC partnership in the implementation of the Roadmap at the country level?

Q 7: Which factors have influenced the implementation of the Roadmap to date? What opportunities could be tapped into for better results?

The implementation of the Roadmap in Somalia has demonstrated progress across several pillars, though significant gaps remain. Stakeholders and document review revealed advancements in coordination, outbreak response, and surveillance, supported by partners such as WHO and UNICEF. However, systemic issues, including limited subnational capacity and infrastructure gaps continue to constrain effectiveness. Specific aspects in line with the Roadmap axes are discussed below.

Axis 1 (Outbreak response) and Axis 2 (Prevention)

Progress in cholera outbreak response continues but remaining gaps in hotspot identification, cross-border coordination and WASH hinder long term prevention.

Somalia has made progress in outbreak response and prevention. This includes improvements in surveillance and reporting which have been achieved through the integration of the Integrated Disease Surveillance and Response (IDSR) System which enhances monitoring of trends and alerts. In addition, district-based Rapid Response Teams (RRTs) have strengthened the detection and validation of cholera cases, which enables more timely responses at the community level. However, cross-border surveillance and coordination with Kenya and Ethiopia remains a major challenge with the majority of cases reported in Somalia coming from border states.

Cholera case management has also advanced with the operationalisation of approximately 50 Oral Rehydration Points (ORPs) and Cholera Treatment Centres (CTCs) between 2022 and 2023 and the deployment of approximately 2 million doses of OCV across 20 districts. However, stakeholders noted that the lack of a hotspot identification strategy within the national cholera plan makes implementation of highly targeted interventions more challenging.

WASH interventions, such as chlorination of wells and distribution of hygiene kits, have played a role in mitigating cholera transmission during outbreaks. However, these efforts remain largely reactive, addressing immediate needs rather than establishing sustainable systems to prevent future outbreaks.

Axis 3 (Coordination)

Collaboration between UN partners and the Somali government is strengthening flood preparedness in Somalia, highlighting prevention efforts for cholera.

As part of Somalia's flood preparedness efforts, OCHA and Somalia Disaster Management Agency (SoDMA) organised a joint After-Action Review workshop on the Deyr flood response, to take stock of the efficiency and effectiveness of preparedness and response. The workshop was attended by representatives from ministries, Inter-Cluster Coordination Group (ICCG) and emergency managers. OCHA is working with key stakeholders including the Clusters and SoDMA to track the progress of the agreed actions and recommendations while the

ICCG is facilitating the implementation of key preparedness, readiness and anticipatory actions, which are outlined in the 2024 Humanitarian Needs and Response Plan for Somalia (HNRP). The main tasks completed so far include mapping existing boats and updating the operating procedures for the Logistics Cluster for timely prepositioning of boats and other essential supplies in hotspot areas. The updated Rapid Needs Assessment tool aims to facilitate timely response and early warning messages have been updated by the Community Engagement Taskforce, in coordination with stakeholders. There are also ongoing efforts to improve Area Based Coordination (ABC) to enhance preparedness and response.

Critical funding gaps impede cholera response efforts.

Despite the continuing efforts and progress made so far, significant gaps exist as the spread and size of outbreaks is expanding. UNICEF, a key partner for cholera response in Somalia, mobilized US$ 3.4 million for cholera response in Somalia in 2024 but projected a need of an additional US$ 4.2 million to reach 700,000 more people. This included gaps in activities, such as procurement of additional cholera kits for case management, deployment of RRTs, capacity building in high-risk districts, enhanced surveillance as well as rehabilitation of damaged water points, communal latrines, and chlorination of wells. It is noted that there should also be a greater focus on coordination of health activities with WASH activities, which accounts for the majority of the funding gap (40%) that could be improved by engaging UNOCHA for inter-cluster coordination.

Outbreak response capacity has improved, but gaps in community-level surveillance, coordination, and preparedness remain.

Interviewees highlighted that the government and other stakeholders have improved capacity to manage outbreak response in aspects such as detection, source tracing and water treatment. Overall, surveillance is considered to have improved, however this relates to event-based surveillance rather than community-level surveillance, which also highlights limited community awareness and engagement. On the other hand, better coordination is needed between stakeholders. There is also a need for improved preparedness, for example advanced planning to address cholera outbreaks when floods/ drought are expected instead of a reactive response, and focus on logistical problems, including security issues and physical access to target areas. There is also insufficient district-level staff capacity with a lack of guidance to direct capacity building.

More broadly, while stakeholders acknowledged the value of technical guidelines and tools provided by the GTFCC, such as case management protocols and OCV deployment frameworks and in particular the GTFCC app,[47] these resources have not been sufficiently disseminated to stakeholders at the state and local levels.

2.5 Sustainability

Q 8: What steps has the GTFCC taken to ensure the sustainability of its interventions under the Roadmap?

Lack of financial resources and political commitment are a significant barrier to sustainability.

The lack of financial resources and political commitment emerged as significant barriers to sustainability through both stakeholder consultations and document review. Stakeholders highlighted critical gaps in

[47] A phone-based application developed by the GTFCC with technical information and practical documents for public health professionals working in cholera control.

support for preparedness and subnational capacity building, which are essential for sustained cholera prevention. While international partners provide crucial emergency funding, the transition to development-oriented financing remains largely unaddressed. As outlined above, in section one, Somalia's political instability, insecurity, and protracted conflicts have severely undermined health and WASH infrastructure, leaving these systems in need of significant investment for restoration. The restoration of such infrastructure requires long-term political will and commitment.

The country's cholera strategy remains heavily focused on reactive humanitarian interventions rather than long-term systemic improvements which, while reflective of the country's situation, poses challenges to the sustainability of cholera efforts. A key issue highlighted is the limited integration of cholera control into broader health and WASH systems. Stakeholders reported that interventions often address immediate outbreaks without adequately investing in infrastructure of health system strengthening needed for sustained prevention. Additionally, competing priorities such as drought, flooding, and conflict further strain resources and reduce focus on cholera control.

2.6 Gender, equity and human rights (crosscutting)

Q 9: To what extent has the Roadmap included GER concerns? To what extent have implementation activities factored equity considerations at the global and country level?

Somalia's cholera outbreak data collection disaggregates cases by age, gender, and geographic distribution (through integrated disease surveillance and response (IDSR) and data management tools), enabling monitoring of the diseases impact on these groupings of people but some GER-related variables are excluded. Relevant GER-related variables, such as disability status and IDP status are not captured, thereby limiting the ability to address the specific needs of these vulnerable groups considering **conflict and insecurity challenges.**

In addition, Somalia's national cholera plan incorporates explicit references to gender equity and social inclusion on multiple occasions, particularly in the context of WASH interventions. While some KIs highlighted the active participation of women mainly as community-level volunteers during cholera outbreaks, particularly in roles that involve direct engagement with affected populations, they also noted that decision-making roles at higher level were predominantly held by men.

Conclusion

Somalia's enduring struggle with cholera reflects the country's broader challenges of poverty, insecurity, climate shocks, and underdeveloped WASH infrastructure. The GTFCC, including the Secretariat and key partners such as the WHO and UNICEF, have provided critical technical guidance and operational support, contributing to advancements in coordination, outbreak response, and surveillance. The alignment of Somalia's cholera response plans with the GTFCC Roadmap demonstrates the framework's relevance and potential to drive progress in the country's efforts to eliminate cholera.

However, significant challenges remain. The heavy focus on reactive, humanitarian interventions over long-term systemic improvements limits the sustainability of current efforts. Limited integration of cholera control into broader health and WASH systems, insufficient subnational capacity, changed with data reporting and inadequate resources exacerbate these challenges. While international partners continue to provide essential

emergency funding, transitioning to development-oriented financing and systemic gaps are core to sustained progress.

The incorporation of gender equity and human rights dimensions in Somalia's national cholera plan, alongside the active participation of women at community level reflects positive progress towards GER principles. However, gaps persist particularly in ensuring decision-making roles are more inclusive.

Moving forward, Somalia's cholera response would benefit from GTFCC support to strengthen national capacity, foster multisectoral collaboration, and advance structural investments in WASH and health systems.

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Consultee list

Stakeholder group	Organization (# of consultees)
Government	Federal Ministry of Health and Human Services / Health Emergency and Response (1)
	Federal Ministry of Health and Human Services / Integrated Disease Surveillance and Response (1)
	Ministry of Energy and Water Resources (2)
Technical Partners	WHO / Emergencies (1)
	UNICEF / WASH (1)

Online survey analysis

This section contains the e-survey questionnaire and results. The e-survey was designed to gather stakeholder views on the progress made by the GTFCC, as well as gather recommendations for improvement, across a wider global, regional and country-level stakeholder base than was feasible through consultations. The survey was available in two languages, English and French and open for over four weeks, from September 9th 2024 to October 10th 2024. A draft questionnaire was reviewed by the WHO and UNICEF Evaluation Offices and select ESG members.

Section I.1 presents the English questionnaire used. Section I.2 contains the e-survey results.

E- Survey Questionnaire

The survey features two sections: Section 1, Respondent Information, was constructed to collect background information on survey respondents and direct them to an appropriate subsection within Section 2, based on whether they worked at the global, regional or country level and their country's engagement with the GTFCC. Section 2 was designed to collect core feedback and comprised three separate sub-sections (2.1: Global, regional, and/or multi-country stakeholders, 2.2: Stakeholders from countries engaged with GTFCC, and 2.3: Stakeholders from countries not engaged with GTFCC). Based on answers given in Section 1, each stakeholder was automatically directed to complete only one of the three subsections in Section 2.

Section 1: Respondent information

1. Which type of organization/ body do you work for? *(Select one that best describes your organization)*

Technical international organization (e.g. UN, CDC or other international organization)
International NGO
Donor (BMGF, Wellcome Trust, USAID etc.)
Country government or government agency
Country level civil society/ NGO or community organization
Research institution – global/ multi-country
Research institution - country level
Vaccine manufacturer
Other (please indicate what type)

2. In what capacity have you engaged with the GTFCC? *(Select all that apply)*

Member of GTFCC internal structures (Steering Committee, Working Group, Independent Review committee, Country Support Platform, Secretariat)
Attend key meetings/ events (e.g., GTFCC annual general assembly, WHA side events)
Access GTFCC resources (e.g., guidelines, technical documents)
Provided GTFCC support at the country level
Received GTFCC support at the country level
Not engaged with the GTFCC
Other (please indicate what your engagement has been)

3. How long have you been working with or have been engaged with the GTFCC? *(Select one)*

0 to 1 year
1 to 2 years

2 to 5 years
Over 5 years
Not working with or engaged with the GTFCC

4. What is your gender? *(Optional)*

Female
Male
Other

5. Does your work in cholera primarily focus on the global, regional or country level?

Work at the global level refers to work that can be applied to a number of countries across multiple regions, e.g., WHO, UNICEF headquarters. Work at the regional level refers to work that can be applied to a number of countries within the same region, e.g., Africa CDC, WHO or UNICEF Regional Offices; work at country level refers to work that focuses on a specific country e.g. country government, partners' country offices.

Global, regional and/or multi-country level *(you will be asked to complete Section 2.1: global, regional and/or multi-country stakeholders)*
Country level

6. Is your country currently engaged or not engaged with the GTFCC?

Countries engaged with the GTFCC include countries which are receiving support from the GTFCC (e.g., technical support from the GTFCC Secretariat, country support platform or Working Groups) as well as countries for which government officials have directly engaged with the GTFCC (e.g., Ministry representatives attending the GTFCC annual general assembly).

Yes *(You will be asked to complete Section 2.2 for stakeholders from countries engaged with GTFCC)*
No *(You will be asked to complete Section 2.3 for stakeholders from countries not engaged with GTFCC)*

Section 2.1 Global, regional and/or multi-country stakeholders

1.
2.
3.

4. The Global Ending Cholera Roadmap *(3)* continues to be fit-for-purpose today.

At a high level, the Roadmap focus on (i) early detection and quick response to contain outbreaks; (ii) a targeted prevention strategy in cholera Priority Areas for Multisectoral Interventions (PAMIs) and (iii) partnership coordination for effective technical support, resource management and progress tracking.

Strongly agree
Agree
Neutral
Disagree
Strongly disagree
I don't have enough information to answer this question

Comments: Please provide any comments in support of your answer. If you do not view the Roadmap as adequately fit-for-purpose today, please recommend key areas for improvement.

5. For each of the GTFCC objectives listed below, please indicate the extent to which you agree that the objective is appropriate.

Select one response in each row that best reflects your opinion

GTFCC objective	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	I don't have enough information to answer
Supporting the design and implementation of global strategies						
Providing a forum for technical exchange, coordination, and cooperation on cholera-related activities to strengthen countries' capacity						
Supporting the development of a research agenda						
Increasing the visibility of cholera as an important global public health problem						

6. What is the GTFCC doing well and less well on in terms of progress towards its objectives? Are there additional activities that the GTFCC should undertake towards these objectives? *(Freeform answer)*

7. The GTFCC facilitates a more coordinated and aligned approach between partners and with countries.
   Strongly agree
   Agree
   Neutral
   Disagree
   Strongly disagree
   I don't have enough information to answer this question
   Comments: Please provide any comments and recommendations in support of your answer

8. The GTFCC Working Groups are functioning well (i.e. appropriate membership, strong leadership and collaboration/ participation, rigorous and useful outputs etc).

   Select one response in each row that best reflects your opinion on the statement above.

Working Group	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	I don't have enough information to answer/ I'm not involved with the Working Group
Case Management						
Epidemiology						
Laboratory						
Oral Cholera Vaccine						
WASH						

Comments: Please provide any comments regarding what has worked well or less well for the Working Groups, highlight key facilitating or hindering factors and share any recommendations on what can be

improved. Your comments can be general relating to all Working Groups or reference specific Working Groups.

---

9. The GTFCC approach to country engagement is working well.

Select one response in each row that best reflects your opinion on the statement above.

GTFCC mechanism of country engagement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	I don't have enough information to answer
Country Support Platform						
Independent Review Panel reviewing National Cholera Plans						
Support provided to countries through GTFCC partners						
Country representatives engagement/ participation in GTFCC governance structures (e.g. Steering Committee, Working Groups)						
Inclusion of country representatives in the GTFCC annual General Assembly						

Comments: Please provide any comments and recommendations in support of your answers. Please make any suggestions on how GTFCC should better engage with countries.

---

10. Partners/ members' engagement with the GTFCC is adequate and enables meaningful participation, strengthens collaboration and promotes synergy between partners.

Strongly agree
Agree
Neutral
Disagree
Strongly disagree
I don't have enough information to answer this question

Comments: Please provide comments as to what has worked well or less well regarding the GTFCC's current approach to partners' engagement and share recommendations for improvement if needed.

Questions 8, 9 and 10 relate to the three axes the Global Cholera Roadmap aims to address. These include:

i. *Axis 1: improving outbreak containment and reducing the global burden of cholera through early detection and rapid response;*
ii. *Axis 2: prevention of disease occurrence through targeted multi-sectoral interventions in cholera hotspots;*
iii. *Axis 3: ensuring effective mechanism of coordination for technical support, resource mobilization, and partnership at local and global levels.*

11. What are the main areas where progress has been made towards **improving outbreak containment and reducing the global burden of cholera through early detection and rapid response**? What do you see as

the main areas of work undertaken by the GTFCC that have enabled progress and what needs changing and/or strengthening to accelerate progress? If you are unsure or do not wish to respond, please write N/A. *(Freeform answer)*

---

12. What are the main areas where progress has been made towards **prevention of disease occurrence through targeted multi-sectoral interventions in cholera hotspots**? What do you see as the main areas of work undertaken by the GTFCC that have enabled progress and what needs changing and/or strengthening to accelerate progress? If you are unsure or do not wish to respond, please write N/A. *(Freeform answer)*

---

13. What are the main areas where progress has been made towards **ensuring effective mechanism of coordination for technical support, resource mobilization, and partnership at local and global levels**? What do you see as the main areas of work undertaken by the GTFCC that enabled progress and what needs changing and/or strengthening towards this aim? If you are unsure or do not wish to respond, please write N/A. *(Freeform answer)*

---

14. Without the Roadmap as a guiding strategy and the GTFCC as the coordinator of partner activities in cholera, the progress observed today would not have been feasible.

Strongly agree
Agree
Neutral
Disagree
Strongly disagree
I don't have enough information to answer this question
Comments: Please provide any comments in support of your answer.

---

15. The Global Roadmap and cholera interventions adequately consider sustainability *(in terms of financial, programmatic and environmental considerations)*.

Select one response in each row that best reflects your opinion on the statement above.

Sustainability area	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	I don't have enough information to answer
Financial considerations						
Programmatic considerations						
Environmental considerations						

Comments: Please provide any comments and recommendations in support of your answer.

---

16. The Global Roadmap and cholera interventions adequately consider gender, equity and human rights.

Strongly agree
Agree
Neutral
Disagree
Strongly disagree
I don't have enough information to answer this question
Comments: Please provide any comments and recommendations in support of your answer.

Section 2.2 Stakeholders from countries engaged with GTFCC

1.
2.
3.

---

4. I understand the role and mandate of the GTFCC well.

Strongly agree
Agree
Neutral
Disagree
Strongly disagree
I don't have enough information to answer this question

Comments: Please provide any comments in support of your answer. If you are not that aware of the GTFCC please provide some recommendations on how the GTFCC can communicate its aims and work better.

---

5. The work of the GTFCC and its partners on cholera response and prevention, is well aligned with country priorities.

Strongly agree
Agree
Neutral
Disagree
Strongly disagree
I don't have enough information to answer this question

Comments: Please provide any comments and recommendations in support of your answer.

---

6. I understand the type of assistance that the GTFCC provides to support cholera response and prevention interventions at the country level.

Strongly agree
Agree
Neutral
Disagree
Strongly disagree
I don't have enough information to answer this question

Comments: Please provide any comments and recommendations in support of your answer.

---

7. The process to request assistance from the GTFCC is clear and simple.

Strongly agree
Agree
Neutral
Disagree
Strongly disagree
I don't have enough information to answer this question

Comments: Please provide any comments and recommendations in support of your answer

---

8. The GTFCC approach to country engagement is working well.

Select one response in each row that best reflects your opinion on the statement above.

GTFCC mechanism of country engagement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	I don't have enough information to answer
Country Support Platform						

Independent Review Panel reviewing National Cholera Plans						
Support provided to countries through GTFCC partners						
Country representatives engagement/ participation in GTFCC governance structures (e.g. Steering Committee, Working Groups)						
Inclusion of country representatives in the GTFCC annual General Assembly						

Comments: Please provide any comments and recommendations in support of your answers. Please make any suggestions on how GTFCC should better engage with countries.

---

9. The current set up of the GTFCC Country Support Platform (CSP) is fit for purpose and enables effective support through the following areas (applicable just for countries who have received support through the CSP).

Select one response in each row that best reflects your opinion on the statement above.

GTFCC mechanism of country engagement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	I don't have enough information to answer/ not applicable as our country does not receive support through the CSP
Coordination of technical support						
Communication and knowledge sharing from the GTFCC						
Capacity building						
Advocacy and resources mobilization to support national cholera plan development and implementation						

Comments: Please provide any comments and recommendations in support of your answers.

---

10. The technical assessment of your country's National Cholera Plan (NCP) by the Independent Review Panel was undertaken in a timely manner and provided useful feedback to strengthen the NCP.

Strongly agree
Agree
Neutral
Disagree
Strongly disagree
I don't have enough information to answer this question/ not applicable as the Independent Review Panel did not assess our country's NCP

Comments: Please provide any comments and recommendations in support of your answer

11. Could you highlight three key areas of progress on cholera control and/ or prevention made by your country in the last few years? How has the GTFCC contributed? If you are unsure or do not wish to respond, please write N/A. *(Freeform answer)*

12. What are the biggest gaps on cholera control/ prevention in your country? What are the key factors inhibiting progress? If you are unsure or do not wish to respond, please write N/A. *(Freeform answer)*

13. Is funding for, and support from, international partners for cholera prevention and/ or control sufficiently coordinated in your country? Has the GTFCC facilitated better partner coordination in your country? If you are unsure or do not wish to respond, please write N/A. *(Freeform answer)*

14. Please rate the following areas of support by the GTFCC:

Select one response in each row that best reflects your opinion.

Area of GTFCC Support	N/A	Very poor	Poor	Satisfactory	Good	Very Good
Technical guidance documents on cholera issued by the GTFCC						
GTFCC annual general assembly						
Assistance to develop your country's National Cholera Plan						
Assistance to implement your country's National Cholera Plan						
Capacity building support						
Advocacy/ communications support/ tools, including for policy and resource mobilization for cholera programming						

Comments: Please provide any comments and recommendations in support of your answer

15. Overall, what support from the GTFCC has been the most useful for your country? What additional support would you ideally like to receive? If you are unsure or do not wish to respond, please write N/A. *(Freeform answer)*

16. With support of the GTFCC and the Roadmap, the cholera interventions in your country have been designed and implemented with adequate sustainability considerations *(in terms of financial, programmatic and environmental considerations).*

Strongly agree
Agree
Neutral
Disagree
Strongly disagree
I don't have enough information to answer this question

Comments: Please provide any comments in support of your answer and how the GTFCC may, or may not, have helped to support consideration of these areas.

17. With support of the GTFCC and the Roadmap, the cholera interventions in your country have been designed and implemented with adequate attention of gender, equity and human rights considerations.

Strongly agree
Agree
Neutral
Disagree

Strongly disagree

I don't have enough information to answer this question

Comments: Please provide any comments in support of your answer and how the GTFCC may, or may not, have helped to support consideration of these areas.

Section 2.3 Stakeholders from countries not engaged with GTFCC

1.
2.
3.

---

4. I am aware of and understand the role and mandate of the GTFCC well.

Strongly agree

Agree

Neutral

Disagree

Strongly disagree

I don't have enough information to answer this question

Comments: Please provide any comments in support of your answer. If you are unaware of the GTFCC please provide some recommendations on how the GTFCC can reach your country better.

---

5. Why has your country not been engaged or stopped engaging with the GTFCC?

Comments: Please provide any comments in support of your answer.

---

6. It would be beneficial for our country to engage more with the GTFCC going forward.

Strongly agree

Agree

Neutral

Disagree

Strongly disagree

I don't have enough information to answer this question

Comments: Please provide any comments in support of your answer.

---

7. What type of support from the GTFCC would be most useful for your country? *(Freeform answer)*

1. Survey results

This section contains information on the e-survey results.

Section I.2.1. provides information on the e-survey response rate. Section I.2.2. contains results by survey question.

Response rate

In total, 134 respondents opened the e-survey across both its French and English versions. The survey was designed with two sections:

Section 1: Respondent Information

Section 1 consisted of six questions designed to gather contextual information about respondents' organizational affiliations, roles, the level which they work on cholera (global, regional, or country level), as

well as direct respondents to the appropriate subsection in Section 2. The structure of Section 1 included a branching logic based on the respondents' answers:

All respondents answered up to Question 5. Based on their responses to Question 5, they were either:

Automatically directed to Section 2.1, or

Required to answer Question 6 in Section 1. Question 6 determined if the remaining respondents would be directed to Section 2.2 or 2.3.

Section 2: Core Feedback

Section 2 was composed of three subsections (2.1, 2.2, and 2.3) and was designed to gather respondent feedback on the functioning and impact of the GTFCC. The section featured mandatory multiple-choice questions and optional open-ended qualitative questions. Respondents were automatically directed to one subsection in Section 2 based on their answers in Section 1.

A submitted survey was defined as one in which a respondent completed all mandatory questions in Section 1 (including any questions they were required to answer based on the survey logic), completed all mandatory questions in their assigned subsection of Section, and pressed the 'Submit' button at the end of the survey. Based on this definition, 105 surveys were submitted, representing a completion rate of 78%. Tables I.1 and I.2 provide an overview and breakdown of the e-survey completion rate.

Table I.1: Overall survey completion rate

Total number of respondents to initiate e-survey	Total number of respondents to complete e-survey	Percentage of respondents to complete e-survey
134	105	78%

Table I.2: Survey response and completion rate by section

E-survey Section	Number of respondents directed to section	Number of respondents who completed section	Percentage of respondents who completed section
Section 1: Respondent information	134	132	99%
Section 2.1: Global, regional, and/or multi-country stakeholders	70	54	77%
Section 2.2: Stakeholders from countries engaged with GTFCC	49	40	82%
Section 2.3: Stakeholders from countries not engaged with GTFCC	13	11	85%

Detailed Response Breakdown

Section 1 Completion:

Of the 134 respondents who initiated the survey, 132 answered all mandatory questions in Section 1 (in accordance with the answer-dependent branched survey logic). Two respondents, who were directed to complete Question 6, dropped off at this point and did not answer Question 6 or proceed further in the survey.

Transition to Section 2:

Among the 132 respondents who completed Section 1, 105 proceeded to answer and submit their assigned subsection within Section 2.

This indicates a drop-off of 27 respondents who completed Section 1 but did not initiate Section 2.

Section 2 Completion:

All 105 respondents who initiated Section 2 completed their assigned subsection, answering all mandatory multiple-choice questions and pressing 'Submit'. There were no drop-offs within Section 2.

Key limitations

Drop-off between Section 1 and 2:

While 132 respondents completed Section 1, there were 27 respondents who did not proceed to answer questions in Section 2. However, all core findings regarding the function and impact of the GTFCC are based on data from Section which was fully completed and submitted by all 105 respondents who initiated the Section.

Partial responses in Section 1:

Two respondents stopped at Question 6 in Section 1 and did not to answer Question 6 or proceed with the rest of the survey. However, Section 1 of the survey only contained contextual information on respondents' background and did not contain any information or feedback on the functioning or impact of the GTFCC.

Survey data presentation:

The results presented in this report include data from both Section 1 and Section 2 of the survey. For each question where respondent feedback is reported as a percentage, the sample size (n=*x*) is clearly indicated.[48] This is particularly important for Section 2, where respondents were divided into three subsections based on their answers to Section 1. As a result, the number of respondents answering a specific question varies, depending on the subsection (i.e. questions answered in Section 2.1 were answered by a different group of respondents than those in Section 2.2).

Results summary by section and by survey question

The following section presents a brief summary of survey results for each section, followed by a breakdown of results for each survey question.

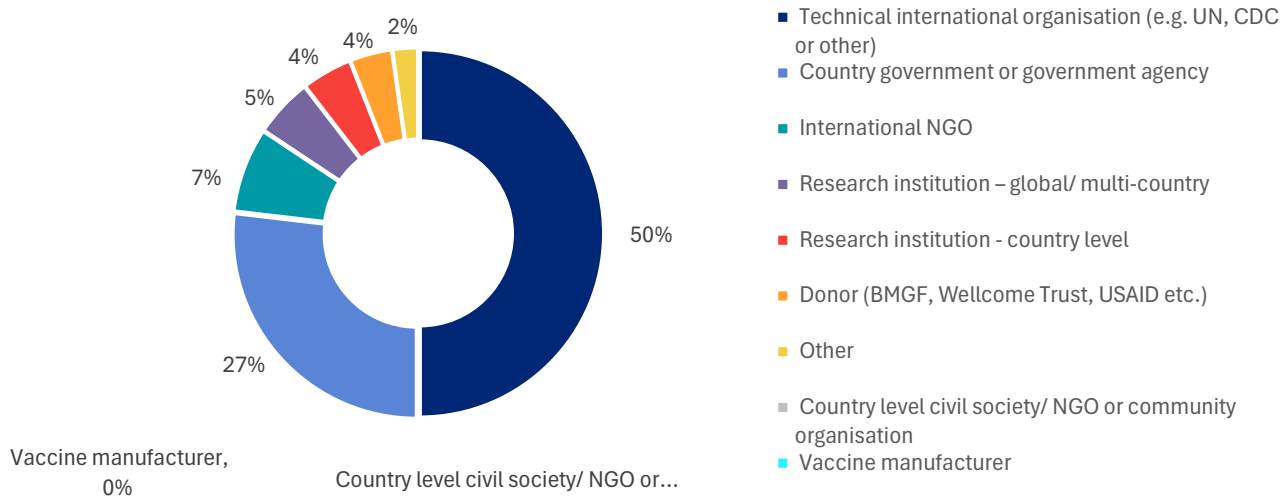
[48] A caveat applies to Question 2 in Section 1, where respondents were allowed to select multiple answers. For this question, results are presented using raw numbers rather than percentages, as individual respondents could choose more than one option.

Section 1: Respondent information

Section summary: Majority of the respondents to the survey were from technical international organizations (e.g. UN, CDC, etc.) and country governments, and had engaged with GTFCC for a reasonably long period of time (i.e. greater than 2 years and many responding greater than 5 years). There were almost equal number of responses from global/ regional/ multi country and country level stakeholders - suggesting particular success of the survey in accessing a wider number of country stakeholders than was feasible through the consultations.

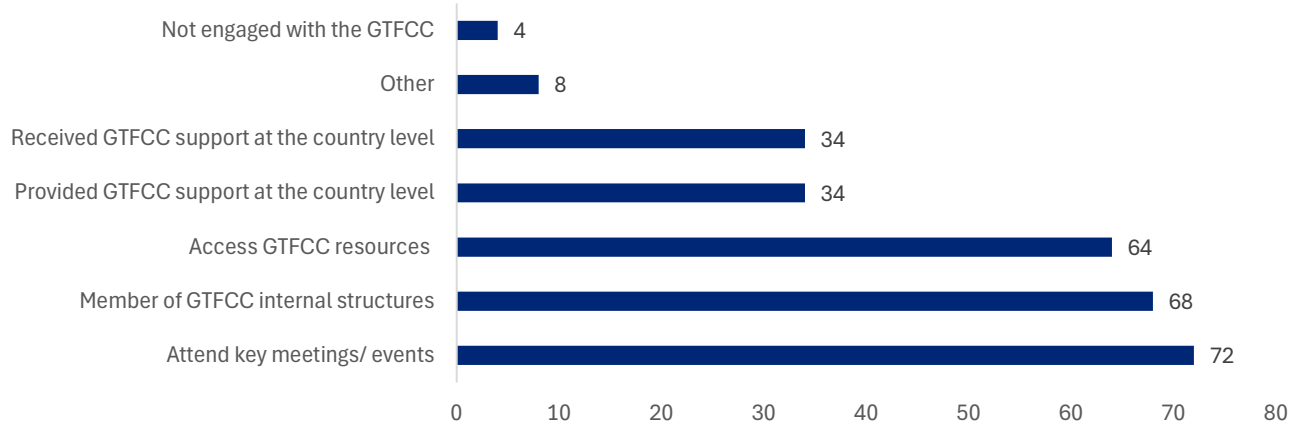
Q1. Which type of organization/ body do you work for? *(Select one that best describes your organization)*

Figure I.1: Response to Q1 by percentage.[49] n=134



Q2. In what capacity have you engaged with the GTFCC *(Select all that apply)*

Figure I.2: Response to Q2.[50]

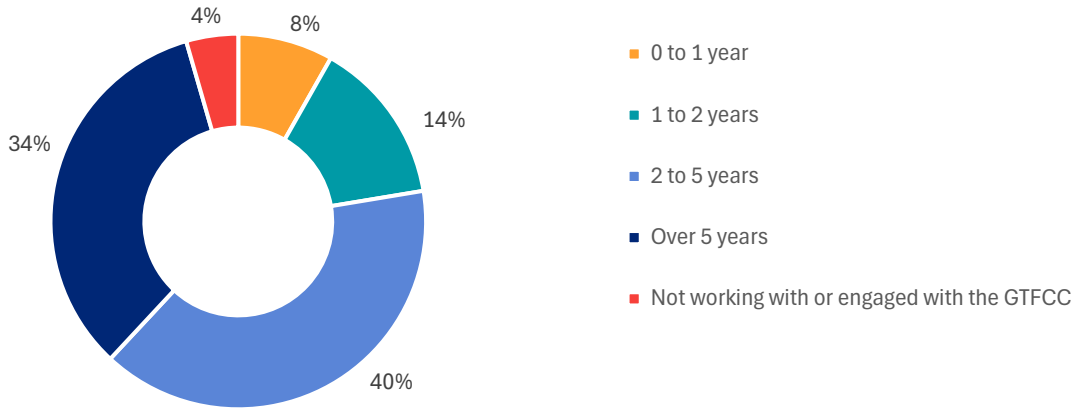


[49] Three respondents (2%) selected "Other" and provided qualitative descriptions of their organizations. One individual indicated working for a private organization focused on vaccine-preventable and non-transmissible diseases, while the other two respondents identified as consultants.

[50] Eight respondents selected “Other” and described diverse roles in their engagement with the GTFCC, including collaborating with GTFCC members, providing technical support to GTFCC internal structures as a consultant, and collaborating with the GTFCC while working for other regional task forces or international agencies with a regional level focus on cholera.

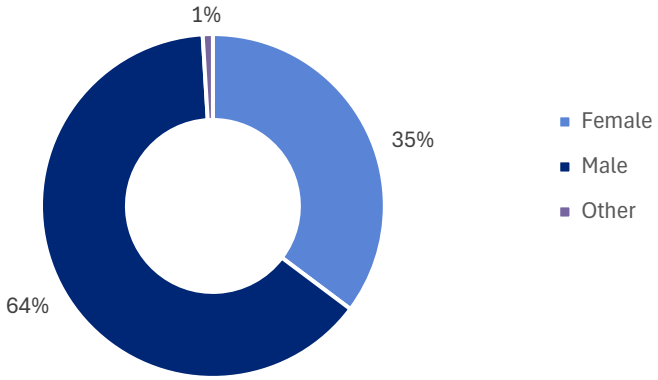
Q3. How long have you been working with or have been engaged with the GTFCC? *(Select one)*

Figure I.3: Response to Q3 by percentage. n=134



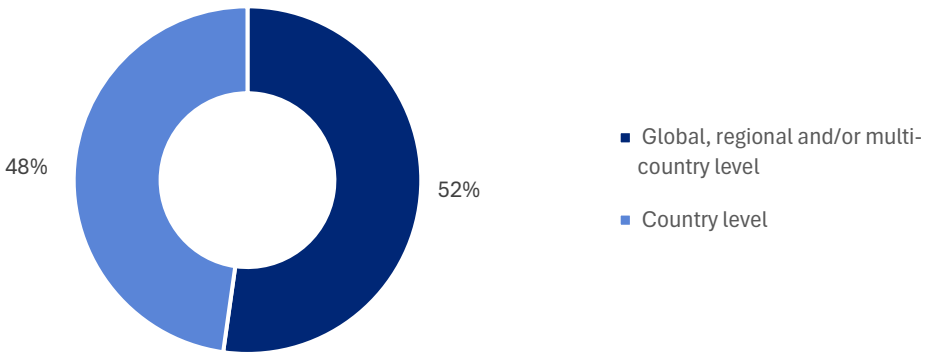
Q4. What is your gender? *(Optional)*

Figure I.4: Response to Q4 by percentage. n=105



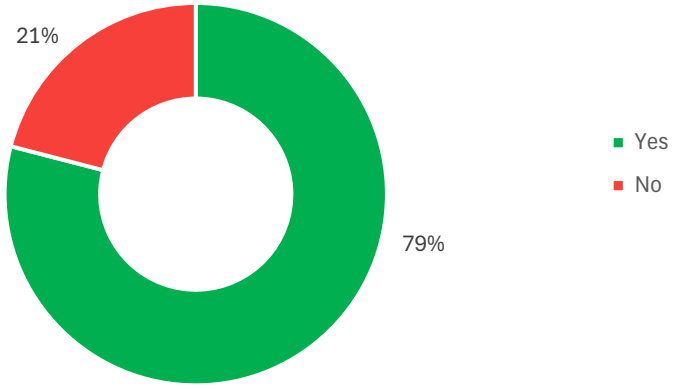
Q5. Does your work in cholera primarily focus on the global, regional or country level?

Figure I.5: Response to Q5 by percentage. n=134



Q6. Is your country currently engaged or not engaged with the GTFCC?

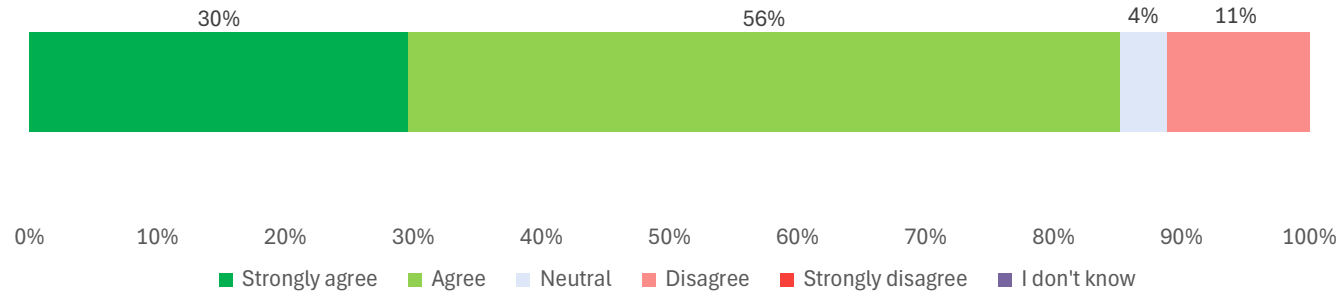
Figure I.6: Response to Q6 by percentage. n=62



Section 2.1 Global, regional and/or multi-country stakeholders

Q7. The Global Ending Cholera Roadmap (Ending Cholera – a Global Roadmap to 2030) continues to be fit-for-purpose today.

Figure I.7: Response to Q7 by percentage. n=54

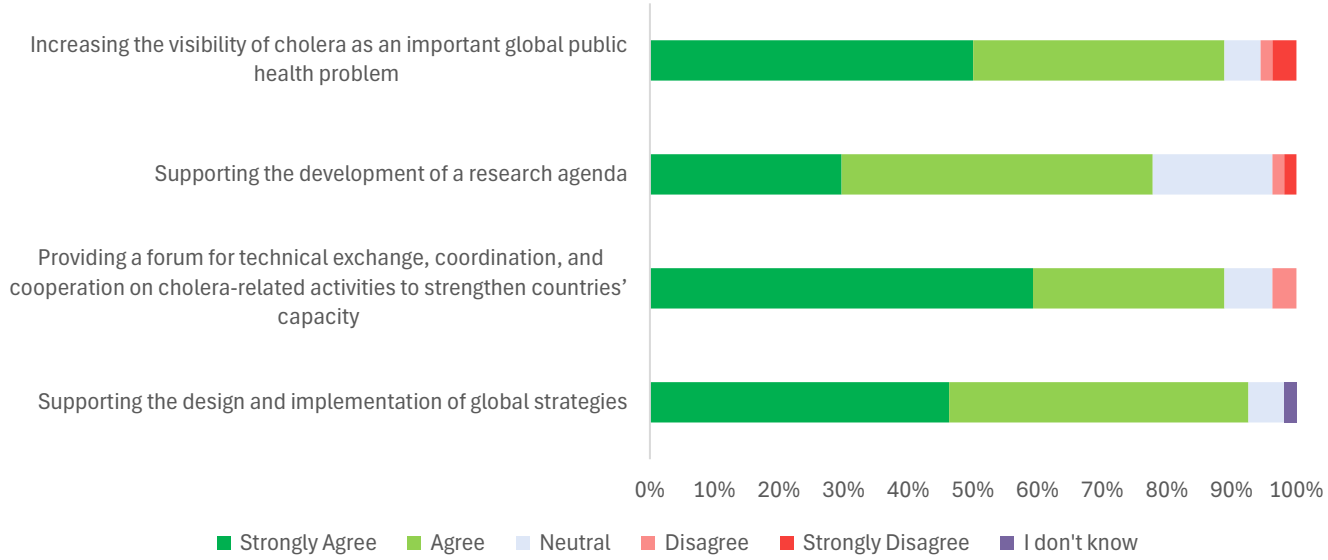


Quantitative results: The majority of respondents (86%) agreed or strongly agreed that The Global Ending Cholera Roadmap continues to be fit-for-purpose today.

Qualitative results: The majority of respondents affirmed the roadmap's ongoing relevance but noted critical gaps in its implementation. Many highlighted the need for a stronger focus on WASH to achieve long-term cholera elimination, while funding constraints were frequently cited as a major barrier. One key element highlighted as missing from the Roadmap was community engagement. A minority of respondents also expressed concerns that the 2030 target for ending cholera might be overly ambitious and challenging to achieve.

Q8. The objectives of the GTFCC are appropriate.

Figure I.8: Response to Q8 by percentage. n=54



Quantitative results: The majority of respondents either agreed or strongly agreed that the objectives of the GTFCC were appropriate, ranging from 78% to 92% for each objective.

Q9 What are the areas where the GTFCC is doing well and not so well in terms of progress towards its objectives? Are there any additional activities that the GTFCC should undertake to achieve its objectives? (*Freeform question)*

Qualitative results: Respondents highlighted the positive role of GTFCC in supporting technical exchange and were positive on the GTFCC's technical guidance, especially in terms of supporting countries with tools like the NCP guidelines, PAMI and case management methodologies, and the multi-annual OCV plan. Positive comments were also made on the WGs (although need for better cross WG coordination was noted) and CSP. A range of issues were highlighted:

- Need to have a balanced approach across all Roadmap objectives – outbreak response and prevention
- Lack of sufficient funding of the GTFCC to deliver on its objectives
- Limited country coverage of the GTFCC
- Improvement in advocacy efforts and visibility of cholera – through a dedicated role at the Secretariat
- Improvement in fund raising and donor engagement – also through a dedicated role at the Secretariat
- Need for greater engagement with bilateral donors and MDBs was emphasised.
- Comments were also provided on good global level coordination, but poorer coordination and the regional and country levels.
- There were also comments that there is more emphasis on research than "doing". It was noted that the GTFCC should go beyond supporting NCP development but also support countries in implementing a multi-sectoral approach to cholera including fund raising and advocacy.
- Need for more active coordination and tracking of the work of GTFCC partner organizations

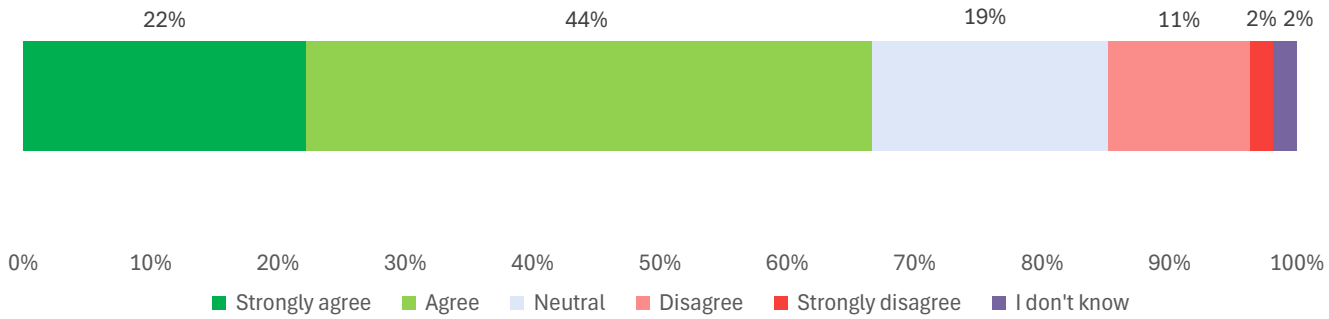
A few comments were also made on GTFCC's work on coordinating the research agenda in terms of need to focus on research questions with a longer term lens and particularly on WASH, link better with the country research agenda and being more inclusive of partnerships for research.

More efforts needed to support progress monitoring

Engagement with private sector stakeholders was also flagged as an issue.

Q10. The GTFCC facilitates a more coordinated and aligned approach between partners and with countries.

Figure I.9: Response to Q10 by percentage. n=54

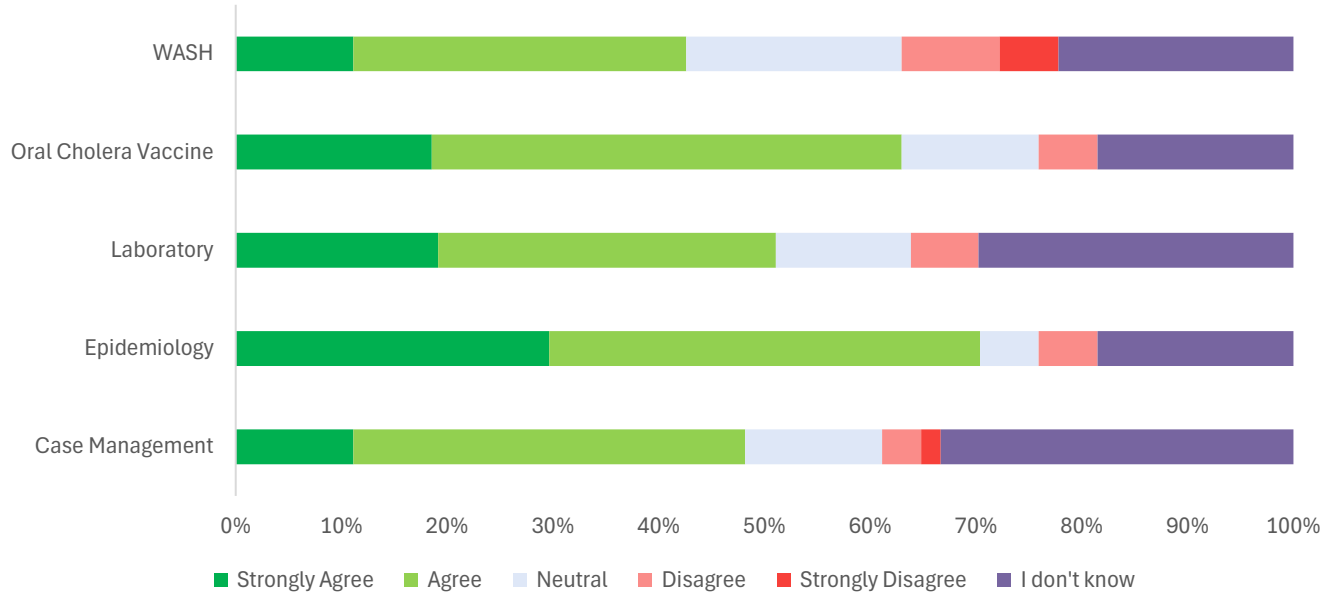


Quantitative results: While the majority of respondents (66%) agreed or strongly agreed that the GTFCC facilitates a more coordinated and aligned approach between partners, the 66% majority represents a relatively modest majority. However, 19% of respondents were neutral on the above claim and 13% disagreed or strongly disagreed.

Qualitative results: The GTFCC plays a vital role in enhancing coordination among partners and countries, particularly through its WGs, which have effectively brought partners together and developed coordinated technical guidelines. However, several respondents noted that while global coordination is relatively strong, there are challenges in translating this alignment to the country level. Coordination at the country level is often less structured, with some countries lacking active participation or consistent engagement, particularly in non-CSP-supported contexts. Furthermore, respondents indicated that more could be done to address resource constraints, build partnerships, and reduce siloed approaches among partners and donors, which would strengthen GTFCC's ability to promote a cohesive, unified response to cholera across affected regions. A more coordinated role between emergency response and WASH is also needed.

Q11. The GTFCC Working Groups are functioning well (i.e. appropriate membership, strong leadership and collaboration/ participation, rigorous and useful outputs etc).

Figure I.10: Response to Q11 by percentage. n=54

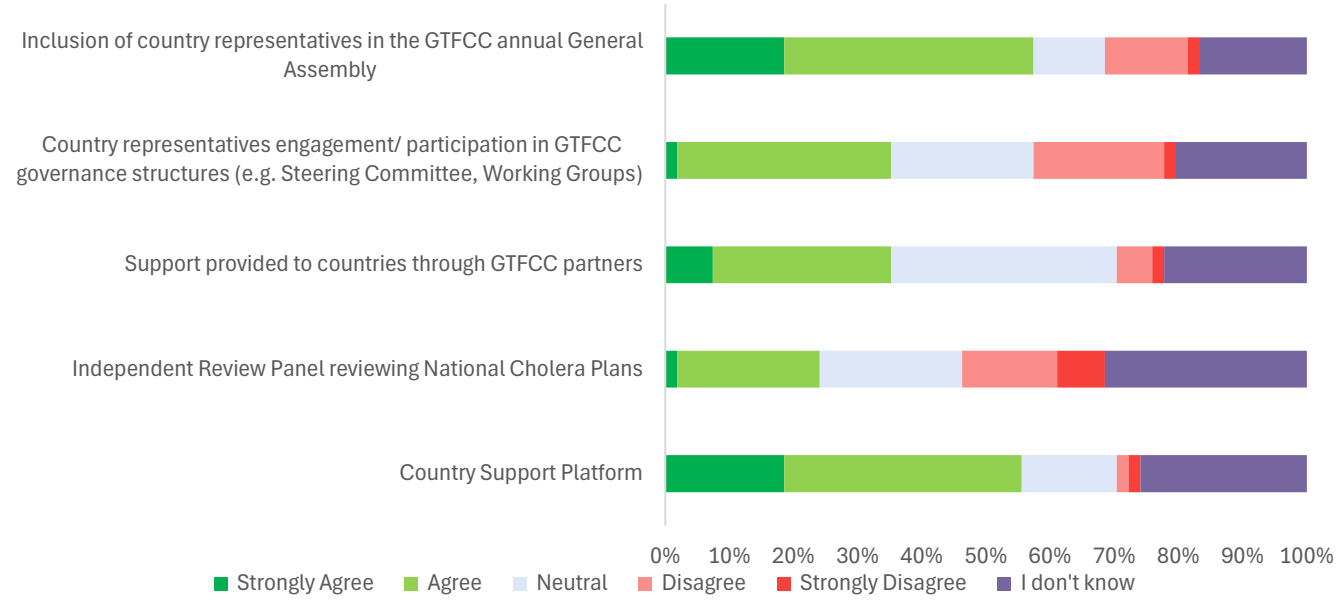


Quantitative results: A good proportion of respondents stating they do not know (ranging from 19%-33%) for each working group is reflective of the fact that individuals may only be involved or engaged in limited selection of working groups. The Epidemiology Working Group had the highest percentage favourable responses (71%), while the WASH Working Group had the highest percentage of negative responses (15%).

Qualitative results: Interestingly, qualitative responses reveal a pattern that slightly deviates from the quantitative results. The OCV was the working group most frequently praised in qualitative responses for its proactive approach and high level of engagement with partners. In alignment with the quantitative responses, the WASH WG attracted the most criticism. Respondents pointed to persistent gaps in WASH's practical guidance and slower progress compared to other groups. Multiple respondents also cited the need for greater cross-WG collaboration in increased targeted engagement with actors in the development and political spheres.

Q12. The GTFCC approach to country engagement is working well.

Figure I.11: Response to Q12 by percentage. n=54

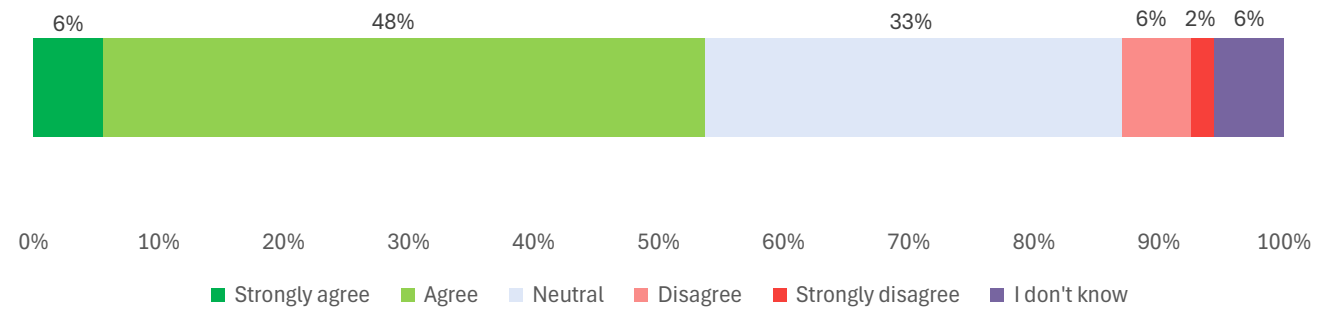


Quantitative results: The inclusion of country representatives in the GTFCC annual General Assembly was the approach most observed to work well by respondents (58%), while the Independent Review Panel reviewing National Cholera Plans was only observed to work well by a minority of respondents (24%). This same question was posed to a separate set of respondents in Section 2.2 (Stakeholders from countries engaged with the GTFCC) of the survey. While 56% of respondent stakeholders from countries engaged with the GTFCC agreed or strongly agreed that the inclusion of country representatives in the GTFCC annual General Assembly was working well, the approach most frequently observed to work well was the Country Support Platform (76%). Respondents from Section 2.2 also ranked the IRP as the approach least frequently found to be working well (53%).

Qualitative results: Responses from respondents were mixed regarding the GTFCC's approach to country engagement. The CSP has received positive feedback for effectively driving progress on the roadmap, especially in areas where it operates directly. However, its limited resources restrict the number of countries it can support, raising questions about the scalability of the model. Respondents emphasised the need for GTFCC to include regional bodies and country representatives from various ministries, beyond health, to strengthen country-level commitment and multisectoral approaches to cholera control. Additionally, feedback suggests that the IRP requires significant reform, as delays in reviewing NCPs hinder momentum at the country level. Respondents also identified the GTFCC Secretariat's limited resources as a bottleneck, indicating a need for increased resources and engagement mechanisms to foster stronger country participation.

Q13. Partners/ members' engagement with the GTFCC is adequate and enables meaningful participation, strengthens collaboration and promotes synergy between partners.

Figure I.12: Response to Q13 by percentage. n=54



Quantitative results: The majority of respondents (54%) agreed or strongly agreed that members' engagement with the GTFCC is adequate and enables meaningful participation.

Qualitative results: The qualitative feedback suggest mixed views on the GTFCC's role in coordination and collaboration. While some respondents acknowledged positive outcomes from the GTFCC's efforts in fostering collaboration among partners, a significant portion of respondents highlighted challenges and areas for improvement. Several respondents expressed concerns that cholera remains insufficiently prioritized as a global health issue, even among partners who participate in GTFCC initiatives. Additionally, respondents noted that partner engagement is often siloed, with limited cross-sectoral collaboration, particularly as it relates to WASH initiatives. Furthermore, respondents stated that the makeup of GTFCC partnerships is overly skewed towards technical experts, with a call for the GTFCC to strengthen its relationships with donors, policy makers and the private sector.

Q14. What are the main areas in which progress has been made to improve the detection of epidemics and rapid responses to contain them? What are the obstacles to progress in this area? *(Freeform question)*

Qualitative results: Progress in detection was attributed to the GTFCC's updated surveillance guidelines, laboratory capacity building, and the use of RDTs, which allow for quicker outbreak confirmation. The GTFCC has also supported the development of tools like the cholera app, which respondents stated aids in data management. However, significant barriers remain, including inconsistent funding, limited lab capacity in high-risk areas, and inadequate multisectoral coordination. While some countries have advanced in adopting surveillance tools, respondents emphasized the need for stronger, more consistent engagement from both countries and global actors to sustain and expand these gains across diverse settings.

Q15. What are the main areas where progress has been made towards prevention of disease occurrence through targeted multi-sectoral interventions in cholera hotspots? *(Freeform question)*

Qualitative results: Respondents acknowledged progress in adopting a multisectoral approach, particularly through the identification of PAMIs, which has enabled more targeted interventions in cholera hotspots. Several respondents noted the development and implementation of guidance on identifying priority areas and aligning them with NCPs as a significant achievement. However, others indicated that despite initial steps toward hotspot identification, multisectoral interventions in these areas are still limited. Many pointed out

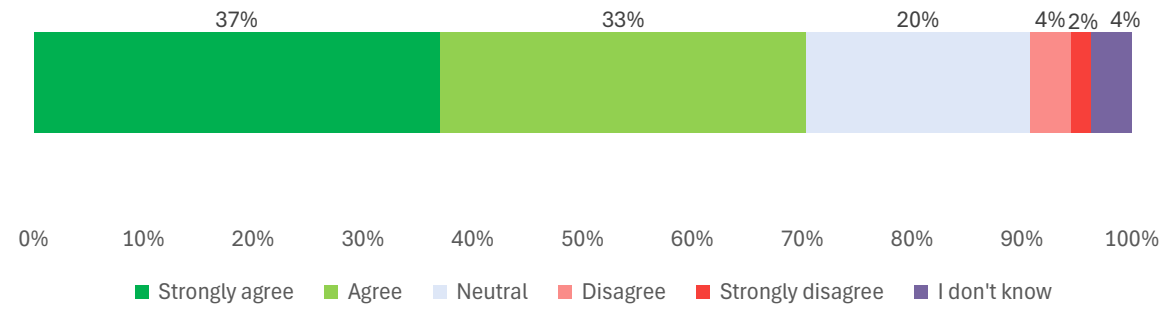
that WASH remains underfunded, and progress has been hindered by heavy reliance on vaccines, rather than sustainable preventative measures.

Q16. What are the main areas where progress has been made towards ensuring effective mechanisms of coordination for technical support, resource mobilization, and partnership at local and global levels? *(Freeform question)*

Qualitative results: The qualitative responses highlight several areas where the GTFCC has made progress in coordinating technical support, resource mobilization, and partnerships. Notably, the CSP is widely regarded as a successful mechanism for facilitating country engagement and supporting the development of robust NCPs, with multiple respondents emphasising the CSP's effective work at the country level. The enhanced quality and alignment of NCPs were also noted as positive developments, especially in countries with CSP-led initiatives. However, resource mobilization remains a notable challenge, as several responses mentioned that funding limitations have restricted the CSP's ability to expand support across all cholera-endemic countries.

Q17. Without the Roadmap as a guiding strategy and the GTFCC as the coordinator of partner activities in cholera, the progress observed today would not have been feasible.

Figure I.13: Response to Q17 by percentage. n=54

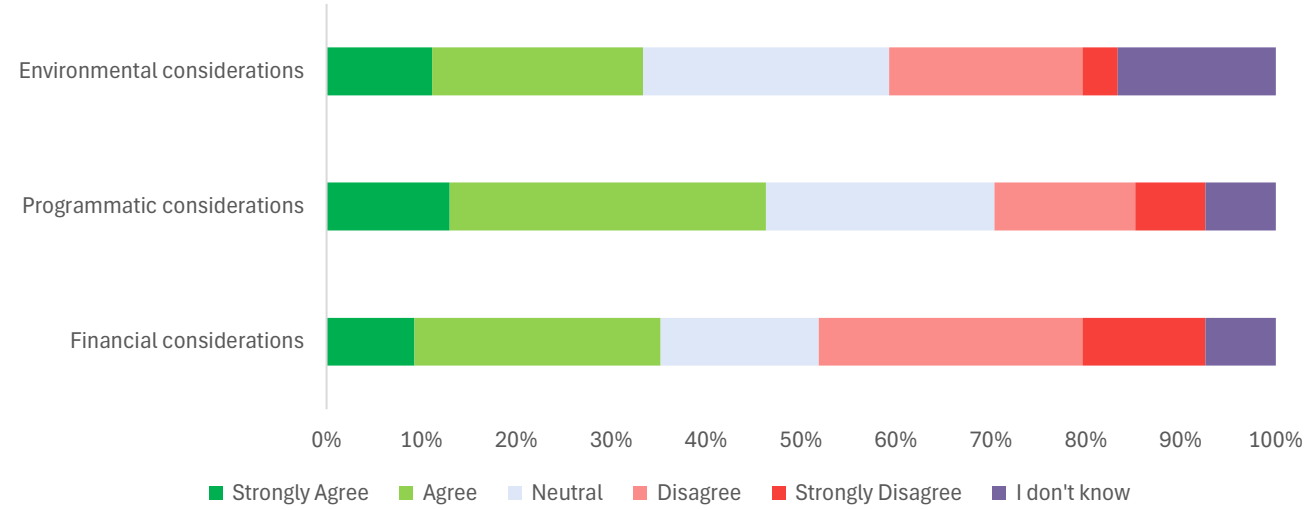


Quantitative results: The majority of respondents (70%) agreed or strongly agreed progress made to-date would not have been feasible without the GTFCC and the roadmap as a coordinator and guiding strategy, respectively.

Qualitative results: Comments from respondents were mixed. Some emphasised the valuable role of the Roadmap and GTFCC in cholera control efforts and stated that "little progress would have occurred" without the Roadmap and "GTFCC has put the fight against cholera back on track". Others however noted that the efforts on the Roadmap have reduced as the focus is on outbreak response and GTFCC efficacy has also declined. The underfunding of GTFCC was also highlighted as a key challenge.

Q18. The Global Roadmap and cholera interventions adequately consider sustainability (in terms of financial, programmatic and environmental considerations).

Figure I.14: Response to Q18 by percentage. n=54

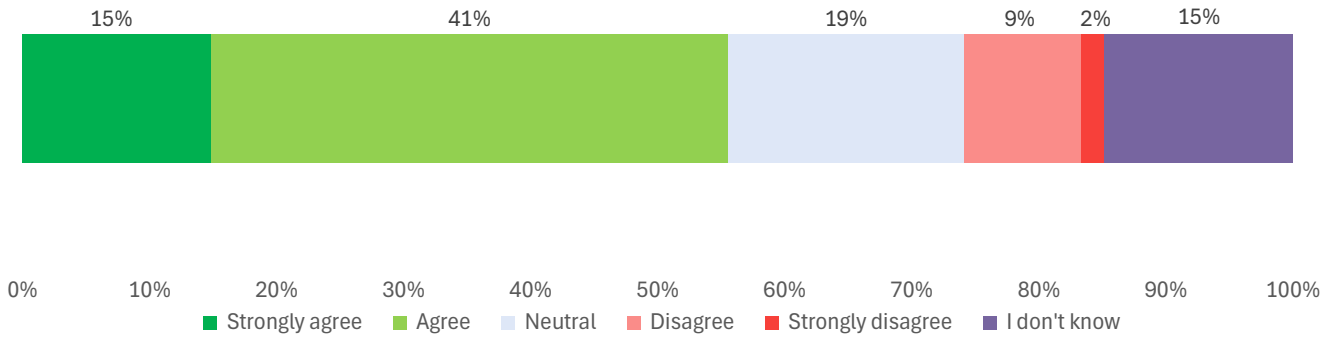


Quantitative results: Only a minority of respondents felt the roadmap and cholera interventions adequately consider sustainability (33%-46%) for the above considerations. With regard to financial considerations, the plurality of respondents (41%) did not consider the roadmap and cholera interventions to adequately consider sustainability.

Qualitative results: Respondents highlighted that while the GTFCC roadmap has supported the establishment of a clear framework, ensuring the sustainability of cholera interventions remains a challenge. Multiple responses pointed to insufficient long-term funding, with current resources inadequate to support ongoing needs beyond outbreak response. Although financial and programmatic elements are central to NCPs, several respondents noted that these plans need deeper integration into broader national health and development agendas to foster true sustainability.

Q19. The Global Roadmap and cholera interventions adequately consider gender, equity and human rights.

Figure I.15: Response to Q19 by percentage. n=54



Quantitative results: The majority of respondents agreed or strongly agreed (56%) that the roadmap adequately considered gender, equity and human rights.

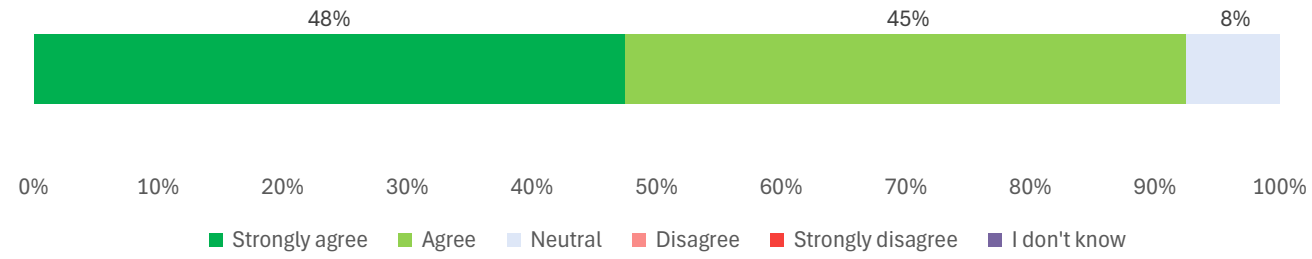
Qualitative results: Qualitative feedback diverged significantly from the quantitative results above. Respondents noted that gender equity and human rights considerations are not prominently addressed within GTFCC documents or meetings. The need for a stronger focus on community engagement was also cited. It should be noted that significantly fewer respondents provided qualitative feedback relative to the number of respondents who provided quantitative feedback by selecting a multiple-choice answer for this question.

Section 2.2 Stakeholders from countries engaged with GTFCC

Section summary: Respondents from countries engaged with the GTFCC were generally positive. Key issues highlighted were with regards to the effectiveness of the IRP, need to increase the scope of the CSP (both in terms of country coverage and scope of work to include aspects such as advocacy and resource mobilization) and need to enhance country participation (across the SC, WGs and in annual meetings).

Q20. I understand the role and mandate of the GTFCC well.

Figure I.16: Response to Q20 by percentage. n=40

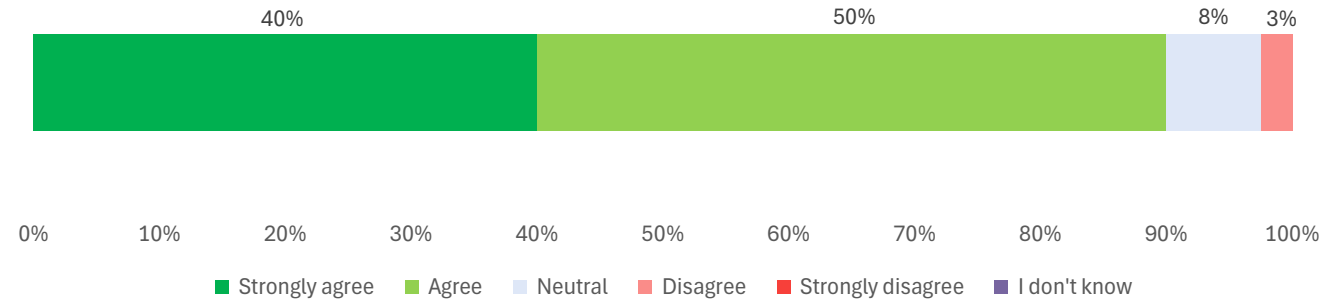


Quantitative results: The overwhelming majority of respondents (92%) stated they understood the role and mandate of the GTFCC.

Qualitative results: Respondents affirmed their understanding of the GTFCC's role and mandate, specifically highlighting its development of guidelines, capacity building, the activity of WGs and the country support through the CSP.

Q21. The work of the GTFCC and its partners on cholera response and prevention, is well aligned with country priorities.

Figure I.17: Response to Q21 by percentage. n=40

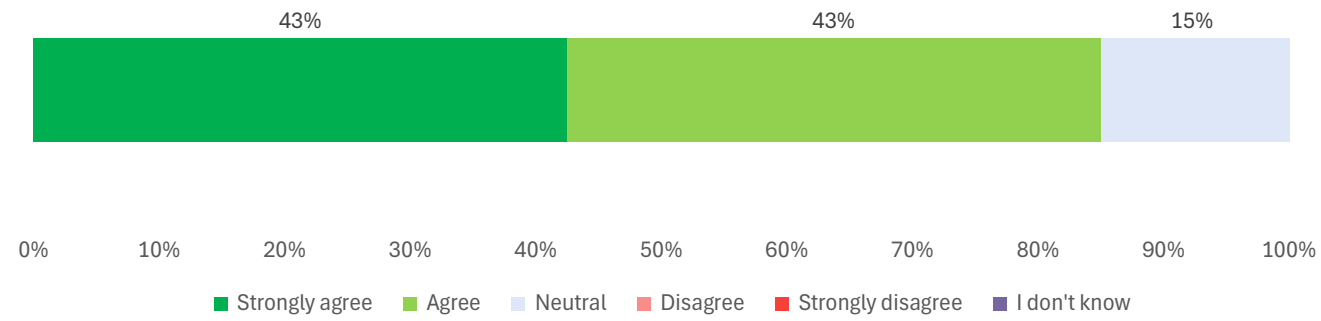


Quantitative results: The majority of respondents (90%) agreed or strongly agreed that the work of the GTFCC and its partners is well aligned with country priorities.

Qualitative results: Respondents affirmed that the work of the GTFCC and its partners is aligned with country priorities, specifically referencing the support provided towards the development of NCPs and technical support towards OCV vaccination campaigns.

Q22. I understand the type of assistance that the GTFCC provides to support cholera response and prevention interventions at the country level.

Figure I.18: Response to Q22 by percentage. n=40

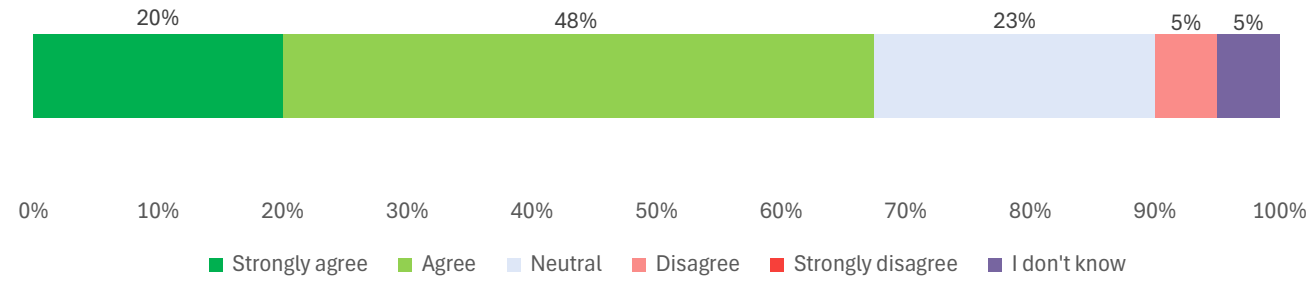


Quantitative results: The majority of respondents (86%) agreed or strongly agreed that they understood the nature of the assistance and support provided by the GTFCC.

Qualitative results: Respondents highlighted the GTFCC's support in developing policies like NCPs and PAMIs, facilitating resources such as vaccines and rapid diagnostic tests, and providing technical guidance.

Q23. The process to request assistance from the GTFCC is clear and simple.

Figure I.19: Response to Q23 by percentage. n=40

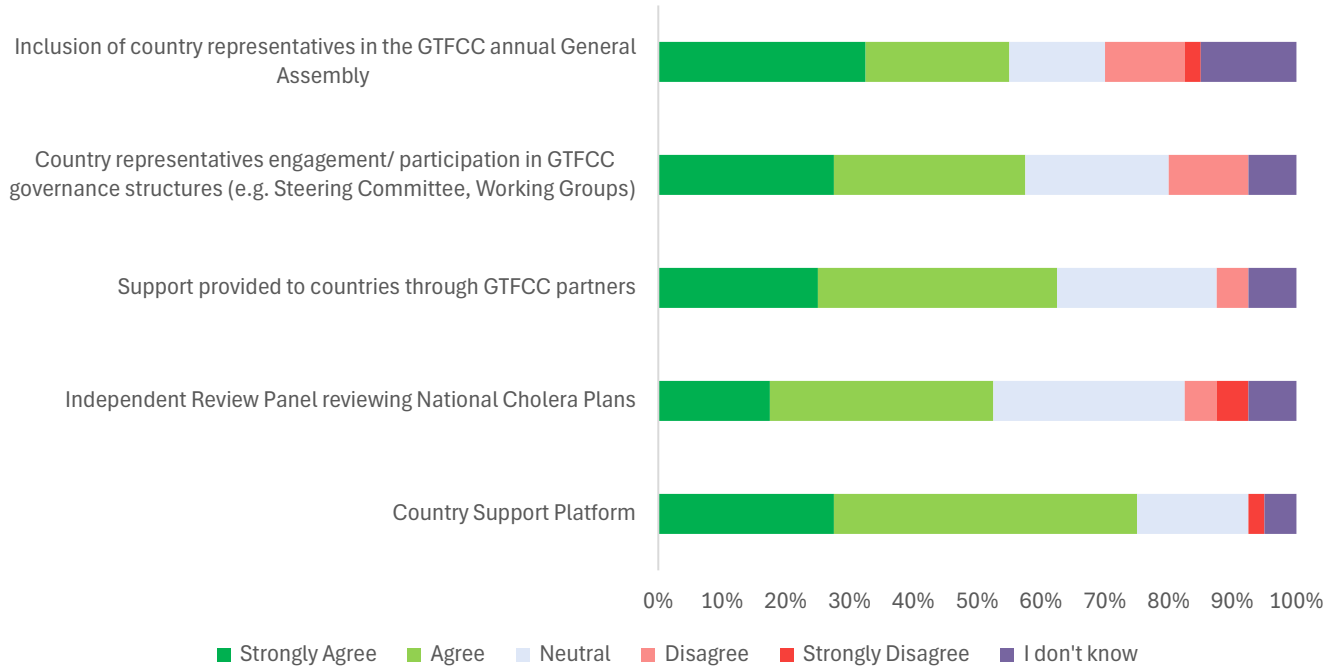


Quantitative results: The majority of respondents (68%) agreed or strongly agreed that the process to request assistance is clear and simple.

Qualitative results: Respondents noted mixed experiences with the process of requesting GTFCC assistance. While some found the process straightforward, especially in CSP-supported countries, others highlighted challenges in countries where the CSP was not active, where the process were viewed as less clear.

Q24. The GTFCC approach to country engagement is working well.

Figure I.20: Response to Q24 by percentage. n=40

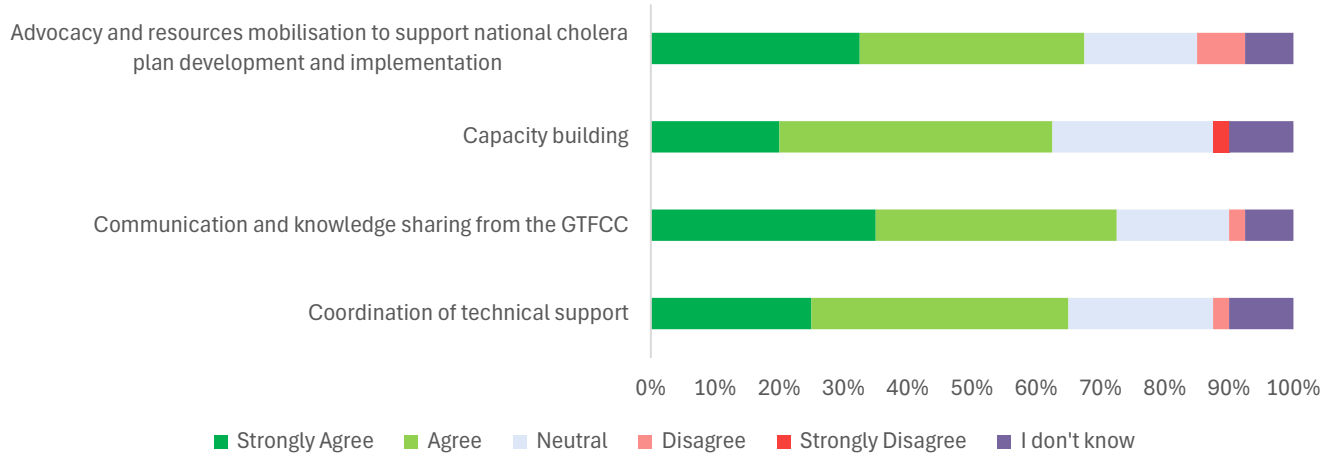


Quantitative results: The majority of respondents agreed that the various approaches for country engagement taken by the GTFCC work well, with responses ranging from 53% to 76%. The approach most frequently found to work well was the Country Support Platform (76%), while the Independent Review Panel reviewing National Cholera Plans was the approach least frequently found to be working well (53%). The same question was posed to a separate set of respondents in Section 2.1 (Global, regional and/or multi-country stakeholders). Respondents to Section 2.1 identified the inclusion of country representatives in the GTFCC annual General Assembly as the approach most frequently found to work well (58%), with the Country Support Platform ranked as the second most favourable form of GTFCC engagement (56%). Respondents in Section 2.1 also ranked the Independent Review Panel as the approach least frequently found to be working well (24%).

Qualitative results: Respondents noted the country level work of the GTFCC through the CSP in guiding cholera control plans and providing tailored support. However, several areas for improvement were highlighted, such as enhancing the IRP's responsiveness, increasing country representation in GTFCC meetings, Steering Committee and working groups, increasing the scope of countries covered by the CSP, and streamlining visa logistics for in-person attendance.

Q25. The current set up of the GTFCC Country Support Platform (CSP) is fit for purpose and enables effective support through the following areas.

Figure I.21: Response to Q25 by percentage. n=40

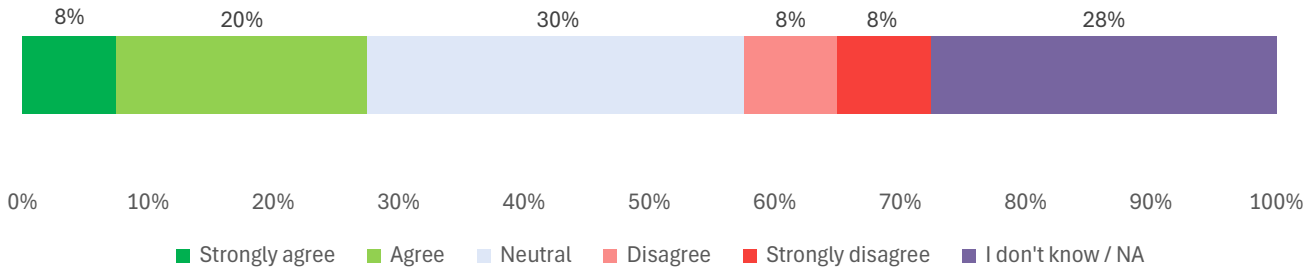


Quantitative results: The majority of respondents agreed that CSP is fit-for-purpose and enables support, with responses ranging from 63% to 73% depending on the mechanism of support.

Qualitative results: Respondents widely noted that the CSP has been instrumental in enhancing multistakeholder coordination, introducing the GTFCC's new tools, and providing technical assistance, including consultants and training. Suggestions for improvement included strengthening advocacy, focusing resource mobilization efforts more specifically on country needs, and enhancing capacity building through targeted training. A few respondents also highlighted the importance of the CSP's role in engaging political leaders.

Q26. The technical assessment of your country's National Cholera Plan (NCP) by the Independent Review Panel was undertaken in a timely manner and provided useful feedback to strengthen the NCP.

Figure I.22: Response to Q26 by percentage. n=40



Quantitative results: Only 28% of respondents agreed or strongly agreed that the technical assessment of NCPs conducted by the IRP were undertaken in a timely manner and provided useful feedback. The majority of respondents (58%) were neutral or did not have enough information to answer.

Qualitative results: Respondents expressed mixed views on the timeliness and utility of the IRP's feedback on their National Cholera Plans. While one respondent appreciated the swift turnaround of feedback, several others noted delays, with some submissions awaiting feedback for up to four months.

Q27. Could you highlight three key areas of progress on cholera control and/ or prevention made by your country in the last few years? How has the GTFCC contributed? *(Freeform question)*

Qualitative results: Respondents highlighted several advances in their national cholera control and prevention efforts, facilitated by the GTFCC. Key achievements included the development and implementation of NCPs, the identification of PAMIs, and strengthened surveillance systems. Many respondents emphasized the success of OCV campaigns targeting high-risk areas

Q28. What are the biggest gaps on cholera control/ prevention in your country? What are the key factors inhibiting progress? *(Freeform question)*

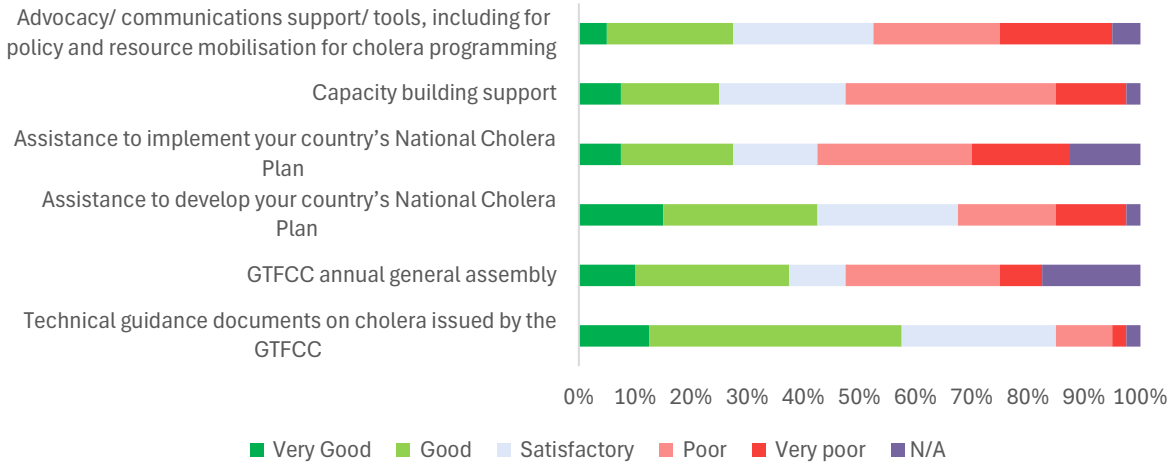
Qualitative results: Respondents identified key difficulties encountered in cholera control, emphasizing limited funding, inadequate WASH infrastructure, and a shortage of OCV for preventive measures as ongoing obstacles. The lack of financial resources affects the full-scale implementation of NCPs. Coordination challenges, especially between WASH and health stakeholders, further complicate efforts. Some respondents also noted insufficient political commitment, capacity, and technical personnel as barriers to sustained cholera prevention.

Q29. Is funding for, and support from, international partners for cholera prevention and/ or control sufficiently coordinated in your country? Has the GTFCC facilitated better partner coordination in your country? *(Freeform question)*

Qualitative results: Responses indicate mixed views on international coordination for cholera funding. Multiple respondents cited insufficient coordination, with gaps in visibility, inconsistent partner engagement, and conflicting priorities. However, multiple respondents also stated that coordination was adequate. Additionally, a number of respondents stated that insufficient funding was consistent challenge.

Q30. Please rate the following areas of support by the GTFCC:

Figure I.23: Response to Q30 by percentage. n=40



Quantitative results: The majority of respondents (58%) rated the technical guidance documents on cholera issued by the GTFCC favourably (scoring 4/5 or 5/5). This was the area of support with the highest favourability rating. The majority of respondents (51%) rated capacity-building support negatively (scoring 2/5 or 1/5).

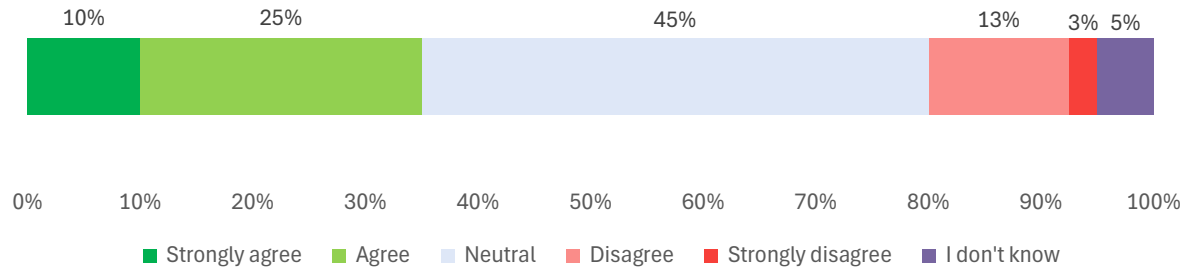
Qualitative results: While technical documents and general assemblies are valued for providing essential guidelines and platforms for exchange, some respondents call for improvements, especially in making tools more practical and user-friendly, and in translating documents for wider accessibility. NCP assistance is largely appreciated, though implementation and resource mobilization challenges remain.

Q31. Overall, what support from the GTFCC has been the most useful for your country? What additional support would you ideally like to receive? *(Freeform question)*

Qualitative results: Respondents indicated that the most valuable GTFCC support for countries has been in the development of NCPs, support for OCV campaigns, and technical guidance.

Q32. With support of the GTFCC and the Roadmap, the cholera interventions in your country have been designed and implemented with adequate sustainability considerations (in terms of financial, programmatic and environmental considerations).

Figure I.24: Response to Q32 by percentage. n=40

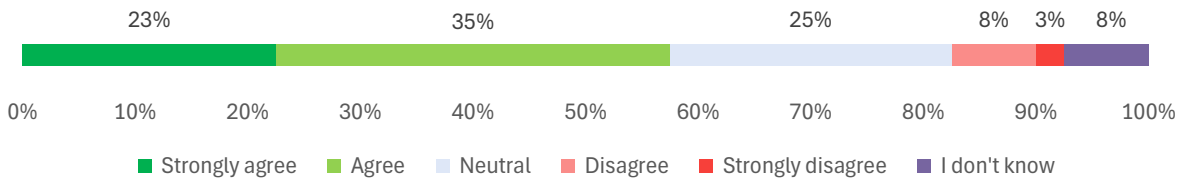


Quantitative results: The plurality of respondents (45%) responded neutrally to the statement that cholera interventions were designed and implemented with adequate sustainability considerations, while 35% either agreed or strongly agreed.

Qualitative results: Respondents identified funding constraints and a lack of adequate resourcing as a threat to sustainability.

Q33. With the support of the GTFCC and the Roadmap, the cholera interventions in your country have been designed and implemented with adequate attention of gender, equity and human rights considerations.

Figure I.25: Response to Q33 by percentage. n=40



Quantitative results: The majority of respondents (58%) agreed that the cholera interventions in their country were designed and implemented with adequate attention to gender, equity, and human rights considerations.

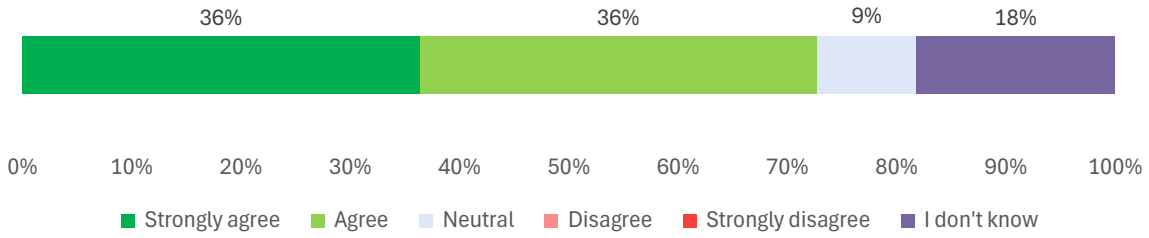
Qualitative results: Two respondents provided examples where gender considerations were incorporated into broader cholera activities, such as in training programs and an example where menstrual health services were considered during the implementation of WASH activities in schools. Additionally, one respondent noted that the GTFCC's emphasis on broad, multi-stakeholder engagement supports gender, equity and human rights considerations in cholera response. It should be noted that significantly fewer respondents provided qualitative feedback relative to the number of respondents who provided quantitative feedback by selecting a multiple-choice answer for this question.

Section 2.3 Stakeholders from countries not engaged with GTFCC

Section summary: Respondents from countries not engaged with the GTFCC were aware of the GTFCC, but mostly indicated that their country had not engaged with the GTFCC due to the absence of cholera in their country (and at times, reluctance of politicians to declare cholera outbreaks).

Q34. I am aware of and understand the role and mandate of the GTFCC well.

Figure I.26: Response to Q34 by percentage. n=11



Quantitative results: The majority of respondents (72%) stated they understood the role and mandate of the GTFCC well, while the remainder (27%) were either neutral or unsure, with no respondents indicating a lack of understanding of the GTFCC's role and mandate.

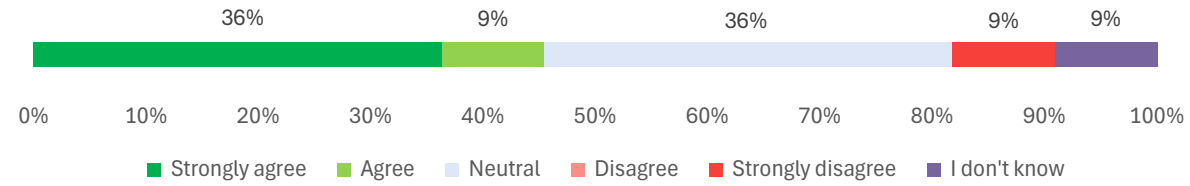
Qualitative results: Respondents indicated they understood the GTFCC's role as a leading body for cholera control and its role in the development of guidelines.

Q35. Why has your country not been engaged or stopped engaging with the GTFCC? *(Freeform question)*

Qualitative results: A plurality of respondents indicated that their country's lack of engagement with the GTFFC was due to the absence of cholera in their country. Other respondents cited political challenges, such as a reluctance of officials to declare cholera outbreaks.

Q36. It would be beneficial for our country to engage more with the GTFCC going forward.

Figure I.27: Response to Q36 by percentage. n=11



Quantitative results: The plurality of respondents (45%) agreed or strongly agreed that it would be beneficial for their country to engage more with the GTFCC. A significant proportion of respondents were neutral (36%).

Qualitative results: One respondent stated it would be beneficial if the GTFCC engaged with the relevant in-country WHO office in order to provide technical and operational support in situations where officials choose not to declare cholera outbreaks. While another respondent stated their country does not have cholera outbreaks.

Q37. What type of support from the GTFCC would be most useful for your country? *(Freeform question)*

Qualitative results: Respondents indicated that their countries could benefit from multiple forms of support from the GTFCC, particularly in resource mobilization, technical guidance, and financial assistance.

List of key GTFCC technical guidance

This section provides a list of key technical guidance documents developed by the GTFCC. It is not comprehensive given information has been collected across multiple progress reports for the GTFCC.

Table 10: Technical documents produced by the GTFCC to support cholera prevention and control

Working group/ Area	Technical document	Publication date
Case management	Use of antibiotics for the treatment and control of cholera	2018
	Risk factors of cholera mortality – scoping review	2022
	Job aid, treatment of children with cholera and severe acute malnutrition (SAM)	2019
Epidemiology and Laboratory	Interim guidance document on cholera surveillance	2017
	Public health surveillance for cholera, interim guidance	2023
	Public health surveillance for cholera, guidance document	2024
	Identification of Priority Areas for Multisectoral Interventions (PAMIs) for cholera control, guidance document	2023
	Identification of Priority Areas for Multisectoral Interventions (PAMIs) for cholera elimination, guidance document	2023
	Identification of Priority Areas for Multisectoral Interventions (PAMIs) for cholera control, user guide	2023
	Identification of Priority Areas for Multisectoral Interventions (PAMIs) for cholera elimination, user guide	2023
	GTFCC Excel-based tool for the identification of priority areas for multisectoral interventions for cholera control	2023
	GTFCC Excel-based tool for the identification of priority areas for multisectoral interventions for cholera elimination	
	Assessment of cholera surveillance, interim guidance document	2024
Laboratory and WASH	Technical note, environmental surveillance for cholera control	2022
Laboratory Laboratory	Interim technical note, the use of cholera rapid diagnostic tests	2016
	Job aid, antimicrobial susceptibility testing for treatment and control of cholera	2024
	Fact sheet, laboratory methods for antimicrobial susceptibility testing (AST) for Vibrio cholerae: points of particular attention	2024
	Job aid: specimen packaging and domestic transportation for laboratory confirmation of Vibrio cholerae	2020
	Job aid: isolation and identification of Vibrio cholerae from faecal specimens	2024
	Job aid: rapid diagnostic test for cholera	2022
	Target product profile for a rapid diagnostic test for surveillance of cholera	2024
	Target product profile for a molecular test for cholera surveillance	2024
OCV	Guidance on process to review OCV MY-POAs	2024
	GTFCC OCV Dashboard	2022
WASH	Technical note: water, sanitation and hygiene and infection prevention and control in cholera treatment structures	2019
	WASH pillar costing tool for NCP development	2024
GTFCC	Interim guiding document to support countries for the development of their national cholera plan	2020

Working group/ Area	Technical document	Publication date
	Template for national cholera plan	2024
	Cholera outbreak response, field manual	2019

Details of GTFCC governance terms of reference

This section includes an overview of the current GTFCC internal structures, i.e., the Steering Committee (SC), Secretariat, CSP, IRP and WGs, their roles and responsibilities, composition and summary of operating processes based on their relevant ToRs) and the document outlining the GTFCC operating model.

Table 11: Overview of GTFCC governance structures

Governance structure	Roles and Responsibilities	Composition	Operating processes
Steering Committee[51]	• Set strategic direction for the GTFCC: including review of activities and preparation of the work plan • Provide oversight and ensure accountability of GTFCC activities • Conduct high level advocacy at the global level to increase awareness and raise the profile of cholera as a public health problem • Meet on a regular basis to review GTFCC activities and ensure that commitments to the Roadmap remain on track • Appoint members of the IRP	• Chair - providing strong leadership to the GTFCC as a whole, coordinating meetings of SC and Annual meeting of GTFCC, acting as an advocate for the Ending Cholera Roadmap and engaging governments, partner organizations and high-level decision makers on behalf of the GTFCC. First Chair appointed by GTFCC Secretariat for 3 years tenures, with subsequent chairs to be appointed by Steering Committee members for the same term length • Membership - 11 members representative sub-group of the GTFCC partners and constituencies • Eight representatives[52] from GTFCC members appointed for a term of 3 years, renewable once. • Three representatives from cholera affected countries one each from the WHO African, South-East Asia and Eastern Mediterranean regions, elected by the General Assembly and appointed for a term of 3 years, renewable once	Decision making • 51% will form a quorum for all meetings • All decisions taken by consensus. In cases where consensus cannot be reached, only core members will be asked to make the final decision (e.g., vote by simple majority) • Recommendations from the SC inform GTFCC work plan, coordinated by the secretariat. • Meetings and LoE • SC to meet on quarterly basis plus ad-hoc calls if strategic decisions required. • Minutes of the meetings and activities publicly available. • Chair dedicates 40 to 50 days annually and compensated for their time.

[51] GTFCC. Steering Committee - Terms of Reference

[52] Including six that are core members: United States Centers for Disease control, World Health Organization, International Federation of Red Cross and Red Crescent Societies, Médecins Sans Frontières, International Centre for Diarrhoeal Disease Research, Bangladesh

Governance structure	Roles and Responsibilities	Composition	Operating processes
			• SC members to commit 1-2 days per month • Secretariat organises the Steering Committee meetings, prepares and proposes the strategic priorities, potential risks, the annual workplan and budgets for review during the Steering Committee meetings.
Secretariat[53] [54]	Coordinates internal operations of GTFCC through: • Organizing meetings of the SC • Supporting overview and monitoring of strategic priorities, potential risks e.g., coordinating annual workplan and budgets including though coordination of WGs • Ensures coordination between the WHO cholera program and the CSP • Supports coordination on WGs (appoint Chair, provide financial, administrative and technical support to the WGs.) • Supports coordination on IRP (identifying members, coordinating NCP development etc.) • WHO may raise funds to support the work of the GFTCC, in accordance with WHO's established policies and principles. • All GTFCC Secretariat funds shall be administered in accordance with WHO's financial regulations, rules, and practices and is subject to WHO's normal programme support costs.	Hosted by WHO. Three members of which some are not fully dedicated to the GTFCC (2.5 FTE).	• Works under the supervision of and reports to the Steering Committee • The operations of the GTFCC shall in all respects be administered in accordance with the WHO Constitution, WHO's Financial and Staff Regulations and Rules, Manual provisions, and applicable policies, procedures and practices.

[53] GTFCC. Global Task Force on Cholera Control Operational Model
[54] GTFCC. Terms of Reference

Governance structure	Roles and Responsibilities	Composition	Operating processes
Country Support Platform (CSP)[55]	Leads multi sectoral support of GTFCC to countries for the implementation of their National Control Plans (NCPs) including • Coordinating technical assistance (short, medium and long term) to countries, deployment of GTFCC multi-sectoral expertise in countries • Supporting the delivery of commodities • Supporting advocacy and the development of national investment cases for cholera. • Supporting monitoring & evaluation of national plans, and the implementation of research projects	5-7 FTE based in its headquarters and an additional 5-10 FTE staff based in selected countries or sub-regions.	CSP is hosted by a partner agency and operates under Secretariat leadership and coordination Budget estimated at US$ 6 million annually at full scale, including staff time, consultancy work, and travel expenses
Independent Review Panel (IRP)[56]	Responsible for providing rigorous, independent technical assessment of country National Cholera Plans for Control or Elimination (NCPs) focusing on: • The multi-sectoral approach and its alignment with the Global Cholera Roadmap goals; • The situational analysis, including • Cholera risk assessment; and • The feasibility of the proposed interventions and their alignment with the situational analysis by Roadmap pillar of the NCP framework.	Team of 5 to 10 experts that are GTFCC members with strong technical expertise: • In cholera, in at least one of: epidemiology, surveillance, management of care, OCV, WASH, community engagement, • Strong programmatic and operational experience in developing, implementing, budgeting, managing, and evaluating and / or reviewing programs related to disease control or elimination at the country level, • Public health expertise including a good understanding and knowledge of health system strengthening frameworks, • Geographically diverse experiences, e.g., persons who work or have worked with a broad range of organizations in multiple developing countries	Members proposed by Secretariat and appointed by the SC The Secretariat is responsible for managing the IRP process, including, but not limited to, identifying its members and ensuring appropriate and timely communication between IRP members and countries The Secretariat cannot serve as a member of the IRP Members must indicate to the Secretariat if they have an interest, affiliation, or other factor that may create actual or perceived conflict of interest

[55] GTFCC. Global Task Force on Cholera Control Country Support Platform
[56] GTFCC. Global Task Force on Cholera Control Independent Review Panel Terms of Reference

Governance structure	Roles and Responsibilities	Composition	Operating processes
		and different contexts (e.g., humanitarian or crisis), • Up-to-date knowledge of the latest scientific evidence related to cholera, GTFCC guidance on the development of NCPs and normative guidance relating to cholera.	The IRP ToR outlines a proposed timeline of 6 weeks for the review of the NCP from kick-off to finalisation and sharing of key conclusions and recommendations with the country The IRP should report to the Secretariat any lessons learned particularly related to assisting other countries with their NCP development and the endorsement process.
Working Groups (WGs)[57]	Provide cholera-specific normative and programmatic guidance on OCV, WASH, Epidemiology, Laboratory, and Case Management to countries and stakeholders. Provide a forum for technical exchange on cholera-related activities Support the implementation of the Global Roadmap Identify research needs and support the development of a research agenda to support the implementation of the Global Roadmap	Membership based on technical expertise, relevance in the field of activity and may include stakeholders representatives. Members act as technical experts and do not represent the views of their organizations. May be designated by their institution or suggested by the WG chair, WG members, other GTFCC members or by the Secretariat. Participation of experts working and/or based in cholera endemic countries strongly encouraged. WGs may mobilize external expertise for answering specific questions identified by the WG when the issue requires additional time, expertise or debates. Individual experts may be consulted and/or invited by the Secretariat to provide advice on specific technical issues. Chairs • Appointed by Secretariat among WG members for three years.	The Secretariat provides financial, administrative and technical support to the WGs. The WGs membership list is reviewed annually to ensure appropriate representation and efficiency of the WGs. The working group should remain manageable in terms of size. Members of other WGs as well as members of the Task Force will be invited to join meetings to ensure good coordination between the different Working Groups. Any WG member – including the appointed chair – presenting a conflict of interest will be excluded from the WG by the secretariat.

[57] GTFCC. Global Task Force on Cholera Control Working Groups - Terms of Reference

Governance structure	Roles and Responsibilities	Composition	Operating processes
		• Coordinates WG with the Secretariat to ensure progress on the annual workplan implementation; and reports progress at the GTFCC annual meeting. • Works closely with the Secretariat to organize the annual WG face to face meetings.	

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