World Health Organization

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

Report

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Cover photo: Oral Cholera Vaccination (OCV) Campaign to Golweyn Internally Displaced Persons (IDP) camp in Daynile District Somalia.
Credit: WHO

Contents

1. **Introduction** **1**
2. **Key findings** **17**
3. **Conclusions** **76**
4. **Recommendations** **81**
5. **Bibliography** **85**
6. **References** **86**

List of figures

Figure 1: GTFCC governance structure 4

Figure 2: Annual resource requirements for the GTFCC and Roadmap implementation 2019–2030 (in US$) 7

Figure 3: Evaluation criteria and questions 9

Figure 4: The ToC for the evaluation 10

Figure 5: E-survey response on whether the Global Roadmap continues to be fit for purpose today (global, regional and multi-country respondents, n=54) 19

Figure 6: E-survey response on how appropriate the objectives of the GTFCC are by percentage (global, regional and multi-country respondents, n=54) 22

Figure 7: Global and regional stakeholder perspectives on the statement, "the GTFCC approach to country engagement is working well" (n=54) 23

Figure 8: Country stakeholder perspectives on the statement, "the GTFCC approach to country engagement is working well" (n=40) 23

Figure 9: Response to the statement, "The GTFCC facilitates a more coordinated and aligned approach between partners and with countries", by percentage. (n=54) 29

Figure 10: Global, regional and multi-country stakeholder responses to e-survey question on whether WGs are working well (n=54) 36

Figure 11: Overview of reported cholera deaths 2010–2023 44

Figure 12: Status of key WASH indicators in health care facilities in least developed countries (36) 50

Figure 13: PAMI identification process as of December 2024 (39) 52

Figure 14: Trend in OCV supply 2011–2022 (41) 53

Figure 15: GTFCC NCP status across countries 58

Figure 16: Factors affecting Roadmap implementation 65

Figure 17: Early impact of COVID-19 on OCV 2013-2021 66

Figure 18: E-survey responses from global, regional and/or multi-country stakeholders on the adequacy of sustainability considerations in the GTFCC Roadmap and interventions (n=54) 70

Figure 19: E-survey responses from global, regional and/or multi-country stakeholders on the adequacy of GER considerations by the Global Roadmap and cholera interventions (n=54) 74

List of tables

Table 1: Number of key stakeholders interviewed by stakeholder group (several stakeholders cover multiple groups) 12

Table 2: Robustness rating for findings 13

Table 3: Limitations and mitigation methods 14

Table 4: Summary findings for relevance 17

Table 5: Summary findings for coherence 25

Table 6: Summary findings for GER 72

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Acronyms

Abbreviation	Definition
BMGF	Bill and Melinda Gates Foundation
CDC	Centers for Disease Control and Prevention
CSP	Country Support Platform
EQ	Evaluation Question
ERG	Evaluation Reference Group
FTE	fulltime equivalent
GER	gender, equity and human rights
GTFCC	Global Task Force on Cholera Control
ICG	International Coordinating Group
IDP	Internally displaced person
IFRC	International Federation of Red Cross
IRP	Independent Review Panel
KII	key informant interview
M&E	monitoring and evaluation
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
WASH	water, sanitation and hygiene
WG	working group
WHA	World Health Assembly

Executive summary

Background

The global health landscape has been marked in recent years by a resurgence of cholera outbreaks, including in previously cholera-free areas, due to a combination of developments such as the higher intensity and frequency of natural hazards, climate change, conflicts and displacements that impact access to health and WASH infrastructure. At the same time, there has been a shortage of oral cholera vaccines (OCV) and increased competition for funding at national level particularly since the COVID-19 pandemic. Globally, progress on reducing cholera related deaths has been slower than expected while overall advancement towards Sustainable Development Goals (SDGs) 3 and 6 *(1)*, respectively for health and well-being and for clean water and sanitation, is lagging behind, with billions of people worldwide lacking access to safely managed drinking water sanitation and basic hygiene services *(2).*

The **Global Task Force on Cholera Control (GTFCC)** was established in 1992 by the Director-General of the World Health Organization (WHO) following a World Health Assembly *(3, 4)*. It was revitalized through a World Health Assembly resolution in 2011 *(5)* to coordinate activities for cholera control at global, regional and country levels. It is a network of 48 institutions (including UN agencies, foundations, civil society organizations, academic and research institutions and government agencies). Its overarching strategy, the **Global Roadmap Strategy (*Ending Cholera – A Global Roadmap to 2030*)**, was issued in 2017 with the objective to reduce cholera deaths by 90%, eliminate cholera in 20 countries by 2030 and prevent uncontrolled outbreaks of the disease *(6)*. To achieve these objectives, the Roadmap sets forth a package of actions across three key axes: (i) early detection and quick response to contain outbreaks; (ii) targeted prevention focusing in Priority Areas for Multisectoral Interventions (PAMIs); and (iii) partnership coordination for effective technical support, resource management and progress tracking. Across the three axes, this includes improving and strengthening water, sanitation and hygiene (WASH) systems, access to preventative and reaction OCV, disease surveillance in PAMI areas (hotspots most affected by cholera), case management and reporting and community engagement.

The GTFCC governance structure includes a Steering Committee; a Secretariat hosted by WHO; Technical Working Groups (WGs) on cholera-specific normative and programmatic guidance on OCV, WASH, epidemiology, laboratory and case management; a Country Support Platform (CSP) established in 2020 and hosted by the International Federation of Red Cross (IFRC) and Red Crescent Societies to support countries with their national cholera plans (NCPs); and an Independent Review Panel (IRP) responsible for review of NCPs. In addition, a General Assembly is held annually to provide stakeholders with the opportunity to review progress and challenges.

Purpose and scope

This evaluation has a **dual purpose of accountability and learning**. It assesses progress in the delivery of the Global Roadmap, draws lessons and makes recommendations for the direction of travel of the GTFCC to 2030. The **scope** of the evaluation covers progress on the Global Roadmap implementation since 2017 with a particular focus on coordination and programmatic delivery at the global, regional and country levels by the GTFCC and partners.

Methodology

This formative evaluation combines a **theory-based, utilization-focused,** and gender, equity and social inclusion responsive approach. The evaluation addressed the OECD DAC evaluation criteria of relevance, coherence, efficiency, effectiveness and sustainability. **Mixed methods were used to collect and analyse data,** including primary and secondary data from focus group discussions and semi-structured interviews with 224 key informants, an online survey with 105 respondents, document review and data analysis and six country case studies (Democratic Republic of the Congo, Haiti, Kenya, Nepal, Nigeria and Somalia).

Key findings

Relevance

The Global Cholera Roadmap to 2030 is a first-time overarching multisectoral strategic framework that emphasizes the urgency to end cholera, supports national cholera responses and contributes to related SDG targets. While generally relevant, its objectives are ambitious and with the SDG agenda in danger of not achieving its goals, there are many political, economic, climatic and epidemiological contextual challenges. While its original intent was to eliminate cholera in 20 countries, the number of countries managing cholera outbreaks increased from 29 in 2017, when the Roadmap was launched, to 51 in 2024. In this context, there is a need to define a prioritized set of actions to guide implementation up to 2030, given the changing external environment and available resources.

The Roadmap has struck a relevant overall balance across its objectives on outbreak response and prevention. The GTFCC has strengthened relevance at country level since 2017 by expanding its country facing structures, and there is a need to further this country focus taking in due consideration available/ potential resources.

Coherence

At the global level, the GTFCC has strengthened external coherence of cholera interventions by promoting greater partner coordination and alignment. Yet in terms of internal coherence within the GTFCC, the roles and responsibilities of GTFCC partners in the implementation of the Roadmap objectives are not clearly delineated. In the absence of a strategic action plan defining priority actions, there has been some confusion among partners on their contributions. There is also a need for a more unified approach between partners on emergency response versus long- term preventative approaches as well as OCV and WASH. This dichotomy is further perpetuated by the differential of funding available for OCV vs WASH.

Coordination and alignment at the regional and country levels are less strong. Engagement at the regional level has been deeper in some regions, with partners providing support to GTFCC activities at regional level, including the WHO Regional Office for Africa, the Africa Centers for Disease Control and others. Further engagement with other regional partners presents a key opportunity to address essential issues, such as cross-border transmission, looking forward. At country level, coordination and partner alignment often remain less structured despite progress since 2017 through partners working at country level; GTFCC structures with extension of Steering Committee membership to country representatives; increased country participation in the GA and the work of the WGs and the Secretariat. In particular, the creation of the CSP to provide additional support to the development of NCPs and PAMIs, and to a lesser extent the IRP, has contributed to this greater focus.

Efficiency

The extent of the efficiency of the GTFCC governance mechanism and its structures has been variable, despite some improvements in the functioning of the GTFCC as a whole since 2017.

Roles and responsibilities of core GTFCC structures need to be better delineated. The Steering Committee mandate and the extent of its role in strategic direction and oversight needs clarifying as SC of a voluntary partner-based task force, where countries' commitment is ultimately required to drive change. Overall efficiency of the Steering Committee could be enhanced by expanding membership to WASH, development partners and additional country stakeholders. The role of the Secretariat is central in terms of driving and coordinating GTFCC activities, despite limited resources and capacity. However, there are challenges in relation to partners' lack of alignment on the extent of agency taken on by the Secretariat and a need to clarify its responsibilities versus the WHO Cholera Programme. The WGs generally function efficiently, despite specific challenges and varying resource levels (funding constraints primarily affect the WASH WG and the operationalization of the risk, communication and community engagement (RCCE) WG). Communication and coherence of workplans across all WGs are areas to improve for greater efficiency.

There have been efficiency gains in country level engagement since 2017, through partners working at the country level, the WGs and the creation of the CSP. Working closely with the Secretariat, the CSP is generally fit for purpose. Yet its reach is limited to a small group of countries, and it faces a significant sustainability risk given limited funding. The IRP has not yet demonstrated its potential, despite NCP reviews having been conducted in five countries, and there is a need to improve its efficiency affected by limited engagement and awareness of its role, engagement and considerable delays in its review work.

Overall, there have been limited funds for cholera and an imbalance between outbreak response/prevention as well as between OCV and WASH. Funding to support the work of the GTFCC has also been limited, and with the GTFCC approaching a funding cliff in 2025, the need for a diversified and sustainable funding base is evident and urgent.

Effectiveness

Despite progress made in key strategic areas, mostly of the Roadmap Axis 1 (outbreak response) and 2 (prevention), the effectiveness of Roadmap implementation has been limited overall. External factors, including conflict and climate change, and internal factors, notably funding shortfalls and importantly the lack of a strategic action plan including a global M&E framework that measures differentiated results across axis and countries, compounded by the absence of a resource mobilization strategy have affected the effectiveness of the GTFCC.

Axis 1: Early detection and outbreak response. Progress has been made in a number of key implementation areas, notably the strengthening of integrated early warning surveillance systems, laboratory capacity and cholera reporting. Yet important gaps remain. Countries still face persistent challenges in surveillance, with chronic problems of data quality and reporting mechanisms that need further strengthening, while political sensitivities continue to generate reluctance to report cases. Mass reactive OCV campaigns are a core strategy under Axis 1, and the International Coordinating Group's (ICG) decision to limit doses has helped address manufacturing challenges, but the GTFCC reported a significant dose gap in 2023 for outbreak reactive campaigns alone, and demand for preventative vaccine was unmet.

***Axis 2:* A targeted prevention strategy focusing interventions in cholera PAMIs.** Progress has been mixed. While PAMI identifications have progressed (23 countries had completed the identification of PAMIs using the GTFCC method in 2023) and NCPs targeted to PAMIs have been developed, they have not been implemented consistently in all

countries or across sectors. Despite efforts at country level to scale up the implementation of multisectoral interventions for the preparedness and prevention of cholera across all key pillars including OCV, surveillance and labs, progress has been slow. The delivery of OCV preventative vaccination has been particularly challenging due to the current global shortage of vaccines, limited manufacturing capacity and reliance on a single manufacturer, which poses a critical risk of OCV-dependent response. Access to WASH remains limited due to severe underinvestment in WASH services, including in cholera hotspots, despite some global progress, particularly in rural areas.

Axis 3: Partnership coordination for effective technical support, resource management and progress tracking. The GTFCC has successfully brought stakeholders together to galvanize cholera efforts, although some key stakeholder groups have not yet been extensively engaged (e.g. WASH partners and multilateral development banks). There has been progress in the development of technical guidance and tools by WGs (especially the NCP guidelines, PAMIs, case management methodologies and the multiannual OCV plan). As of 2024, ten countries had finalized their NCPs with GTFCC support, eight were developing NCPs, and seven were considering developing NCPs. However, progress in implementing the NCPs has been more limited. The GTFCC research agenda has advanced with the benefit of dedicated funding. Despite efforts in advocacy and resource mobilization to keep cholera on the global health agenda and foster political commitment, in particular through high-level meetings such as the World Health Assembly and side events, this remains a weak and critical area affecting all aspects of the Roadmap implementation, particularly prevention.

Sustainability

While the Roadmap emphasizes sustainability as a core aim, including long-term WASH, capacity-building and government-led cholera response, key aspects underpinning sustainability remain insufficiently embedded in GTFCC operations, notably WASH, advocacy and resource mobilization. Overall resources for the cholera response and the GTFCC itself are at a critically low level and may compromise sustainability of progress made to control cholera, with risks of impending funding shortfalls. Intended to be developed with a broad coalition of stakeholders, NCPs, which are part of the Roadmap's cholera response, are ultimately designed to be owned and led by governments. While there has been good progress in the development of NCPs, with ten finalized NCPs and eight under development in 2024, their implementation is lagging behind.

Gender, equity and human rights (GER)

While the Roadmap explicitly highlights the correlation between poverty and the increased risk of cholera affecting poorer communities, it does not incorporate a specific emphasis on gender, equity or human rights considerations. The multisectoral approach of the Roadmap advances GER objectives by prioritizing areas with lower economic status, including through PAMIs that focus on high burden areas with limited health care and WASH services. The Roadmap lays out a strategy to address these through combining OCV and WASH strategies and using OCV as an immediate response to disrupt transmission cycles, while allowing more time to implement long-term WASH solutions. The Roadmap's mitigation measures to reduce cholera risks from unexpected events such as conflict or natural disasters address vulnerable groups, and the monitoring system to trigger GTFCC support highlights the use of OCV for refugees and displaced populations in high-risk areas, yet there is no direct implementation plan.

There has been progress at country level in addressing geographical and economic inequities, with more disaggregated data by age, gender and geography, but other GER dimensions are not integrated sufficiently explicitly and systematically in data collection, monitoring frameworks and implementation strategies.

Key conclusions

Relevance

The GTFCC Global Cholera Roadmap to 2030 continues to be a relevant overarching strategic framework to guide multisectoral cholera responses worldwide. Noting the context of the ambitious targets of the Roadmap vis-à-vis the overall SDG agenda 2030, there is a need for a prioritized set of actions to guide operationalization of the Roadmap and GTFCC partner contributions up to 2030. The relevance of the GTFCC model of country engagement has evolved considerably since 2017, and there is a continuing demand to strengthen country engagement in a feasible way that considers available/potential resources

Coherence

Overall, the GTFCC has strengthened coherence externally, promoting greater partner alignment and coordination, particularly at global level. Coordination is less strong at regional and country levels. Within the GTFCC, partners' roles and responsibilities in the implementation of the Roadmap need clarifying. Partners have also been less aligned on the relative prioritization of outbreak and preventative responses in general, and between OCV and WASH in particular. There is a need to engage with WASH (especially non-humanitarian WASH) actors and wider development partners (e.g. bilateral donors and multilateral development banks), the private sector, regional bodies and country representatives beyond health ministries.

Efficiency

Despite some improvements in the functioning of the GTFCC governance model since 2017, overall efficiency of its mechanisms and core structures has been variable. There is a need to clarify the roles and responsibilities of GTFCC core structures (e.g. Steering Committee, Secretariat), strengthen coordination among WGs and deepen regional and country level engagement. The limited availability of resources has affected the functioning of GTFCC core structures and created funding imbalances between outbreak response and prevention and between OCV and WASH. There is an urgent need for a diversified and sustainable funding base for the GTFCC.

Effectiveness

Overall effectiveness of the GTFCC roadmap implementation towards achieving its goals by 2030 has been mixed. There has been progress in some key strategic priorities: on Axis 1 and 2 in early warning surveillance systems, laboratory capacity and cholera reporting, and in Axis 3 partner coordination, with the development of technical guidance and tools as well as, in a growing number of countries, the development of PAMIs and NCPs, which have yet to be implemented. However, persisting challenges remain with key aspects concerning the quality and availability of country level cholera data, the shortage of OCV supply and advocacy and resource mobilization. External factors have affected Roadmap implementation, with the imperative to address the resurgence of outbreaks and the overall shortfall of funding for cholera, in particular for prevention. Within prevention, progress regarding WASH for cholera has remained slow. The operationalization of the Roadmap has also been challenging due to the absence of a costed strategic action plan and an M&E framework measuring global results across axis and countries as well as the lack of a resource mobilization strategy for cholera response.

Sustainability

Overall sustainability of gains in cholera control is vulnerable, particularly in view of impending funding shortfalls. Sustainability is central to the

Roadmap, which promotes multisectoral, long-term interventions, sustainable WASH infrastructure development, capacity-building and government ownership through NCPs. However, implementation has not been fully embedded in Roadmap operations. In particular, advocacy to raise the visibility of cholera in global health and resource mobilization efforts urgently need reinforcing.

Gender, equity and human rights

Equity considerations are essential to addressing cholera, which primarily affects poorer communities, and the Roadmap directly addresses economic inequalities in cholera response. However, it does not address other aspects of GER including gender and human rights to the same extent. There is room for stronger, more explicit engagement with GER principles.

Recommendations

1 – To effectively implement the Roadmap through 2030, develop a strategic action plan with prioritized objectives, a results framework, costed workplan, budget and clearly defined stakeholder roles.

i. Review priority objectives to 2030 (as well as activities and outcomes), ensuring an appropriate balance across outbreak response and prevention and OCV and WASH, and integration with other disease/epidemic control efforts.

ii. Develop a results framework, including specifying partners' contributions.

iii. Develop a prioritized costed workplan to 2030, taking into account priorities and prospective resource availability.

Time frame: Next six months. **Action:** GTFCC Secretariat in consultation with partners and Steering Committee.

2 –Enhance engagement of GTFCC partners at country and regional levels to maximize results at country level.

i. Increase focus on and priority for country-level work building on progress in developing country NCPs. Identify barriers and address implementation challenges through more specific approaches and greater integration with other disease/epidemic control and health systems strengthening efforts. Continue to engage with countries to identify WG priorities and increase dissemination and use of WG products among countries.

ii. Strengthen and build on the CSP approach by 1) identifying and sourcing funding to capacitate the CSP and 2) clarifying the scope and role of the CSP.

iii. Explore regional approaches to facilitate greater coverage of countries and strengthen cross-border coordination for cholera responses. Enhance engagement with regional partners, including GTFCC members and networks, as well as regional meetings and South to South exchange and learning.

Time frame: Next 12 months. **Action**: GTFCC Secretariat, CSP in consultation with partners, Steering Committee

3 – Clarify the roles and responsibilities of GTFCC core structures to improve partner engagement and ownership and facilitate decision-making.

i. Steering Committee: 1) Clarify its decision-making role in line with WHO hosting approaches and rules and clarify expectations on strategic direction and oversight; and 2) consider expanding and diversifying its

composition (notably from WASH and country stakeholders) without making it too large.

ii. Secretariat: In addition to overall coordination of GTFCC, 1) reinforce its role in relation to implementing the Roadmap action plan (see Recommendation 1), with partners taking on additional roles and responsibilities in areas where they have specific capacity/comparative advantage; and 2) clarify its role vis-à-vis the WHO Cholera Programme and dedicate a fulltime equivalent (FTE) for the GTFCC Secretariat.

iii. Working Groups: 1) Strengthen systematic cross-WG coordination of priorities, workplans and exchange; 2) consider the need for technical subcommittees (or equivalent) to further specific areas building on members' motivation and available resources; and 3) reassess the need to operationalize the RCCE WG.

iv. The IRP: Assess continuing need for the IRP in light of challenges met and limited availability of resources and/or measures to improve timeliness of IRP support.

v. General Assembly: Expand partner engagement within the GTFCC by increasing 1) the contribution and role of WASH and development partners; 2) participation of countries, for example by holding some General Assembly meetings in cholera-affected countries; and 3) involvement of multiple sectors including the private sector.

Time frame: Next 6 months - **Action:** Steering Committee, Secretariat, specific GTFCC structures

4 – Enhance communication, advocacy and resource mobilization for cholera at the global, regional and country levels to support Roadmap implementation, GTFCC structures and multisectoral integrated approaches.

i. Develop a communication and advocacy plan based on the strategic action plan (see Recommendation 1) to raise the profile of cholera and identify new opportunities.

ii. Develop a resource mobilization strategy identifying key priorities linked to the operational plan (see Recommendation 1), targeting high-profile international efforts and positioning cholera in integrated approaches and joint resource mobilization efforts in connection with health and climate change and WASH/development..

iii. Explore innovative resourcing strategies, including the use of models to mobilize small grants for local partners to advocate at country level and nontraditional approaches for partner support at global, country and regional levels (e.g. secondments, other in-kind support, leveraging partners communication and/or resource mobilization teams).

Time frame: Urgently for resource mobilization for the structures of the GTFCC - **Action:** Secretariat, Steering Committee, CSP

5 – Increase engagement, integration and alignment with WASH interventions and programmes highlighting priority WASH areas in the Roadmap and cholera integration in WASH investments at national and subnational levels.

i. Strengthen the WASH WG, including by expanding its membership to partners who are familiar with and can influence policy-making in cholera-affected countries and at the global level (e.g. World Bank, African Development Bank Group, UN Water, etc.), and by integrating into the WG workplan. Where possible, engage WASH in other WGs.

ii. Adopt a more holistic/integrated approach to WASH (relevant to multiple disease control efforts), increase linkages with WASH activities at country, regional and global level and support the transition from "emergency" WASH to more of a long-term WASH focus by strengthening engagement with other organizations' WASH frameworks and with relevant events/initiatives

(e.g. UN System-wide Strategy for Water and Sanitation)

Time frame: Next 12 months - **Action**: Secretariat, WASH WG, Steering Committee

6 – Reinforce monitoring and evaluation (M&E) for implementing the global Roadmap and continue efforts to strengthen country-level data collection and collation frameworks.

i. Develop a robust M&E framework (further to Recommendation 1) to assess progress on the Global Roadmap, clarifying roles and responsibilities in data collection and use; conduct periodic progress reviews and integration of lessons into re-prioritization and expand reporting.

ii. Continue to expand initiatives to enhance country capacity to report on cholera; monitor and evaluate cholera responses.

iii. Enhance and support collection of disaggregated data at the country level to further address GER concerns.

iv. Emphasize the need to facilitate more timely and transparent sharing of data by countries to focus advocacy efforts to reduce stigma of cholera (See Recommendation 4).

Time frame: Next 12 months - **Action**: GTFCC Secretariat (M&E of the Roadmap) and Epidemiology WG, Steering Committee

1. Introduction

The introduction section provides information on the evaluation background, including the evaluation context and object (Section 1.1); evaluation purpose and objectives (Section 1.2); evaluation framework, questions and methodology, including limitations (Section 1.3) and the structure of the report (Section 1.4).

1.1. Evaluation background

Evaluation context

The global cholera landscape has been marked in recent years by a resurgence of outbreaks, including in previously cholera-free areas (e.g. Lebanon, Mali, South Africa, amongst others): in 2023, 35 countries were managing outbreaks compared to 29 in 2017.[1] Several key developments are impacting on the cholera situation.

1. **Shortages in the cholera vaccine.** A global upsurge in cases has led to the unprecedented demand for oral cholera vaccines (OCV) from affected countries and a consequent strain on the global stockpile. The use of the stockpile for emergency response is managed by the International Coordination Group for Vaccine Provision (ICG), whose secretariat is hosted by the World Health Organization, with support from Gavi. In 2018, the Gavi Vaccine Investment Strategy called for the inclusion of OCV as a preventative vaccination in hotspot areas, which in the short term further increased demand and exposed the limits of supply.[2] In October 2022, this shortage led to the unprecedented ICG decision to suspend two dose strategies in favour of a single-dose strategy for outbreak response, advice upheld by the Strategic Advisory Group of Experts. In April 2024, WHO announced that a new OCV, Euvichol-S, had received WHO prequalification and can now be made available to impacted countries. This approval was forecast to increase the global OCV supply from 38 million does in 2023 to 50 million in 2024 alongside other capacity and manufacturing expansions and investment *(7).*
2. **COVID-19 pandemic impact.** The pandemic has significantly altered the global health landscape and highlighted the need for improved pandemic prevention, preparedness and response. Multilateral agencies and international organizations embraced the need to strengthen surveillance systems, local manufacturing of health products, health systems and community management of cases. COVID-19 (compounded with other emergency public health priorities) has had crucial implications for the management of diseases with epidemic and pandemic potential and negatively impacted funding for cholera, due to competing priorities for limited resources, including domestic resources.
3. **Climate change, conflicts and displacements.** These factors have increased the frequency and re-emergence of cholera outbreaks with: (i) climate change increasing the intensity and frequency of natural hazards such as cyclones and flooding and (ii) conflicts and displacements impacting access to health and WASH infrastructure. Major cholera outbreaks occurred in 2022 in Pakistan, Malawi and Nigeria. There is

[1] GTFCC, Data on number of countries with outbreaks per year, 2024.

[2] In the longer term it is expect that the preventative programme launched in January 2023 within Gavi will increase global supply availability, as it is expected to help provide predictable demand for manufacturers.

also growing recognition of the climate change-health nexus through fora such as the 28th meeting of the Conference of the Parties (COP28).

In this context, with the number of cholera outbreaks increasing over time, overall progress on reducing cholera-related deaths has been slower than expected. Global advancement towards Sustainable Development Goals (SDGs) 3 and 6, respectively for good health and well-being and for clean water and sanitation, has generally been slow, notably due to limited funding in some key areas, especially long-term Water, Sanitation, and Hygiene (WASH). Concerning SDG 6 on water and sanitation, global progress is off track to meet the 2030 SDG timeline and targets, especially in low- and middle-income countries : a recent UN-Water report estimated that billions of people worldwide continue to lack access to safely managed drinking water sanitation and basic hygiene services *(2)*.

This context for cholera provides the rationale for this mid-term evaluation of the Global Task Force on Cholera Control (GTFCC) in 2024, as the midpoint of the period 2017 to 2030, which marks the end of the Global Roadmap on Cholera (Ending Cholera – A Global Roadmap to 2030). The evaluation seeks to assess progress made in the delivery of the Roadmap and GTFCC and draw the way forward to ensure successful adaptation to a global landscape marked by significant epidemiological, political and climatic changes.

Evaluation object

The object of the evaluation is the GTFCC, including an assessment of the design and implementation of both the GTFCC as a platform and the Global Roadmap Strategy (Ending Cholera – A Global Roadmap to 2030).

The **GTFCC** was established in 1992 by the WHO Director-General following the adoption of the World Health Assembly resolution WHA44.6 (1991) *(3)* *(4)*. It is a network of 48 institutions (18 international organizations, 16 academic and research institutions, 3 UN agencies, 4 foundations and 7 government agencies) to coordinate activities for cholera control at global, regional and country levels. The GTFCC was originally created with the aim of supporting Member States in reducing morbidity and mortality rates associated with cholera and diminishing the social and economic consequences of the disease.

The GTFCC has been through various phases with mixed progress over 15 years between 1992 and 2007, for a number of reasons, including changes in the external and internal environment for GTFCC and cholera overall (including similar external aspects to those highlighted above in the evaluation context section and internal aspects being changes in leadership and funding). After a period of inactivity, the GTFCC underwent a revitalization between 2011 and 2014 to further strengthen the GTFCC's impact on cholera, as reflected in WHA resolution WHA64.15(2011) *(5)*. The period from 2017 onwards marks the new phase of the GTFCC following the implementation of reforms emerging from the revitalization.

The **Global Roadmap Strategy (Ending Cholera – A Global Roadmap to 2030),** was issued in 2017, and WHO Member States committed to the Roadmap at the 71st World Health Assembly *(8).* The Roadmap provides the new 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 *(6)(9)*.[3] The Roadmap's objective is to reduce cholera deaths by 90%, eliminate cholera in 20 countries by 2030 and prevent uncontrolled outbreaks of the disease. The Roadmap aims to achieve short-term results as well as implement long-term measures such as disease surveillance, case management and other control measures. The package of measures includes WASH, leadership and coordination, case management, surveillance and reporting, OCV and community engagement. The Roadmap focuses on the 47 countries affected by cholera in 2017 through axes at different levels – Axis 1 and 2 are focused on the country response to outbreaks and prevention of cholera, while Axis 3 is on support and coordination by the GTFCC for Axis 1 and 2, including resource mobilization and partnership at local and global levels.

- **Axis 1: Early detection and quick response to contain outbreaks at an early stage.** The strategy focuses on containing outbreaks through early detection and rapid response, which are critical elements for reducing the global burden of cholera. The emphasis is on interventions like robust community engagement, strengthening early warning surveillance and laboratory capacities, health systems and supply readiness and establishing rapid response teams.
- **Axis 2: A multi-sectoral approach to prevent cholera in hotspots in endemic countries.** The strategy also calls on countries and partners to focus on cholera "hotspots", the relatively small areas most heavily affected by cholera, which experience cases on an ongoing or seasonal basis and play an important role in the spread of cholera to other regions and areas. Cholera transmission can be stopped in these areas through measures including improved WASH and through use of OCV.
- **Axis 3: An effective mechanism of coordination for technical support, resource mobilization and partnership at the local and global level.** As a global network of organizations, the GTFCC is positioned to bring together partners from across all sectors and offers a platform to support advocacy and communications, fundraising, inter-sectoral coordination and technical assistance.

The GTFCC brings organizations together and serves as a coordination platform to support countries in the implementation of the Global Roadmap. The **objectives of the GTFCC** are to:[4]

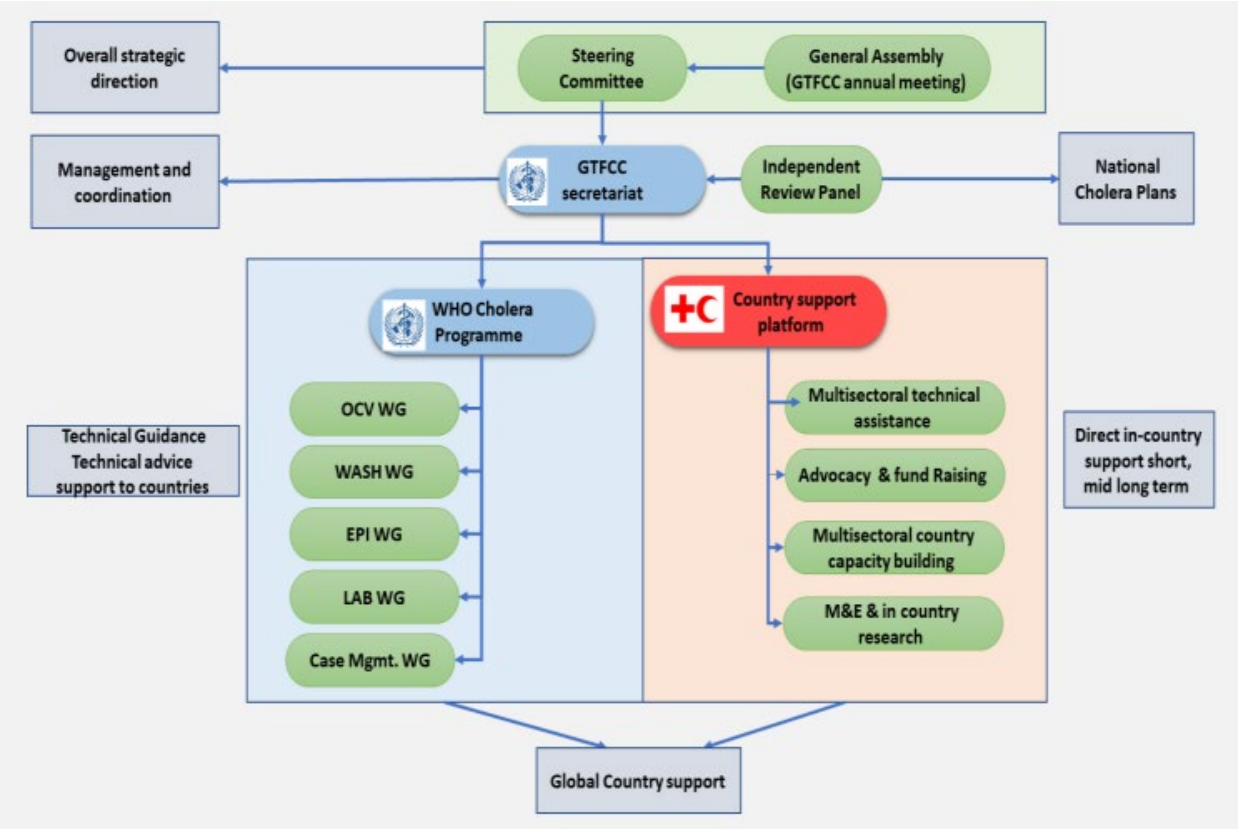
- support the design and implementation of global strategies to contribute to cholera prevention and control globally;
- provide a forum for technical exchange, coordination and cooperation on cholera-related activities to strengthen countries' capacity to prevent and control cholera, especially those 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; and

[3] At the regional level, the Regional Framework for the Implementation of the Global Strategy for Cholera Prevention and Control 2018–2030 adopted by the WHO Regional Office for Africa supports the implementation of the Roadmap. It sets forth concrete actions to enhance epidemiological and laboratory surveillance, cholera hotspot mapping, timely access to treatment, partnerships and community engagement, investments in WASH for the most vulnerable, and research.
[4] GTFCC, Mid-term independent evaluation of the Global Task Force on Cholera Control (GTFCC) 2017–2030: terms of reference, 25 January 2024.

- 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.

The governance structure of the GTFCC along with summarized roles is presented in Fig. 1. and detailed below. As per the Terms of Reference (ToR) for the GTFCC, it is "administered by the WHO. It is a collaborative mechanism between interested parties including WHO and GTFCC members and is not an independent legal entity".[5] As explained in the ToR, "for this reason, the GTFCC cannot conduct any actions in its own name. 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".

Figure 1: *GTFCC governance structure*[6]



[5] GTFCC, Terms of reference, 23 April 2024.
[6] Secretariat, GTFCC, HR and financial update, July 2024.

Key GTFCC structures include:

- **the Steering Committee**:[7] The Steering Committee is responsible for oversight, strategic direction and accountability for the GTFCC as whole. As per its ToR, the Steering Committee includes six core members from the US Centre for Disease Control (CDC), UNICEF, WHO, International Federation of Red Cross (IFRC), Médecins Sans Frontières and the International Centre for Diarrhoeal Disease Research, Bangladesh, and two further members from partner organizations. It is also to include three representatives from cholera-affected countries. There are defined operating procedures for its meetings (e.g. definition of a quorum, decision by consensus, rotation of members, quarterly meetings, etc.).
- **the Secretariat**:[8] The Secretariat is hosted by and operates within WHO. As of October 2024, it was composed of two Full-Time Equivalents (FTEs) for overall coordination, with daily activities managed by three staff, with only 1.5 FTEs of those two Secretariat Coordination positions funded. The team also includes an extended group, comprising the technical focal points of the GTFCC working groups (see below). Those positions are currently in the WHO cholera programme under the Health Emergencies Programme. As per its ToR, the Secretariat works under the supervision of and reports to the Steering Committee. The Secretariat also reports through the Executive Director of the Health Emergencies Programme, the Director-General and to the governing bodies of WHO. The Secretariat is the driving force of the GTFCC: as per the ToR, it organizes the meetings of the Steering Committee; prepares and proposes strategic priorities, workplan and budgets and potential risks for review by the Steering Committee; coordinates the GTFCC; provides financial, administrative and technical support to the Working Groups; organises the GTFCC General Assembly meetings; and leads, guides and coordinates the work of the Country Support Platform (CSP), including its coordination with the WHO Cholera Programme.
- **Technical Working Groups (WGs)**:[9] WGs provide cholera-specific normative and programmatic guidance on (i) OCV, (ii) WASH, (iii) epidemiology, (iv) laboratory and (v) case management. The WGs have a chair (GTFCC partner institution), a focal point (who are WHO staff from the WHO Cholera Program) and members from a range of organizations engaged in the GTFCC. Across the five WGs there are 201 members and 106 observers in total.[10]
- **The CSP**: The CSP was established in 2020 and is housed at the IFRC and Red Crescent Societies. The GTFCC terms of reference indicate that it is to operate under the GTFCC Secretariat's leadership and provide multisectoral operational support as well as the advocacy, coordination and policy guidance necessary for countries to develop, fund, implement and monitor their NCPs effectively, ensuring consistency and alignment with the Global Roadmap. This includes technical assistance, advocacy and fundraising for national cholera plans (NCPs), monitoring and evaluation of national plans and the implementation of research projects. The CSP supports the short, medium and long-term deployment of GTFCC multisectoral expertise in countries. Five "primary operational countries" have received

[7] Steering Committee, GTFCC, Terms of reference, 2019.
[8] GTFCC, Operational model, 2019.
Working Groups, GTFCC, Terms of reference, 2020.
[10] The composition by WG in order of total members is as follows: Epidemiology: 43 members and 95 observers, Laboratory: 42 members and 11 observers, WASH: 50 members, OCV: 41 members and Case management: 26 members.

substantial support: Bangladesh, Democratic Republic of the Congo, Mozambique, Nigeria and Zambia. In addition, another four countries (Ethiopia, Jordan, Malaysia and Tanzania) have received ad-hoc technical support, and there are five additional countries currently to be included for technical support with a longer-term vision (ongoing in Cameroon, Kenya, Nepal; early discussions with Burundi and Malawi). *(11)*

- **The Independent Review Panel (IRP):***(12)* The IRP is an independent technical review mechanism responsible for the transparent and in-depth review of NCPs so as to advise the Secretariat and GTFCC on the endorsement of plans. The ToRs indicate that the IRP is to comprise a team of 5-10 experts who are GTFCC members with strong technical expertise, proposed by the Secretariat and approved by the Steering Committee. At present there are approximately 9–12 active members.
- **The General Assembly:** The GTFCC General Assembly is held annually, provides stakeholders with the opportunity to review progress and highlight challenges faced and enables country representatives to express their needs.

The GTFCC **model of partner engagement** – in other words, how GTFCC engages with partners, with partners referring to GTFCC members and other stakeholders engaging with cholera and/or the GTFCC – includes the following mechanisms: (i) the General Assembly; (ii) other meetings convened by the GTFCC Secretariat; and (iii) the range of GTFCC structures, including the Steering Committee, WGs, CSP, etc.[11]

The GTFCC **model of country engagement** refers to work undertaken by the GTFCC for countries through direct support provided by the GTFCC partners for country programmes and through GTFCC structures, primarily the Secretariat, WGs and CSP, as well as the IRP and participation in the General Assembly and other GTFCC meetings.[12] At country level, GTFCC partners play a crucial role in supporting countries in implementing cholera responses, particularly where there are capacity gaps in humanitarian and conflict-affected countries.

At the regional level, the Regional Framework for the Implementation of the Global Strategy for Cholera Prevention and Control 2018–2030 adopted by WHO Regional Office for Africa supports the implementation of the Roadmap. It sets forth actions to enhance epidemiological and laboratory surveillance, cholera hotspot mapping, timely access to treatment, partnerships and community engagement, investments in WASH for the most vulnerable, and research[13].

While the Roadmap provides the GTFCC's global strategy, there is no **overarching strategic action plan** that sets out priority areas of work for the Task Force, including identifying partner roles and responsibilities as well milestones and timelines. Some individual GTFCC bodies and specific areas have operational workplans (e.g. Secretariat and Working Groups, and an advocacy workplan). Work is currently ongoing by the Secretariat to assess the M&E framework of the global Roadmap.

GTFCC resources to implement the Roadmap. In 2019, GTFCC estimated annual resource requirements for the GTFCC mechanism for the period 2019–2030 (i.e. annual costs for coordination, technical guidance and country support through the GTFCC Secretariat, WHO cholera programme and CSP) as well as country level costs for implementation of surveillance and M&E for select countries, OCV for non-Gavi eligible countries and targeted

[11] Not defined in any documents but inferred from this evaluation.
[12] Not outlined specifically in any document but inferred from this evaluation.

WASH interventions for cholera control. Fig. 2 provides this estimation, totalling to between US$ 14.5 million and US$ 19.5 million *(13)*.

Figure 2: Annual resource requirements for the GTFCC and Roadmap implementation 2019–2030 (in US$)[14]

GTFCC MECHANISM: Annual costs for coordination, technical guidance and country support

	COMPONENT	COST
1	Global coordination- The GTFCC secretariat	$668,100
2	Technical guidance- The WHO cholera program	$2,238,300
3	Country operational support- The Country Support Platform (CSP)	$3,846,900
	TOTAL	$6,753,300

COUNTRY SUPPORT: ANNUAL COSTS FOR IN-COUNTRY IMPLEMENTATION

	IN-COUNTRY IMPLEMENTATION	COST
A	Surveillance, monitoring & evaluation	$4,800,000
B	OCV for non-Gavi-eligible countries	$3,000,000 - $8,000,000
C	Targeted WASH interventions for cholera control	
	TOTAL	$7,800,000 - 12,800,000

The CSP TORs indicate an annual budget of US$ 6m for the CSP. Furthermore recent GTFCC documents[15] dated 2024 provide different newer updated estimates for resource requirements for the GTFCC Secretariat (e.g. US$ 2.8 million for personnel and US$ 650 000 for activity costs) and the CSP (e.g. US$ 4.5-4.7 million with 50% for staffing).

1.2. Evaluation purposed and objectives

The **purpose** of this mid-term evaluation is to assess the delivery of the GTFCC Global Roadmap (2017–2030) and draw the way forward to ensure successful adaptation to a global landscape marked by significant epidemiological, political and climatic changes, incorporating risk analysis and reprioritizing accordingly. The evaluation will be used to generate evidence that will inform decisions about the strategic and operational future of the GTFCC and include recommendations that will help identify ways to better adapt and effectively deliver the 2030 Roadmap. It is expected that the findings from this evaluation will inform the direction of travel of the GTFCC and implementation of the Roadmap going forward until 2030.

[14] Ibid.
[15] Steering Committee, GTFCC, Meeting, 2024.

This evaluation is primarily formative and forward-looking in nature. It strikes a balance between elements focused on accountability and forward-looking aspects concerned with learning and incorporating good practices into a potential new operational and strategic vision to enhance implementation and programme performance, as well as to inform relevant future discussions and decisions.

The evaluation has the following **core objectives**:

- documenting the extent to which results have been reached at the country level and assessing progress and gaps as documented in the GTFCC monitoring and evaluation frameworks, its indicators and targets and overall strategy milestones;
- identifying key achievements, best practices, challenges, gaps and areas for improvement in the design and implementation of the GTFCC;
- pinpointing the key contextual factors and changes that are affecting cholera spread and transmission risk profile and influencing programme implementation;
- establishing the adequacy of the governance structures, mechanisms and processes of the GTFCC, including its Secretariat, to achieve agreed goals; and
- making recommendations as appropriate on the way forward to improve performance and adaptation to a changed global landscape and to ensure sustainability beyond 2030.

The **scope** of the mid-term evaluation covers progress of the GTFCC Global Roadmap implementation during the time frame from 2017 to May 2024 across various Task Force 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 also considers the changing global landscape and risk profile for cholera. Events pre-2017 are outside the scope of this evaluation. The evaluation covers the criteria of relevance, coherence, efficiency, effectiveness and sustainability (see below) and does not include impact.

1.3. Evaluation framework, questions and methodology

Evaluation framework, criteria and questions

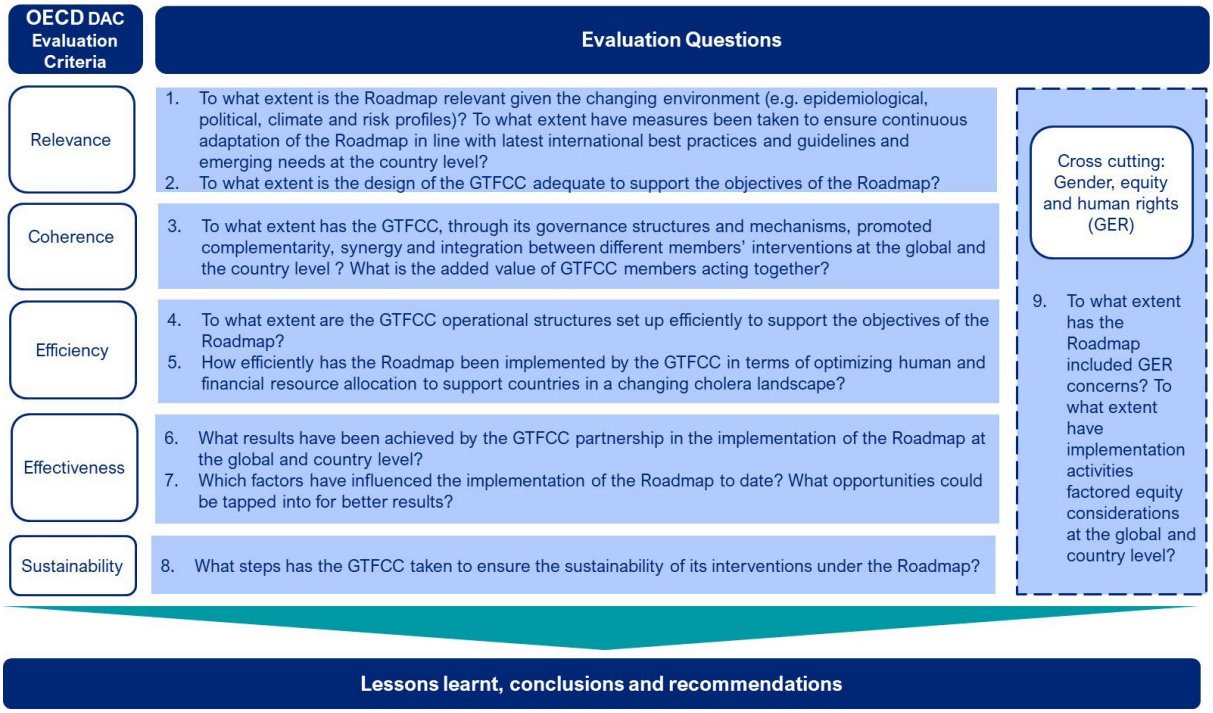
Fig. 3 sets out the **evaluation framework, structured around the OECD DAC evaluation criteria**. The criteria include:

1. Relevance – is the intervention doing the right things?
2. Coherence – how well does the intervention fit?
3. Efficiency – how well are resources being used?
4. Effectiveness – is the intervention achieving its objectives?
5. Sustainability - will the benefits last?

The evaluation framework comprised **nine evaluation questions (EQs)** that made it possible to assess the OECD DAC evaluation criteria of relevance, coherence, efficiency, effectiveness and sustainability as well as a crosscutting question around GER.

The evaluation ToRs are included in the web annexes, and the modifications to the ToR EQs are presented in 'Revised evaluation questions' of the web annexes .

Figure 3: Evaluation criteria and questions



Evaluation approach and principles

This section outlines the main aspects of the evaluation approach, including reasons for selecting different approaches.

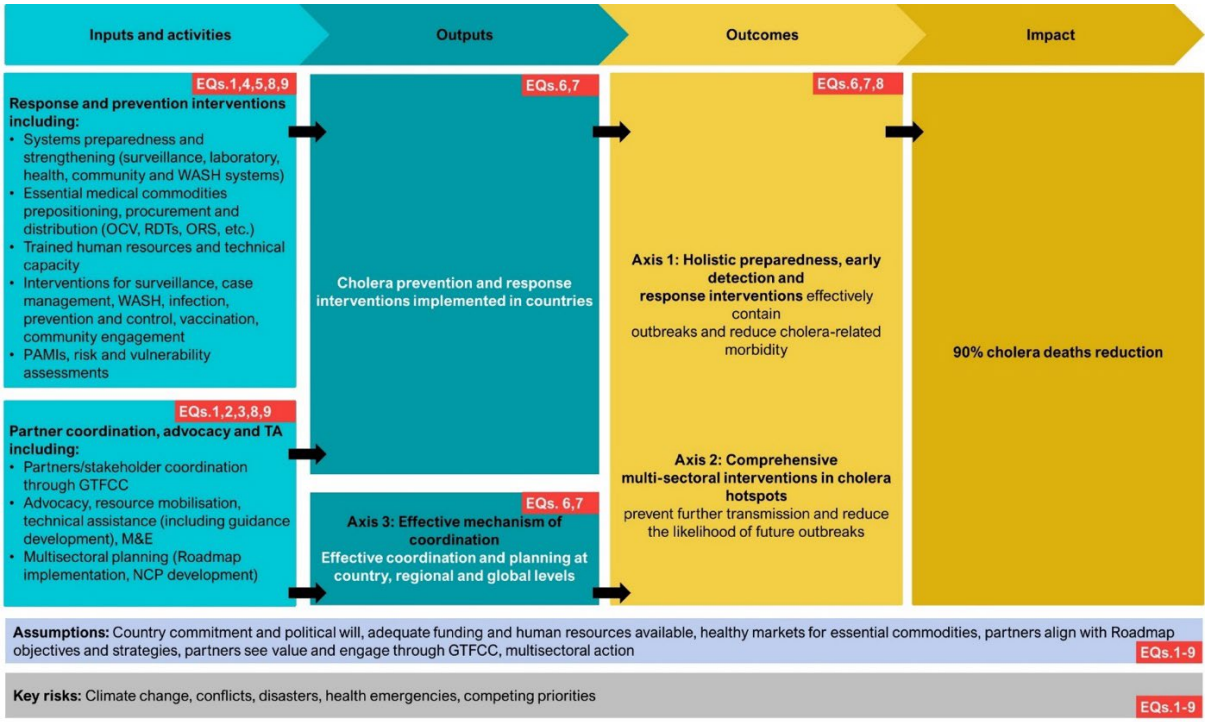
The **overall approach for this evaluation was theory-based**, which means that it was grounded in a **Theory of Change (ToC) for the GTFCC and the Global Roadmap**.

The ToC (Fig. 4) was developed in the inception phase of this evaluation. This ToC was adapted[16] from the existing Global Roadmap ToC, updated to articulate the pathway to impact from country-level cholera prevention and control activities to the three axes of the Roadmap as well as the specific added value of the GTFCC partnership.

The evaluation used the ToC as a base to consider how actions from the GTFCC partnership have worked in practice to deliver results, assess any deviations from the theory and explore reasons for deviation. EQs are mapped onto the ToC in red boxes to reflect this.

[16]Through a comprehensive review of the Roadmap and key documents as well as consultations in the inception phase.

Figure 4: The ToC for the evaluation



The evaluation used a **non-experimental approach** as the nature of the GTFCC and its Roadmap are not amenable to other approaches such as randomization or case control designs.

It was delivered utilizing a **mixed-methods** (interviews, document review and data analysis, survey) and case-study approach (described in the next section). Mixed methods were selected to capture different sources of information and ensure a well-balanced and triangulated (i.e. robust) evaluation.

The evaluation team adhered to the United National Evaluations Group (UNEG) Ethical guidelines for evaluations and WHO evaluation policy. The evaluation fostered inclusive participation through stakeholder consultations held with a broad scope of interviewees. Table 1.1 in the next section provides a breakdown of interviews by region, stakeholder group and gender. Validation of findings through consultations with diverse stakeholders was conducted to enhance the accuracy of results and foster a sense of ownership among stakeholders.

The evaluation aimed to be **utilization-focused,** through consultations with key stakeholders for the evaluation and through review of draft inception and evaluation reports by an Evaluation Reference Group and Evaluation Steering Group detailed in the web annexes.

Evaluation methods

This evaluation entailed a mixed-methods approach. Key reasons for inclusion of different methods and sampling strategies (where appropriate) are detailed below.

- **Desk-based review of documents and data** including the Roadmap; GTFCC governance ToRs; GTFCC General Assembly annual meetings documents; GTFCC guidance documents and commissioned reports; CSP reports, documents from partners and donors such as WHO, UNICEF, Gavi, etc.; relevant

academic and grey literature on cholera and select databases (e.g. cholera case dashboards, WHO/JMP Joint Monitoring Programme on Water, Sanitation, and Hygiene (WASH)). Additional country-specific documents were reviewed as part of the country case studies. Document review forms the base and the first evidence source that was examined for this evaluation. A list of references is provided in the web annexes.

- **Stakeholder consultations** including semi-structured key informant interviews (KIIs) and focus groups discussions to gather a range of perspectives and insights for this evaluation. This complements the document review, and also has unique importance given several review aspects can be discerned more comprehensively and deeply through consultation feedback. A total of 44 consultations with 79 individuals were held, including with the GTFCC Steering Committee members, Secretariat, CSP, IRP, WGs as well as the wider partner base of the GTFCC (UN agencies, implementing partners, donors, research organizations, community organizations) and country-level stakeholders. The interview guides are presented in the web annexes.

The evaluation undertook purposive sampling for KIIs and group discussions and aimed at selecting stakeholders close to issues at hand from the range of GTFCC internal structures, various types or partner organizations in the GTFCC and stakeholders from global, regional and country levels. Input for the list was provided by the WHO and UNICEF Evaluation Offices, GTFCC Secretariat, Evaluation Steering Group and ERG. Table 1 includes the numbers of key stakeholders interviewed ,including from the country case studies detailed in the next paragraph. Almost half the interviewees at the global level were female, but participation was lower at the regional and country levels despite the inclusive sampling strategy.

Table 1: Number of key stakeholders interviewed by stakeholder group (several stakeholders cover multiple groups)

Stakeholder group	Global level	Regional and country level (excluding country case studies)	Country case studies (DRC, Haiti, Kenya, Nepal, Nigeria, Somalia)	Total number of interviewees
GTFCC Steering Committee	1 *(11 in total with the remaining 10 members captured under UN partners and other partners in the rows below)*	n/a	n/a	1
GTFCC Secretariat	2	n/a	n/a	2
GTFCC Working Groups	12	n/a	n/a	12
GTFCC Country Support Platform	4	2	2	8
GTFCC Independent Review Panel	2	n/a	n/a	2
Government	n/a	5	54	59
UN Partners	12	3	53	68
Other partner (donors, other technical partners, nongovernmental organizations, research institutions)	34	3	36	72
Total number of interviewees	**66**	**13**	**145**	**224**
% of female interviewees	**44%**	**8%**	**23%**	**28%**

- **Six case studies** for the Democratic Republic of the Congo, Haiti, Kenya, Nepal, Nigeria and Somalia.[17] The case studies provided a key source of evidence for gathering of country perspectives and a deeper assessment of the work of the GTFCC and implementation of the Roadmap, as well as country specific learnings – thereby complementing the global level insights. Each case study included a review of key documentation and interviews with relevant country stakeholders. 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 CSP formally operates (CSP countries); (iv) countries where the CSP does not formally operate (non-CSP countries);[18] (v) countries that have had a PAMI exercise conducted; (vi) countries that have an NCP; and (vii) countries in a fragile/conflict context. A second selection was conducted to (i) make sure 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) and (ii) ensure feasibility to conduct the case studies based on country contexts as well as availability of countries to be included as a case study. More details are provided in the web annexes. Country case study reports are provided in the annexes to the report (published separately). The list of interviewees in each country is included with the country case study report.

[17] The Democratic Republic of the Congo, Kenya and Nigeria case studies were undertaken in person; the Haiti and Nepal case studies were undertaken remotely; and a hybrid approach was used for Somalia. Country case studies included interviews of between 6 and 41 stakeholders.

[18] Noting that non-CSP countries may still receive some support from CSP and other GTFCC structures.

- **An online survey** was conducted to gather feedback from a wide range of stakeholders at global, regional and country level. The survey also supports quantification of feedback on the different EQs. A total of 105 completed surveys was received from respondents with the following profile: global regional and/or multi-country stakeholders (54), stakeholders from countries engaged with the GTFCC (40) and stakeholders from countries not engaged with GTFCC (11). The web annexes provide the survey questionnaire and survey results.
- **Participation and engagement at the annual General Assembly and key stakeholder workshops.** The evaluation team attended the GTFCC General Assembly in the week of 17 June 2024, which provided inputs for the evaluation through engagement with key stakeholders and participation in the technical sessions. Workshops have been held with the Evaluation Steering Group and ERG in the inception phase on the evaluation focus and methodology.

All the data collected through the various methods have been organized and triangulated through the use of evidence matrices. The evidence matrices also include the strength of the evidence/robustness rating for each of the findings, considering both the quality and quantity of the evidence. Table 2 summarises the **robustness assessment framework** used to assess the strength of the collected evidence across a four-point scale. In the summary findings tables in Section 2, an explanation is included detailing the most important sources of evidence that have supported the findings. Each summary table also includes an assessment against the GTFCC ToC.

Table 2: Robustness rating for findings

Rating	Assessment of the findings by strength of evidence
Strong	• The finding is supported by data and/or documentation which is categorized as being of good quality by the evaluators; and • The finding is supported by a majority of consultations and including stakeholders from country case studies; and • The finding is well supported through the e-survey responses.
Good	• The finding is supported by a majority of the data and/or documentation with a mix of good and poor quality; and/or • The finding is supported by a majority of the consultation responses including from the country case studies and/or • The finding is reasonably well supported through the e-survey responses.
Limited	• The finding is supported by some data and/or documentation which is categorized as being of poor quality; or • The finding is supported by some consultations (global/country) as well as a few sources being used for comparison (i.e. documentation) or • The finding is partially supported through the e-survey responses.
Poor – not included in the evaluation report	• The finding is supported by various data and/or documents of poor quality; or • The finding is supported by some/few reports only and not by any of the data and/or documents used for comparison; or • The finding is supported only by a few consultations (global/country) or contradictory consultations and e-survey responses.

Human rights, gender equality and disability inclusion

The evaluation process and the findings and conclusions presented below have sought to consider human rights, gender, equity and disability inclusion aspects throughout. The composition of the evaluation team, with both genders represented, and the approach to stakeholder selection for interviews, which considered diversity and inclusivity, exemplified this. Confidentiality was ensured, and ethics standards were observed (see below). This was also fostered through the design and administration of data and analytical tools, especially the global, regional and country-level interviews (e.g. using sensitive language in the design of evaluation tools). Stakeholders were assured anonymity and confidentiality at the beginning of the interviews/focus group discussions. Stakeholders responding to the survey have been assured that their responses have been treated confidentially and anonymously. Finally, a focused EQ on GER was included (EQ 9).

Vulnerable groups affected by cholera particularly include people from lower socioeconomic backgrounds, people living in conflict areas and fragile states, internally displaced people (IDPs) and women. To assess the incorporation of human rights, gender equality and disability inclusion by the GTFCC Roadmap and its implementation, evaluators conducted document reviews and stakeholder consultations and utilized e-survey responses. This included examining dimensions of gender equity and human rights as well as vulnerable populations within relevant country-level cholera response documents and the Roadmap itself and evaluating the disaggregation of data collected for cholera outbreaks by age, gender, disability, internally displaced person (IDP) status, refugee status and geographical distribution (as available). In addition, the e-survey and stakeholder interview guides included questions specifically designed to gather insights on the incorporation and implementation of GER principles in cholera response plans and programmes. Country case study interviews further explored these dimensions at the national level. Table 1.1 above provides a breakdown of stakeholders interviewed as part of this evaluation, including stratification by gender.

The evaluation team has complied with the relevant United Nations Evaluation Group (UNEG) and WHO guidance including: Guidelines on integrating human rights and gender equality in evaluations (2011), 2014, and 2024, WHO guidance note on integrating health equity, gender equality, disability inclusion and human rights in WHO evaluations and WHO policy on disability.

Ethics

The evaluators have maintained professional integrity by ensuring that information, knowledge and data gathered during the evaluation process have been used exclusively for the evaluation process. The evaluators have not had any conflicts of interest in any aspects of the work and sought to ensure the independence of the evaluation findings and conclusions. The evaluation team has also complied with the UNEG Ethical guidelines for evaluations and WHO evaluation policy.

Limitations and mitigations

Key limitations to the evaluation methods and their mitigations are summarized in Table 3 below.

Table 3: Limitations and mitigation methods

Limitation	Mitigation measures
Difficult to assess GTFCC and partner contributions over time. Some documents, in particular on GTFCC	The evaluation supplemented and triangulated evidence from documents

Limitation	Mitigation measures
priorities and workplans, funding and partner contributions, are high level or available in different formats over time, and the information has been difficult to collate for this evaluation. Some documents are outdated and do not reflect current stakeholder understanding of the GTFCC. Some data were presented and disaggregated in varying ways over time, which proved challenging to cross-reference and analyse to build a "story line".	with stakeholder interviews, country case studies and the e-survey.
Absence of an M&E framework for the Global Roadmap and challenges with progress reporting. The Global Roadmap's M&E framework objectives and targets (there are baseline, midline and endline targets) do not have concomitant progress reporting. Complete progress reports for the GTFCC and CSP for the full evaluation period are not available (e.g. progress reports for 2017 and 2018).	The evaluation has collated evidence based on the other reports provided (e.g. Steering Committee notes) and supplemented it with qualitative information gathered from the interviews and country case studies.
Challenge of generalizing findings from the country case studies given unique country contexts, diversity of GTFCC support received and some issues with accessing stakeholders, particularly in complex and fragile countries. While only six country case studies have been covered under this evaluation, they include a good mix and balance across country and cholera epidemic types. Robust sampling criteria were developed in discussion with key GTFCC stakeholders. Notwithstanding this robust selection, it is recognized that generalizing country findings is a limitation given different country contexts. Further, stakeholders in some countries were difficult to access due to the complex and fragile political situation (e.g. Democratic Republic of the Congo, Haiti, Somalia). In some instances, the evaluation had to rely on a limited number of key informants, in part due to difficulties in scheduling the visit and collecting data in the country within the time frame available for the evaluation and to the limited availability of key stakeholders. While four country case studies were conducted in person (Democratic Republic of the Congo, Kenya, Nigeria, Somalia), additional remote interview meetings were required to complement information in one case (Somalia). The balance two case studies were conducted remotely (Haiti, Nepal).	The country case studies were not used to generalize findings but rather to illustrate and complement findings as appropriate. In addition, three further countries have been covered through remote consultations to strengthen the evidence base (Chad, Malawi, South Africa). Findings from country case studies have been triangulated with stakeholder interviews and the document review.

Limitation	Mitigation measures
Challenge with key informant bias. Evaluation methods applied (i.e. the online survey and interviews) were generally prone to both selection and information bias, particularly so in the case of limited numbers of informants in some country case studies.	Introduction of selection bias was minimized by ensuring a diversity of informants and triangulation of data with other evidence streams and saturation for interviews/group discussions. To mitigate the impact of social desirability bias and to stimulate honesty and truthful answers, all informants (including survey respondents) were guaranteed confidentiality. Triangulation was applied during the analysis to minimize bias by comparing information across different categories of KIIs/respondents, the document review and the survey results

1.4 Structure of the report

This report is structured as follows: Section 2 provides the evaluation analysis and findings following the evaluation criteria of relevance, coherence, efficiency, effectiveness, sustainability and gender, equity and human rights. Section 3 provides the overall evaluation conclusions and Section 4 provides recommendations. The main report is also supported by web annexes.

2. Key findings

This section provides findings by evaluation criteria of relevance (Section 2.1), coherence (Section 2.2), efficiency (Section 2.3), effectiveness (Section 2.4) and sustainability (Section 2.5) as well as the crosscutting issue of GER (Section 2.6).

2.1. Relevance

The relevance evaluation criterion covers questions on the relevance of the Roadmap (EQ1) and the appropriateness of the design of the GTFCC (EQ2).

1. **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?**

2. **To what extent is the design of the GTFCC adequate to support the objectives of the Roadmap?**

The first EQ seeks to assess the extent to which the Roadmap continues to be relevant in the face of a changing environment for cholera and whether it has been adequately adapted over time in line with country needs. The assessment is based on a critical examination of the Roadmap document and some key recent global/regional frameworks for comparison (detailed below), feedback from global, regional and country-level stakeholders on the appropriateness of the Roadmap, and e-survey responses (where this was one of the most widely answered questions with 54 responses to the multiple choice question supplemented by an additional 24 qualitative responses to the question).

The second EQ assesses the adequacy of the design of the GTFCC to support the objectives of the Roadmap. The assessment was based on a review of key GTFCC documentation, and feedback from a wide range of stakeholders (global, regional and country; stakeholders internal to the GTFCC, such as the Secretariat and Steering Committee members, and those that are external to the GTFCC or more at arms' lengt) such as some partner organizations). Interview feedback has also been triangulated with e-survey responses.

Table 4 presents the key findings and their robustness rating. Each finding is then detailed in turn below.

Table 4: Summary findings for relevance

Summary finding on relevance: The GTFCC Global Cholera Roadmap remains relevant, serves well as an overarching strategic framework for cholera responses globally and emphasizes a first-time multisectoral approach. It has struck a relevant balance between global and country action and between response and prevention. While generally appropriate, the Roadmap's objectives form an ambitious and high-level strategic framework that requires a prioritized set of actions to guide implementation, given the limited progress towards SDGs 2030 and resource constraints for cholera. The GTFCC has strengthened relevance at country level considerably since 2017 through increased engagement, and there is a need to further this focus giving due consideration to available and potential resources.

Finding 1.1. The Roadmap serves well as an overarching strategic framework to guide cholera responses worldwide and reflects many components of the changing environment.	Strong	Based on review of Roadmap and majority of stakeholder, e-survey and country case study feedback
Finding 1.2. Noting the context of the ambitious targets of the Roadmap, the risk that the overall SDG agenda 2030 is will not achieve its goals and limited resources for cholera, there is a need for a prioritized set of actions to guide operationalization of the Roadmap and GTFCC partner contributions.	Strong	Strong view across majority of consultations. Well supported by document review, country case studies and e-survey
Finding 1.3. The GTFCC model of country engagement has evolved considerably since 2017 in particular with the creation of the CSP and IRP, and there is scope to expand country engagement even further in a feasible way that considers available/potential resources.	Good	Based on majority of consultations, e-survey and country case studies but there was some divergence of views
Review against ToC: The lack of prioritization and focus of activities limits achievement of results. Several assumptions of the ToC have not worked in practice such as "partners align with the Roadmap objectives and strategies" and "partners see value and engage through the GTFCC", given the lack of a prioritized set of actions to guide operationalization of the Roadmap and partner action.		

Finding 1.1. The roadmap serves well as an overarching strategic framework to guide cholera responses worldwide and reflects many components of the changing environment.

The Roadmap was developed in 2017 following a revitalization of the GTFCC and new energy and ambitions amongst partner organizations to drive the cholera agenda.

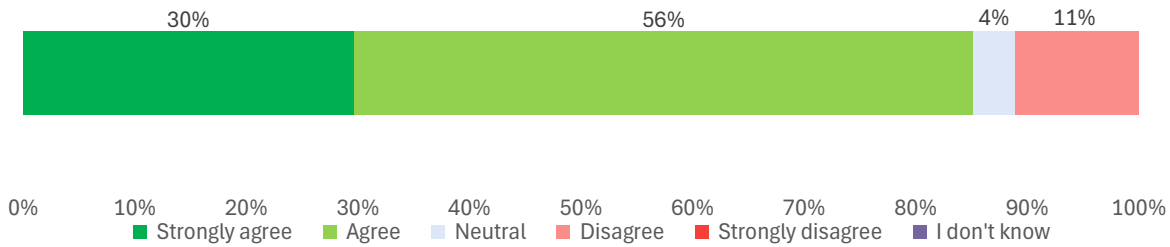
The Roadmap was developed through a **participatory and engaged approach** involving stakeholders from cholera-affected countries, donors and technical partners to reaffirm their commitment to ending cholera as a threat to public health by 2030 *(14)*.

A review of the Roadmap indicates that it is serves well as an overarching strategic framework, reflecting several of the changing contexts described previously in Section 1.1, including challenges presented for cholera through conflicts, natural disasters and climate change. It highlights the **urgency to end cholera**, a renewed strategy that **considers the importance of both outbreak response and prevention** as well as a **multisectoral approach** and emphasizes the value of investing in the Roadmap versus the status quo. Critical to its value is that it presents a first-time multisectoral approach and incorporates both elements of prevention and outbreak response.

Almost all of the stakeholder interviews conducted for this evaluation affirmed the relevance of the Roadmap, noting that its vision and comprehensive approach are appropriate and it is adequately reflective and cognisant of the evolving landscape. Interviews at the country level as part of the country case studies were also supportive of the Roadmap. Stakeholders noted that the Roadmap has been mirrored in many country-level NCPs – e.g. in the Democratic Republic of the Congo, Kenya, Nepal, Nigeria – reflecting the relevance of its overall approach

and construct. A large majority of the e-survey respondents agreed or strongly agreed that the Roadmap continues to be fit for purpose today (see Fig. 5).

Figure 5: *E-survey response on whether the Global Roadmap continues to be fit for purpose today (global, regional and multi-country respondents, n=54)*



The Roadmap is an **ambitious plan**, as it seeks to eliminate cholera in 20 countries and avoid any more uncontrolled outbreaks in fragile settings so as to ultimately lead to a 90% reduction in cholera deaths by 2030. This has been challenging in the context of the epidemiological changes with many more outbreaks than anticipated at the time of development of the Roadmap. The vast majority of the stakeholders consulted for this evaluation have, however, emphasized that downgrading the ambitious plan for the Roadmap does not send the right signals and that **efforts should not be diverted to an update of the Roadmap** in this regard as there are many more pressing issues for the GTFCC (see subsequent findings).

Other issues with the Roadmap highlighted during consultations include the following. These were also emphasized by stakeholders as "issues at the margin" rather than warranting an update of the Roadmap. Indeed, these were also noted as aspects to consider in an action plan for the GTFCC (see next finding) and/or technical assistance to countries rather than through an update of the Roadmap:

- the Roadmap is relatively vague about the proposed approach to complex settings facing acute conflicts and multiple challenges at once (e.g. poverty, conflict, natural disasters) and the needed mitigations (raised during consultations for the Haiti case study); and
- the Roadmap does not address regional coordination which is key given the importance of cross-border transmission issues (raised during some country-level interviews from sub-Saharan Africa).

While the Roadmap is a valid strategic framework in general and given the proximity of 2030, an update of its objectives is not warranted at this time but will be required in the future.

Box 2.1 assesses the Roadmap against other recent frameworks and approaches. it finds that the Roadmap is relevant, although it is less reflective of a multidisease integrated approach, which presents an opportunity to harness additional donor and other stakeholder interest and funding looking forward.

Box 2.1. Comparative review of the Global Roadmap on cholera with other recent global frameworks

Both the WHO global strategic preparedness, readiness and response plan (SPRRP) for cholera 2023–2024 and the Water, sanitation and hygiene strategy 2018–2025 refer directly to the GTFCC Roadmap *(15)*. Both documents incorporate the dissemination and utilization of GTFCC guidance into their targeted responses to cholera outbreaks and WASH initiatives. This alignment points to relevance and a potential pathway for the

GTFCC to explore further synergies with more horizontal global health initiatives, facilitating a more unified response to global health challenges.

While the GTFCC Roadmap is exclusively vertical in its focus on cholera, recent WHO health frameworks and roadmaps have increasingly adopted a multidisease, integrated approach to enhance health system efficiency and leverage pooled resources. The WHO roadmap for neglected tropical diseases (NTDs) 2021–2030, for example, promotes an integrated strategy to address a range of NTDs through shared health infrastructure, allowing for a more comprehensive response across disease groups *(16)*. Similarly, the Pandemic Influenza Preparedness Framework (2024 –2030) targets a family of viruses, rather than a single pathogen, while explicitly seeking to leverage COVID-19 pandemic infrastructure to enhance preparedness for future outbreaks *(17)*. The WHO water, sanitation and hygiene strategy 2018–2025 mentions cholera but focuses on safely managed service delivery in **low- and middle-income countries** to prevent all-cause diarrhoeal disease and benefit a wide range of health outcomes, with additional focus on the effects of climate change and antimicrobial resistance *(18)*. The recent WHO framework on emergencies is also integrated in its approach, and across the "5 Cs" approach, integration is emphasized in terms of integrated surveillance and integrated community responses, amongst others *(19)* This level of deeply integrated horizontal approach to global health planning further facilitates engaging funders and technical partners from non-health sectors.

Finding 1.2. Noting the context of the ambitious targets of the roadmap, the risk that the overall SDG agenda 2030 will not achieve its goals and the limited resources for cholera, there is a need for a prioritized set of actions to guide operationalization of the roadmap and GtFCC partner contributions.

While stakeholders consulted confirmed the relevance of the Roadmap in the current environment (and indeed the Roadmap makes reference to the range of priorities for cholera today, including climate change, complex settings, etc.), the key challenge has been with its operationalization. There are a number of reasons for this.

- Several changes in the external environment have made it impossible to operationalize the Roadmap as envisaged. Key is the changing epidemiology of cholera – where outbreaks have required considerable attention on outbreak response from some partners diverting from the two-pronged response-prevention approach envisaged in the Roadmap.
- (b) Funding for cholera as a whole and for the activities of the GTFCC in particular has been limited *(16)*. There has been an imbalance in funding, with certain areas such as OCV receiving more funding than other aspects of cholera response, for example WASH, case management, etc. *(20)* *(21)*.[19] The funding mismatch for the GTFCC is presented in Section 1. As one respondent to the e-survey said, "The resources mobilized so far are not yet sufficient to meet the needs of response and prevention."
- (c) There has been a lack of a strategic action plan to guide the priorities of Roadmap implementation and define partners roles and responsibilities. For example, stakeholders have stated:

  > The Roadmap as defined remains completely valid …The question is therefore not to revise the Roadmap, but how to implement it. / The overall Roadmap is relevant at a global level, but there has not been any other detailed plans/ frameworks to ensure that we are conducting the right activities to meet the goals and

[19] Also based on consultations.

> objectives stated in the Roadmap./ The Roadmap is fit-for purpose…. For me what is missing is the next step, the more detailed steps on how to meet these goals. / The GTFCC needs a [operational] strategy… the lack of a GTFCC internal strategy leads to the lack of effective prioritization.

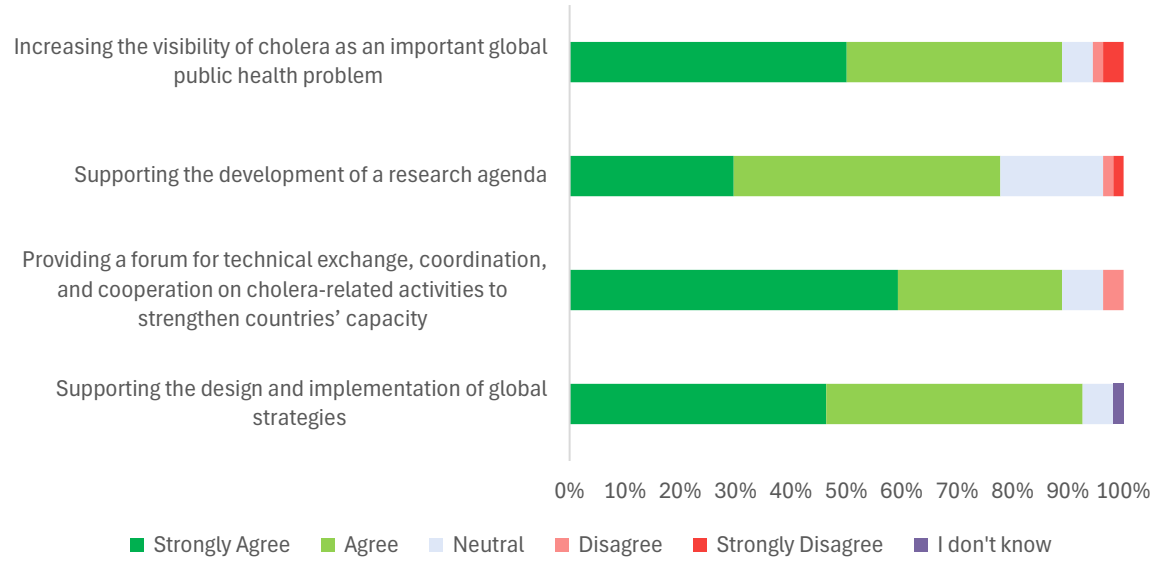
In particular, a strategic action plan for the GTFCC would encompass:

- what the priorities for the GTFCC are, especially in a resource constrained environment;
- the balance and integrated approach between outbreak response and prevention efforts linking the key approaches to adopt OCV and WASH while addressing the resurgence of cholera outbreaks for greater sustainability of interventions (a significant number of key stakeholders reportedly concurred that the GTFCC focus on prevention aspects ought to be strengthened);
- the roles and responsibilities of the various structures of the GTFCC (e.g. the GTFCC Secretariat versus the Steering Committee and GTFCC partners);
- how the different structures of the GTFCC need to work together towards the aims of the Roadmap (e.g. importance of collaboration across WGs);
- the resources required to deliver on the Roadmap and objectives; and
- specific activities towards fulfilling the GTFCC objectives – in particular, while the objectives are deemed appropriate (see below), how they are translated into operations in terms of the forum/modality/responsibilities across stakeholders.

In 2022, steps were taken by the Secretariat to develop a logical framework for the Roadmap with the objective of improving Roadmap implementation and monitor progress. A draft logframe developed at the request of the Secretariat was presented at the June 2023 Steering Committee meeting. The Steering Committee decided to pause the development of the logframe and wait for the strategic recommendations of this evaluation process to feed into the finalization of the logframe.

The GTFCC has also defined objectives (see Section 1.1 on the evaluation object which details these). However, stakeholders were either: (i) unaware of these objectives or (ii) somewhat aware but did not fully appreciate the scope and what they meant in practice and also considered them to be too ambitious in relation to available resources. In general, stakeholders across global, regional and country-level consultations were not clear on what the GTFCC is primarily aiming to achieve. As one stakeholder noted, "clarifying exactly what the purpose and position of the GTFCC is, is important." E-survey responses indicated that the majority either agreed or strongly agreed that the objectives of the GTFCC were appropriate, ranging from 78% to 92% for each objective (see Fig. 6 below). However, given the limited funding available for the GTFCC, a majority of stakeholders consider that there is a need to review objectives and ambitions in terms of what is feasible to achieve. This is reflected in one stakeholder comment that "GTFCC has become too diluted with a lack of capacity for execution of tasks". In particular, some stakeholders queried whether research should be a primary objective in a resource constrained environment.

Figure 6: E-survey response on how appropriate the objectives of the GTFCC are by percentage (global, regional and multi-country respondents, n=54)



Country stakeholders also stated that the GTFCC objectives need to be translated in practical operational terms and that the GTFCC was being too ambitious, given the level of resources and international and local commitment to cholera. For example, in Haiti, which is not a CSP country and where GTFCC has not engaged much as a body per se (although several partners of the GTFCC provide direct emergency support), stakeholders interviewed indicated that it is not evident how the GTFCC is looking to translate the high-level objectives of the Roadmap to the specific complex situation of Haiti. In the very different context of Kenya and Nepal, stakeholders indicated that there is a need for more clarity on the role that GTFCC can play in addressing coordination challenges and boosting advocacy and resource mobilization efforts. While there is an expectation that the GTFCC's involvement will contribute to addressing these issues, the specific role that GTFCC can play in doing so and how this will align with existing support from others, such as WHO and UNICEF, is less clear to in-country stakeholders.

Finding 1.3. The GTFCC model of country engagement has evolved considerably since 2017 in particular with the creation of the CSP and IRP, and there is scope to expand country engagement even further in a feasible way that considers available/potential resources.

GTFCC's model of country engagement refers to how it has balanced a centralized/global focus versus regional/country-level engagement and includes work through the various GTFCC structures and especially the CSP, IRP, Secretariat and WGs; participation in the General Assembly and other GTFCC meetings; and direct support provided through the range of GTFCC partners for country programmes. Within this question, the GTFCC approach to country engagement is considered at a strategic level, and more details about the specific functioning of the various GTFCC structures that engage with countries are discussed in Section 2.3 on efficiency, alongside other points related to these structures.

Country engagement efforts have grown significantly since 2017, through the work of the WGs, increased participation in the GTFCC annual assembly and the creation of the CSP and IRP that interact directly with countries for technical assistance support. At regional level, GTFCC partners often work through regional entities such as the Regional Offices of WHO which provide support to activities. For example, in AFRO, the cholera focal

point is supporting the development of NCPs and identification of PAMIs in several African countries that are not covered by the CSP.

As seen in Figs. 7 and 8, global and regional stakeholders consider the CSP and General Assembly to be working well in terms of engaging country stakeholders. Feedback is less positive on other areas of GTFCC country engagement, especially the IRP. Country stakeholders surveyed who had engaged directly with the GTFCC had more positive views on the GTFCC approach to country engagement than stakeholders from the global and regional level. More than half of country respondents "strongly agree" or "agree" that each GTFCC mechanism is working well, with the most positive response pertaining to CSP support.

Figure 7: Global and regional stakeholder perspectives on the statement, "the GTFCC approach to country engagement is working well" (n=54)

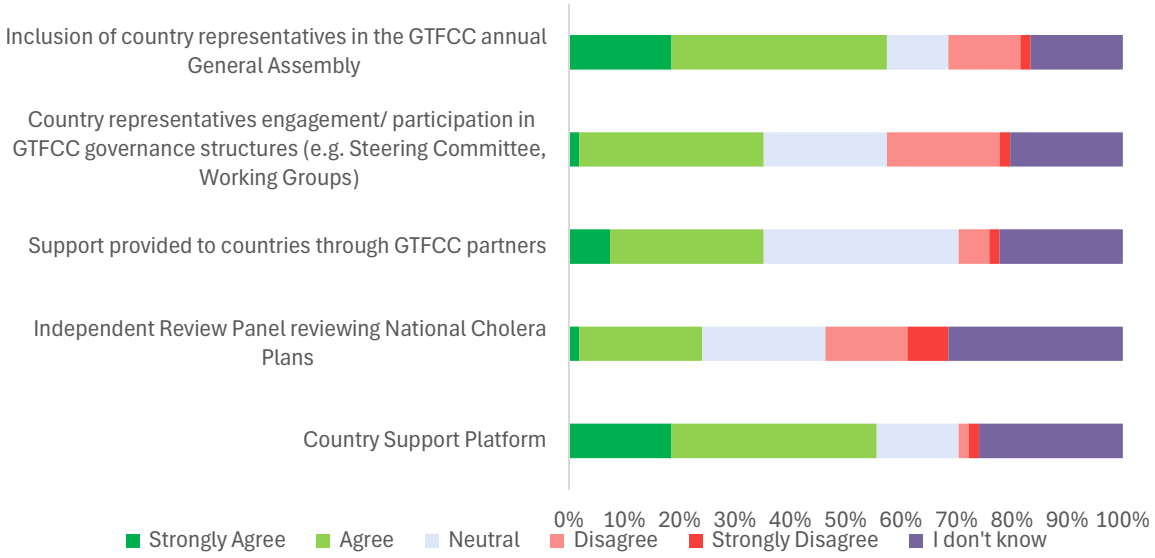
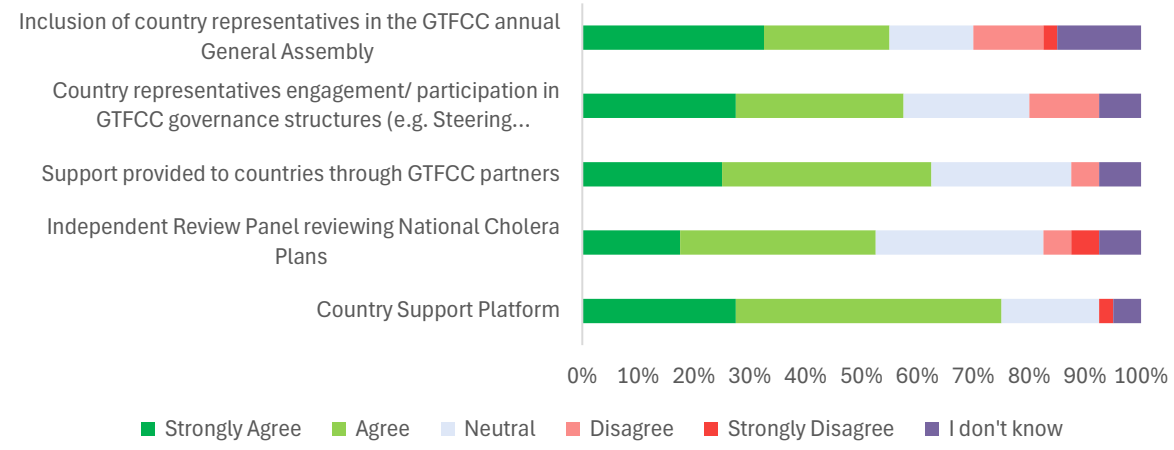


Figure 8: Country stakeholder perspectives on the statement, "the GTFCC approach to country engagement is working well" (n=40)



Overall, stakeholders are requesting that the GTFCC expand its work at the country level. Box 2.2 includes feedback from country case studies demonstrating the demand to expand country engagement to support coordination in country, especially through the CSP.[20]

Box 2.2. Examples of demand to expand country engagement approaches to support coordination

In **Kenya**, some stakeholders expressed views that a dedicated GTFCC presence in the country (e.g. through the CSP) or regionally would be highly beneficial to enhance coordination at national level between partners and national actors and to support intergovernmental coordination.

In **Nepal**, there are hopes that formally becoming a CSP country will further boost coordination efforts in the country to facilitate effective implementation of the NCP 2025–2030 (currently in final draft form). There was positive recognition that GTFCC's support is to enhance what is being done at country level and it is seen as boosting government accountability, focu, and responsiveness to the idea of working at a multisectoral level. As one Nepal stakeholder said, **"multisector work is challenging, so if there are clear cut guidelines like a Roadmap, it is easier to work with key stakeholders."**

In **Nigeria**, the role of the CSP was generally praised, especially for its strong coordination in developing the draft NCP 2024–2028. Stakeholders highlighted their preference for even more technical assistance from the CSP if possible, including in outbreak response.

In **Haiti**, while stakeholders highlighted that additional support would be very important in such a complex setting with critical needs in relation to cholera, they were not clear how GTFCC/CSP could provide concrete support.

In previously non-engaged countries like **South Africa**, which has seen an outbreak of cholera in recent years, stakeholders have highlighted the renewed need to engage with the GTFCC/CSP.

That said, some have noted that in a resource-limited setting, there may be a need to prioritize global level work (e.g. focusing on developing global guidance, research and technical exchange). However, this is viewed by a majority of stakeholders as "stepping back" rather than moving forward and not aligned with country demand and needs.

Stakeholders have indicated that the GTFCC and CSP need to be clear on their role and scope of work with countries (e.g. in the example on Nepal cited previously, country stakeholder expectations need management in that GTFCC does not provide funding; another example cited by some stakeholders was whether the WGs should engage directly with countries for technical assistance given the extent of technical expertise included in the WGs). Stakeholders have also noted that the GTFCC/CSP needs to consider how it can have a wider reach in the context of limited resources (e.g. through more regional approaches) and how its work can be appropriately adapted to different settings (e.g. the Haiti's needs as a country with outbreaks are very different from Nepal's, where there have been no recent outbreak).

[20] Some country respondents to the e-survey noted that their country did not have cholera or did not want to declare cholera and hence does not engage with the GTFCC/CSP.

2.2. Coherence

The coherence dimension considers the extent to which the GTFCC model of partner engagement works and coordination exists between partners in practice (EQ3).

3. 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 EQ is informed largely by stakeholder consultations and country case studies and supplemented by some e-survey quantitative responses and comments. Available documents do not provide evaluative evidence in relation to many of the findings under this dimension and hence have been a less relevant source of information.

Table 5 presents the key findings and their robustness rating. Each finding is then detailed in turn below.

Table 5: Summary findings for coherence

Summary finding on coherence: The GTFCC has strengthened the overall coherence of global cholera partner alignment and coordination. Within the GTFCC, however, roles and responsibilities are not well delineated, creating confusion among partners. Partners are also less aligned on the relative prioritization of outbreak and preventative responses in general and between OCV and WASH in particular. The GTFCC is less engaged with WASH (especially non-humanitarian WASH) and development sector actors. At the country and regional level, coordination is often less structured and requires greater partner alignment around the two axes of the Roadmap.		
Finding 2.1: At the global level, the GTFCC has promoted greater partner coordination and alignment. Yet the roles and responsibilities of the task force partners in the implementation of the Roadmap objectives are not clearly delineated. In the absence of a strategic action plan defining priority actions, there has been some confusion among partners about their contributions.	Good	Based on majority of consultations, e-survey and country case studies
Finding 2.2. The GTFCC has promoted greater partner coordination and alignment at global level through partners and its core structures. There is a need to strengthen coordination and alignment at the regional and country levels. There is also a need for a more unified approach between partners on emergency response versus long-term preventative approaches as well as OCV and WASH.	Good	Based on majority of consultations, e-survey and country case studies
Finding 2.3. The GTFCC has a growing partner base and includes many key members actively engaged on cholera. However, some key stakeholders are not well represented – particularly WASH, wider development partners, the private sector, regional bodies and country representatives beyond health ministries.	Strong	Based on document review of GTFCC partners list and some stakeholder interviews
Review against ToC: A review of the GTFCC ToC indicates partial achievement of the output on "Axis 3:		

effective mechanism of coordination", given the gaps highlighted through the three findings above.

Finding 2.1. At the global level, the GTFCC has promoted greater partner coordination and alignment. Yet the roles and responsibilities of the task force partners in the implementation of the roadmap objectives are not clearly delineated. In the absence of a strategic action plan defining priority actions, there has been some confusion among partners on their contributions.

As described in Section 1, the GTFCC model of partner engagement includes (i) the General Assembly which is organized annually by the Secretariat and aims to provide all relevant stakeholders with the opportunity to review progress and highlight challenges faced as well as enabling country representatives to express their needs; (ii) other meetings convened by the GTFCC Secretariat; and (iii) the range of GTFCC structures including the Steering Committee, WGs, CSP, etc.

A number of stakeholders note that the **GTFCC has done "tremendous work" in bringing together stakeholders** who are working in cholera, especially through the GTFCC General Assembly, the WGs, the Secretariat as a coordinator of the GTFCC and increasingly through the work of the CSP. This partner engagement is considered to have helped galvanize cholera efforts. Some key stakeholder groups have, however, not yet been extensively engaged with the GTFCC, notably WASH partners and multilateral development banks as well as others in areas including surveillance, case management and primary health care (discussed further in the findings below).

Specifically, the annual GTFCC General Assembly is noted to be a very useful event for bringing stakeholders working in cholera together for information-sharing purposes. The General Assembly has been held in Annecy in recent years. Considering alternative locations in particular in endemic regions could foster high-level political engagement in host countries and shine the spotlight on cholera, strengthening country ownership and engagement. Additionally, some country stakeholders consider that the use and feedback of country reporting at the General Assembly should be strengthened.[21] Partner coordination across other GTFCC structures is discussed in Section 2.3 on efficiency.

More generally, although the GTFCC partner engagement model is considered a strength, **there is a need for a strategic action plan to implement the Roadmap, with clearly defined roles and responsibilities for partners to maximize their engagement and contribution.**

[21] Currently, countries are asked to compile a report with details of progress on key indicators at the country level, considered to be a lengthy and demanding process. Reports across countries are then compiled and analysed, before high-level global trends and key country details are shared with the General Assembly. However, country stakeholders stated that they receive very limited feedback once the report has been shared with the Secretariat, which would be a valuable exchange.

Finding 2.2. The GTFCC has promoted greater partner coordination and alignment at global level through partners and its core structures. There is a need to strengthen coordination and alignment at the regional and country levels. There is also a need for a more unified approach between partners on emergency response versus long-term preventative approaches as well as OCV and wash.

Stakeholders have stated that **partner coordination works better at the global than regional and country levels**. As noted, the WGs are a good forum for partner coordination, and these function at the global level. There has been limited coordination and engagement at the regional level and with key regional bodies, although this has worked better in some regions (e.g. the WHO Regional Office for Africa) than others as evident from KIIs and country case study consultations[22].[23] An example of good practice is reflected in the Democratic Republic of the Congo country case study (see web annexes) where the CSP facilitated collaboration between the Democratic Republic of the Congo and neighbouring Zambia and Burundi for cholera control and prevention through hosting transboundary meetings and developing joint action plans. Stronger coordination at the regional level would be a key element to reach better results, considering cross-border transmission of cholera. The Kenya case study provided an example of these challenges as stakeholders reported that a lack of intergovernmental and cross-border coordination for cholera interventions limited the efficiency of cholera interventions (e.g. at the border between Kenya and Somalia, where an additional challenge is that Kenya is covered by the WHO Regional Office for Africa while Somalia is covered by the WHO Regional Office for the Eastern Mediterranean). Similarly in Nepal, stakeholders expressed a need for attention to be paid to how in-country efforts link to regional control, particularly with regards to Bangladesh and India.

Global and country-level stakeholders mentioned a number of existing regional platforms and key forums where cholera could be discussed to facilitate high-level political engagement and better technical and operational coordination of cholera interventions. Noting the Africa CDC engagement with the GTFCC, especially through its Lab WG and the PAMI coordination group, other crosscutting agencies could be engaged more closely including the African Union, African Development Bank, and Southern Africa Taskforce on Cholera Control in the African Region and the South Asian Association for Regional Cooperation and Asia Development Bank in Asia. Several relevant subregional forums were also highlighted (e.g. the Nile Basin Initiative, Intergovernmental Authority on Development, and Lake Victoria Basin Commission in East Africa). Engagement in these platforms has been impeded by various challenges including a lack of a dedicated GTFCC focal point (although the CSP has started to broaden its presence) and limited capacity (human and financial resources) within the GTFCC to effectively engage a large number of partners.

As evident from KIIs and country case studies, coordination at the country level is mixed with some good examples where countries have prioritized coordination of cholera responses. However, it is often less structured, and the GTFCC model of partner coordination is not very well translated at the country level. GTFCC Secretariat engagement has varied by country depending on resources and competing priorities. There are some examples from the country case studies where the Secretariat's involvement has been considered particularly useful (e.g. Kenya, Somalia). In addition, the CSP has played a notable role in select countries and supported alignment, especially through the development of NCPs. An example is from Nigeria where the CSP has been

[22] As an example, key informants in Nigeria highlighted the usefulness of the WHO Regional Office's production of concise summaries of GTFCC guidelines.

[23] It is noted that the Regional Offices for Africa, the Eastern Mediterranean and South-East Asia have contributed to the GTFCC, e.g. the Africa office cholera focal point is supporting the development of NCPs and identification of PAMIs in several African countries that are not covered by the CSP (covered under GTFCC partner support).

involved (see Box 2.3). In addition, in the Democratic Republic of the Congo, the CSP was pivotal in establishing technical working groups 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 based on GTFCC working group tools and guidance.

Box 2.3. The CSP helped serve as a critical bridge between the GTFCC and Nigeria, including convening multisectoral stakeholders and supporting collaboration among key government ministries.

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 multisectoral stakeholders and ensure collaboration among key government ministries, such as the Ministries of Health and Social Welfare, Water Resources and Sanitation, and the Environment, alongside international technical partners and state-level actors. Key agencies that are crucial to providing a coordinated response against cholera, such as the Nigeria Centre for Disease Control and the National Primary Health care Development Agency, similarly benefit from the coordinating activities of the CSP, as it has facilitated their engagement with these partners.

An example of this coordination is seen in the development of Nigeria's National Strategic Plan of Action on Cholera Control **(**NSPACC). Nigeria previously developed an NCP in 2018, before the CSP's involvement. Now, with the CSP's support, a new draft NCP (yet to be launched), the National Strategic Plan of Action on Cholera Control 2024–2028, has been developed over the past two years, incorporating the latest GTFCC guidance and expanding the base of involved stakeholders to facilitate the development of a robust and balanced plan. Stakeholders described the new draft NCP as a major improvement on the previous iteration, given the technical focus which has been developed using GTFCC guidance and the additional stakeholders that have been involved in the plan development who will also be involved in the implementation of the plan (e.g. state-level actors).

In general, country engagement with the various GTFCC structures has largely emphasized health ministries with less focus on other relevant ministries responsible for water, sanitation and/or emergencies (e.g. as reported in Nepal in Box 2.4).

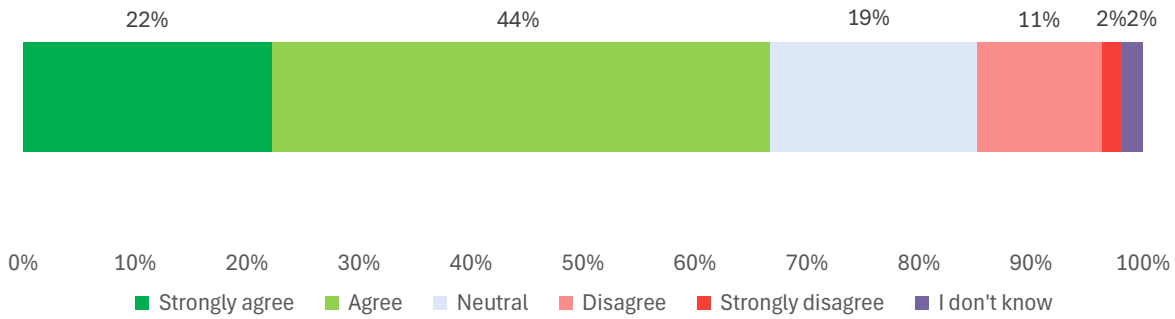
Box 2.4. Need for stronger multisectoral response in Nepal

To enable key progress to be made against Nepal's new NCP, stakeholders state that a shift is needed in the prioritization of cholera control activities among non-health partners and the complexity/comprehensiveness of their engagement. The WASH components of cholera control are recognized as challenging since they require involvement of a range of subsectors, such as engineering. WASH stakeholders engaged to date have also largely focused on response efforts, rather than longer term, preventative efforts. While engagement under the WGs 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 multisectoral working.

Another issue where partners are less well aligned is with regards to the relative prioritization of outbreak and preventative responses in general and OCV and WASH in particular. The various outbreaks have warranted a greater emphasis on outbreak response approaches from some GTFCC partners. Partners focusing on longer term prevention and WASH reported feeling that efforts on long-term prevention aspects had received less attention as a result. Another challenge is greater funding available for OCV (e.g. particularly through Gavi) than WASH (where several WASH partners are also not engaged with the GTFCC – see next finding). The lack of an overarching GTFCC strategy to implement the Roadmap (Finding 1.2) and ensuing confusion on relative prioritization of these aspects has created a degree of conflict and lack of clarity amongst partners.

Survey responses reflect this finding (Fig. 9): the majority of respondents expressed largely positive views on partner coordination and alignment (a total of 66% agree or strongly agree). A majority of comments to the questions noted that there are challenges translating the global-level alignment to the regional and country level and that a more coordinated approach between emergency responses and WASH is needed.

Figure 9: Response to the statement, "The GTFCC facilitates a more coordinated and aligned approach between partners and with countries", by percentage. (n=54)



Finding 2.3. The GTFCC has a growing partner base and includes many key members actively engaged on cholera. However, some key stakeholders are not well represented – particularly wash, wider development partners, the private sector, regional bodies and country representatives beyond health ministries.

The GTFCC partnership brings together 48 institutions (18 nongovernmental organizations, 16 academic and research institutions, three UN agencies, four foundations, and seven government agencies) to coordinate activities for cholera control at global, regional and country levels.[24] Through this partnership, many key organizations – both technical and implementing partners – collaborate to support countries in the implementation of the Roadmap and related cholera efforts.[25]

However, despite this growing network, many stakeholders flag a membership that is currently too focused on health and emergency and is missing key partners across other relevant sectors such as WASH (especially non-humanitarian WASH actors such as WASH nongovernmental organizations, donors and national research institutions who are not engaged with the WASH WG) and wider development partners (e.g. bilateral donors

[24] Steering committee, GTFCC, Meeting; Secretariat presentation, 18 June 2024.
[25] GTFCC (2024). Partners in action.

and multilateral development banks such as the World Bank). In addition, stakeholder feedback and evidence from the survey highlight the need to engage private sector stakeholders. More generally, the GTFCC is still not well-known among some partners working in cholera, including some stakeholders from donor organizations (e.g. Agence Française de Développement).

Further, whilst CSP efforts to strengthen cross-sectoral coordination at country level are recognized, survey responses and consultations emphasized the need for the GTFCC to include regional bodies and country representatives from ministries beyond health, to strengthen country-level commitment and multisectoral approaches to cholera control.

Some stakeholders also noted that at times partner engagement can be reflective of an individual or a few individuals from that organization only acting in their own capacity/expertise, rather than representative of the organization as a whole.

2.3. Efficiency

The evaluation criteria on efficiency looks at: (i) how efficiently the GTFCC structures are functioning (EQ4); and (ii) efficiency in the allocation of human and financial resources (EQ5).

3. **To what extent are the GTFCC operational structures set up efficiently to support the objectives of the Roadmap?**
4. **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 assessment for EQ4 covers the functioning of the GTFCC in terms of its various structures (Steering Committee, Secretariat, WGs, CSP, IRP and General Assembly) and what works well and less well. Findings consider ToRs for these structures (as summarized in Section 1 and web annexes) as well as reviews of meeting reports and are triangulated with stakeholder consultations (where views from members of each of these structures is triangulated with those of stakeholders external to the respective structure). Country case study feedback has been drawn on especially for the CSP and IRP. E-survey responses have also corroborated feedback received during stakeholder consultations.

The assessment for EQ5 considers available information on funding for the GTFCC and country cholera programmes. As comprehensive data are not available, stakeholder feedback also informs this assessment.

Table 2.3 presents the key findings and their robustness rating. Each finding is then detailed in turn below.

Table 2.3. Summary findings for efficiency

Summary finding on efficiency: Overall efficiency of the functioning of the GTFCC has been variable and impacted by funding constraints. Clarification regarding the roles and responsibilities of core GTFCC structures as well as strengthening of coordination among WGs would be beneficial. Limited funding has also hampered the cholera response and created imbalances between outbreak response/prevention. Within prevention, there has been an imbalance between OCV/WASH. As the GTFCC is approaching a funding cliff in 2025, the need for a diversified and sustainable funding base is evident and urgent.

Finding 3.1. The Steering Committee mandate and the extent of its role in strategic direction and oversight need clarifying, and overall efficiency could be enhanced by streamlining its meetings and expanding membership with regards to WASH, development partners and additional country stakeholders.	Good	Based on review of documentation and majority of stakeholder consultations.
Finding 3.2. The role of the Secretariat is central in terms of driving and coordinating GTFCC activities despite limited resources and capacity. But there are challenges in relation to partners' lack of alignment on the extent of agency taken on by the Secretariat and conflation of roles with the WHO Cholera Programme.	Good	Based on review of documentation, stakeholder consultations and country case study feedback.
Finding 3.3. The WGs generally function efficiently with notable achievements across the five technical areas covered. They each face specific challenges, with varying levels of resources. Communication and coherence of workplans across all WGs are areas to improve for greater efficiency.	Strong	Based on review of documentation, majority of stakeholder consultations and e-survey feedback.
Finding 3.4. The CSP is generally fit for purpose. Yet, its reach is limited to a small group of countries, and gaps remain in terms of support for NCP implementation. In addition, the CSP faces a significant sustainability risk given limited funding.	Strong	Based on review of documentation, e-survey feedback and majority of stakeholder consultations and country case studies.
Finding 3.5. There is a need to improve the efficiency of the IRP as currently there is limited awareness of its role, lack of engagement and considerable delays in its review work.	Strong	Based on review of documentation, e-survey feedback and majority of stakeholder consultations.
Finding 3.6. Limited funding generally available for cholera has hampered implementation of the Roadmap, and there is a funding imbalance between outbreak response/prevention as well as between OCV/WASH. There have been limited funds to support the work of the GTFCC, and as the GTFCC is approaching a funding cliff in 2025, the need for a diversified and sustainable funding base is evident and urgent.	Good	Based on vast majority of stakeholder consultations (global and country) and some documentation. However, quantitative data on funding gaps are not available.
Review against ToC: A review of the GTFCC ToC indicates one of the key assumptions for results – "adequate funding and human resources available" – has not borne out in practice.		

Finding 3.1. The steering committee mandate and the extent of its role in strategic direction and oversight need clarifying, and overall efficiency could be enhanced by streamlining its meetings and expanding membership with regards to wash, development partners and additional country stakeholders.

The Steering Committee terms of reference state that its role is to set the strategic direction, provide oversight and ensure accountability.[26] As was evident from the interviews for this evaluation, stakeholders are (i) not

[26] Steering Committee, GTFCC, Terms of reference

familiar with the Steering Committee ToRs; and (ii) understand the role of the Steering Committee to be on overall decision-making for the GTFCC. However, there is a wrong expectation from stakeholders of this role since the GTFCC as a network hosted by WHO is not a legal entity, and the high-level governing body (i.e. the Steering Committee in this case) does not have the authority or agency to make decisions akin to a Board for a WHO-hosted partnership. **As such, the extent to which the Steering Committee has functioned as a decision-making body has been limited in practice**.

- It is **not empowered by GTFCC member organizations to make decisions** that implicate partner resources (staff time or financial resources), including with regards to the WHO-hosted Secretariat that is subject to the WHO governing bodies, as well as to the WHO Constitution and Staff Regulations and Staff Rules, as noted in Section 1.1.
- The **voluntary nature of the role** means that **not all stakeholders attend all meetings** (and country representatives in particular have not attended frequently, except for the previous Chair). There have also been differing views amongst Steering Committee members. **The** terms of reference **operating procedures requiring a quorum and decisions by consensus have not always been strictly followed or been feasible because of these issues** (also see next point).
- It has **not always been clear what decisions need to be made by the Steering Committee,** and a review of Steering Committee meeting minutes over the years indicates that priorities have not always been addressed consistently with a tendency towards including ad-hoc issues lacking strategic focus (e.g. sometimes a technical discussion on ongoing research or guidelines development, sometimes an operational matter with the Secretariat, etc.). The Steering Committee is reliant on the Secretariat to coordinate their meetings, but, as noted in KIIs, the Secretariat has often been limited in its resources and therefore **meeting support has not always been optimal** (e.g. late arrangement and sharing of background papers, ad-hoc agendas without sufficient prioritization).

As a result, decisions were often not reached during these meetings, especially if there were more difficult issues to be decided upon. This was evident from the meeting minutes where available but also feedback from Steering Committee members. This results in ambiguity on ways forward and the Secretariat needing to take on greater agency to progress aspects. For example, the decision on whether to establish an RCCE WG has not yet been made, in part due to considerations regarding a lack of resources and of partner engagement.

In terms of **composition**, a strength is the range of organizations represented. As described in the Steering Committee ToR, the Steering Committee is supposed to have six core members from US CDC, UNICEF, WHO, IFRC, Médecins Sans Frontières and International Centre for Diarrhoeal Disease Research, Bangladesh and two further members from partner organizations, which are currently Gavi and the Gates Foundation. It is also to have three representatives from cholera-affected countries; this has included International Centre for Diarrhoeal Disease Research, Bangladesh, and a representative each from Pakistan and (previously) South Africa.[27] There are three key issues.

- A majority of the Steering Committee members is health-focused, and there is a strong view that more balanced representation from WASH (especially non-humanitarian WASH) and development stakeholders is needed.

[27] Ibid.

- In addition, country representation and engagement have been insufficient. There are supposed to be three members from cholera-affected countries but these posts have not been consistently filled, and there has been insufficient active and continuous attendance from country government representatives in the Steering Committee meetings.
- In addition, a key point of feedback from stakeholder consultations was whether the right level of representatives was appointed to the Steering Committee in terms of seniority within their respective organization. While it is noted that senior-level representation is required to support advocacy and effectuate decision-making in partner organizations, some key informants suggested that the GTFCC mandate requires representation from cholera-focused technical experts, a competence which may not always reside with senior leaders of partner organizations. This is in keeping with the Steering Committee's role of providing advice and guidance to the GTFCC Secretariat to implement its work, which requires good cholera technical expertise.

Finding 3.2: The role of the secretariat is central in terms of driving and coordinating GTFCC activities despite limited resources and capacity. But there are challenges in relation to partners' lack of alignment on the extent of agency taken on by the secretariat and conflation of roles with the who cholera programme.

As set out in Section 1.1 on the evaluation object, the GTFCC Secretariat plays a central role in coordinating work across the different structures (i.e. Steering Committee, WGs, CSP, IRP) and in linking countries with the various GTFCC structures and partners – a role much appreciated by regional and country stakeholders. Examples from country case studies include (i) Kenya, where the Secretariat has engaged with and supported the government for a number of years, including in developing the NCP, help coordinate the IRP review process and apply for OCV, amongst other aspects and (ii) Somalia, where a recent mission by the WHO Cholera Programme/Secretariat led to the adoption of key decisions by national authorities, including initiating the process of identifying PAMIs.

Much of the good work of the GTFCC can be directly or indirectly linked to the work of the Secretariat. Yet there are some challenges to the Secretariat's functioning in terms of partners expectations and perceptions, including partners' reporting concerns that insufficient prioritizing is detrimental to a more focused strategic outlook.

- **Lack of alignment on extent of agency and accountability:** There is a mismatch in expectations regarding the extent of the Secretariat's agency and accountability within the GTFCC. This is in part due to the challenges with the Steering Committee described above, which have resulted in the Secretariat having to drive things forward much more. This greater leadership role of the Secretariat within GTFCC has reportedly been perceived by some GTFCC members as taking away to some extent from the task force's collaborative way of working with members. Further, as the ToRs of the GTFCC state, the GTFCC is not a formal partnership entity but rather "a collaborative mechanism between interested parties including WHO and GTFCC members and not an independent legal entity."[28] Formally, therefore, the Secretariat is not accountable to the Steering Committee. However, stakeholders' definition and/or understanding of the Secretariat's role can be confused –some expect to report to the Steering Committee but are ultimately accountable to WHO as WHO staff. As one stakeholder said, "it's unclear

[28] GTFCC, Terms of reference, 2014.

who GTFCC (Secretariat) are accountable to, or where the recognized accountability lines are within WHO."

- **Issue of clarity of roles with the WHO Cholera Programme:** This is compounded by the way the GTFCC Secretariat is organized within the WHO. There are many benefits of having the Secretariat housed within the WHO Cholera Programme, including: (i) WHO's convening role aiding with point of entry in high-level health fora, (ii) coordination with countries and partners, (iii) the technical credentials that WHO provides and (iv) benefiting from the technical expertise from staff in the WHO cholera program.[29] Yet many stakeholders also highlighted a degree of confusion about whether the Secretariat is acting in its capacity as GTFCC Secretariat or the WHO Cholera Programme given different roles[30]. Some stakeholders also reported perceptions that the Secretariat has prioritized outbreak response in recent years to the detriment of prevention efforts, in part due to the increase in cholera outbreaks and the difficulty of delineating the Secretariat from the WHO Cholera Programme work.
- **Lack of adequate financial resources (and risks to continuity) contributing to inefficiencies in functioning:** As noted in Section 1.1, there is a discrepancy between budgets and available resources for Secretariat personnel and activity costs. In addition, one of the two Secretariat fulltime equivalents is facing a risk of continuity due to completion of grant funding for the post in September 2024. The resource constraints faced by the Secretariat are compounded by the challenges faced by the Steering Committee in delivering its role (and thereby requiring greater agency by the Secretariat) and the growing role of the Secretariat (reportedly viewed by some as a function of the need for a more collaborative way of working with other members).
- **Some gaps in capacity:** An advocacy task team[31] supported by external consultants has been established further to the Secretariat's requirement for focused expertise in advocacy and resource mobilization.

Finding 3.3. The working groups generally function efficiently with notable achievements across the technical areas covered. They each face specific challenges, with varying levels of resources. Communication and coherence of workplans across all working groups are areas to improve for greater efficiency.

The GTFCC WGs – established to support cholera preparedness and response and coordinated by the Secretariat – mostly function well and have made notable achievements across the five technical areas they cover. This is aided in part by the structure of having WG chairs who are from GTFCC partner organizations and focal points from the WHO Cholera Programme who coordinate to the work of WGs. However, each WG faces specific challenges, with varying levels of resources, partner engagement and implementation barriers shaping their outcomes.

The **Case Management WG** has benefited from active engagement and support from technical partners including the US CDC for the development of several tools, UNICEF for funding a consultant and several partners contributing to different research projects. However, funding constraints have impeded further progress with

[29] The incident management support team leads preparedness, readiness and response activities in affected countries.
[30] The head of the Secretariat is also a member of the ICG for cholera vaccines.
[31] Advocacy Task Team, GTFCC, 2024 Atlanta meeting concept note, 2024.

limited capacity for in-person meetings and sustained partner engagement. This lack of resources has impacted the momentum necessary to address emerging needs effectively.

The **Epidemiology WG** has benefited from structural adaptations and strategic engagement to improve efficiency and overcome the challenges of its voluntary participation model. A key determinant of success has been the leadership of the WG chairs, with stakeholders highlighting the importance of their availability and flexibility. Key enabling factors include the establishment of a technical committee to streamline workflows and ensure progress on priority tasks with support from the Secretariat focal point. The WG has also leveraged external consultants to bolster capacity.

The **Laboratory WG** has adopted several approaches to sustain engagement and maximize the utilization and efficiency of its volunteer-based structure. Key enabling factors include funding from a number of donors (until the end of 2025) including for external consultants, which significantly bolstered capacity, a very active chair and focal point and recognizing individual contributions by publishing member names alongside their organizations, an approach that has been positively received.

The **OCV WG** has benefited from several enabling factors, including having strong partner support from organizations, such as Gavi, WHO, BMGF, US CDC and Médecins Sans Frontières. Funding and other contributions have also enabled the WG to conduct regional training workshops with country stakeholders. Challenges with the work of the WG relate to broader external issues in connection with OCV supply (discussed under Section 2.4) and some diverging visions and objectives among partners.

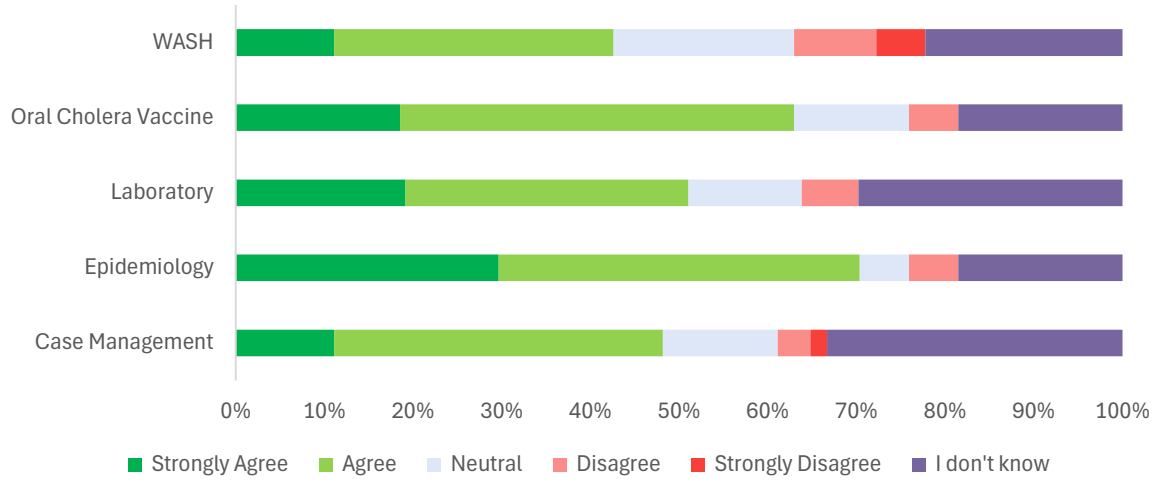
The **WASH WG** has struggled with significant challenges that have hindered its progress: chronic funding shortfalls have limited the WG's ability to actively engage with national level stakeholders, while weaknesses in internal WG communication have further dampened partner interest and participation, which is a missed opportunity with as many as 50 members being part of this group. Additionally, the WG would benefit from having a strategy for engaging with donors. Stakeholders also stated that current WG membership could include greater representation from key development actors.[32]

Across the WGs, a few common challenges emerged, including the need for consistent funding, targeted strategies for key partner engagement and enhanced opportunities for cross-WG collaboration *(20)*. Stakeholders noted limited collaboration between WGs and a lack of coherence and alignment across overarching workplans. Stakeholders also highlighted challenges in communication with the Steering Committee, with a perceived lack of transparency in decision-making even when it directly affected WGs. Another weakness is the lack of an RCCE WG, due in part to a lack of resources and commitment. This could represent an opportunity to further work in this area, given the benefits RCCE work can directly provide to cholera response and prevention efforts (e.g. through risk communication campaigns and door-to-door provision of supplies) and its support for other pillars such as OCV, case management and WASH (e.g. through demonstrating chlorine usage or establishing oral rehydration points).

Fig. 10 demonstrates e-survey feedback from global, regional and multi-country stakeholders on the perceived functionality of the WGs.

[32] Some examples include the Swedish International Development Association and the WASH Advisors or Humanitarian Teams at the UK's Foreign, Commonwealth and Development Office.

Figure 10: Global, regional and multi-country stakeholder responses to e-survey question on whether WGs are working well (n=54)



Finding 3.4. The CSP is generally fit for purpose. Yet its reach is limited to a small group of countries, and gaps remain in terms of support for NSP implementation. In addition, the CSP faces a significant sustainability risk given limited funding.

The CSP had a slow start in 2020, partly due to the COVID-19 pandemic. However, the last few years have seen the CSP working productively, helping to translate global level work (e.g. guidance) to the country level. For example, stakeholders described the role of the CSP as "catalytic" in Nigeria. (see also Finding 4.6). Some specific strengths highlighted by stakeholders include:

- the way in which the CSP can adopt a multisectoral approach;
- the important role the CSP plays in linking the Roadmap to country level NCPs and encouraging countries to access and use global guidance;
- the ability to support countries with their identification of (PAMIs), working with WHO experts leading epidemiology WG;
- the ability to provide technical assistance on a variety of areas; and
- the design of the Secretariat and CSP working together closely.

However, some **issues** have been highlighted.

- The CSP still has a limited reach with five primary operational CSP-specific countries (Bangladesh, Democratic Republic of the Congo, Mozambique, Nigeria and Zambia). However, an additional nine countries have received some support from the CSP (Burundi, Cameroon, Ethiopia, Jordan, Kenya, Malawi, Malaysia, Nepal and Tanzania). In other countries that have not yet engaged with the CSP such as Haiti, stakeholders indicated that a different model would be needed for its specific circumstances. While the CSP has had a positive effect in the countries it has been engaged with, it is difficult to expand it to more countries considering limited resources available. A regional approach could help increase coverage of the CSP as reported by a key informant, "a regional hub can bring touch to country when needed".

- While developing NCPs is considered useful, a big gap remains in supporting countries in implementing the NCPs – an area in which not much work has been undertaken to date. This is discussed in more detail under Finding 4.6.
- The CSP has received Sw.fr. 8.49 million in funding since October 2020 from BMGF, Swiss Agency for Development and Cooperation, Wellcome Trust and UK Foreign, Commonwealth and Development Office. Funding for much of the CSP (40%) was due to finish in October 2024.[33] This is a very significant risk to the sustainability of this work. Some stakeholders consider that the CSP has not done enough on resource mobilization to help address this challenge.
- A minority of stakeholders believes the model of the CSP being housed in an institution (i.e. IFRC) has affected how nimble and useful support from the CSP could be. With the current structure, requests for support from countries or partners and the funding from donors need to go through IFRC, which is seen as an impediment to efficiency. Instead, some partners and donors think a model where the CSP could more independently manage these aspects would be more efficient. Some stakeholders also flagged that more could be done with regards to transparency and that the CSP being housed at the IFRC means that partners do not always see how the CSP requests come in. Greater transparency could influence the perception of the value of the CSP.

Finding 3.5. There is a need to improve the efficiency of the IRP as currently there is limited awareness of its role, a lack of engagement and considerable delays in its review work.

The IRP has provided reviews of five NCPs (Benin, Democratic Republic of the Congo, Ethiopia, Kenya, Zimbabwe).[34] In general these reviews have been considered useful, for example in Kenya, where this support was reportedly timely and helpful, especially to strengthen the NCP alignment with the Global Roadmap.

However, while this structure of the GTFCC is considered useful in theory, it has not yet reached its potential in practice for several key reasons. One stakeholder described it as “an important mechanism which is currently neglected.”

- Very few key informants at the global and country levels were aware of the IRP, highlighting its limited reach to date.
- There is a limited number of members on the IRP due in part to the voluntary nature of the role, requiring experts to provide capacity without compensation. This has contributed in part to having too few IRP members available to undertake reviews of NCPs. In addition, there is a very limited sense of cohesion amongst IRP members, which affects collaboration and motivation.
- According to key informants and e-survey responses, reviews of NCPs and the provision of feedback to countries have taken too long, and this has significantly affected the usefulness of the process. Whilst there have been some good examples (e.g. Kenya, as noted above), only 28% of survey respondents from engaged countries considered the technical assessment of NCPs timely and useful. As an example, Nigeria’s draft NCP, submitted to the IRP in May 2024, remains under review as of

[33] CSP positions at risk based on data from June 2024 are: CSP NCP/OCV Roving Delegate, NCP Coordination Officer, Advocacy and Resource Mobilization Officer, Programmatic Support Officer.
[34] Steering Committee, GTFCC, Meeting, 2024.

November 2024, well beyond the anticipated six-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/or Secretariat's limited communication regarding the delay has compounded these issues, creating uncertainty around expected timelines for the launch. Multiple stakeholders cited the delay as a cause of frustration and suggested that it could eventually lead to a loss of momentum in support for the NCP and GTFCC.

- The process for reviewing NCPs is not adequately standardized, creating a lack of clarity for IRP members and country stakeholders. That said, the CSP and Secretariat have worked on a number of tools, such as a flowchart to show clear process, but these have not yet been finalized. In addition, the CSP and Secretariat helped create an NCP template to strengthen drafting process. The NCP is now reviewed by CSP before sending to IRP, which is expected to help improve the quality of NCPs and take less time for the IRP to review.

Finding 3.6. Limited funding generally available for cholera has hampered implementation of the roadmap, and there is a funding imbalance between outbreak response/prevention as well as between OCV/wash. There have been limited funds to support the work of the GTFCC, and as the GTFCC is approaching a funding cliff in 2025, the need for a diversified and sustainable funding base is evident and urgent.

Resources for Roadmap implementation. The Roadmap does not include an estimate of required funding to implement its targets and three axes nor its available resources. It refers to cholera imposing a significant global economic burden on cholera endemic countries of US$ 2 billion annually. A sample estimation is provided for the Democratic Republic of the Congo on the total cost to control cholera in its hotspots: between US$ 607 million and US$ 1.1 billion over 10 years, assuming a target population living in hotspots of between 5 and 6 million people. Some indicative figures are also provided on WASH interventions and related costs (e.g. emergency WASH interventions would be between US$ 5 and US$ 10 per person per outbreak response; and investment in developmental, long-term WASH programming to provide sustainable and affordable services to the target population would be US$ 40 to US$ 80 per person over a ten-year period). The Roadmap notes that the overall cost of its implementation will depend on several factors and that cost estimates will rely on countries' in-depth mapping of cholera hotspots, the proportion of urban versus rural areas and their key priorities. The Roadmap also notes that work has already started on developing a cholera investment case in the first half of 2018, although this does not appear to have been completed. Subsequent work done in 2019 estimates Roadmap costs at US$ 11 per person per year.

There is limited data on funding for the cholera response in countries and how funding is allocated to specific activities in the Roadmap.[35] The GTFCC reports the following financial contributions towards activities in line with Axis 1 of the Roadmap:

[35] This is due partly to partners taking on different activities and documenting them separately.

- BMGF funded US$ 4.6 million in 2021–2025 for surveillance in Haiti;
- Gavi funded US$ 71 million in 2023 for technical assistance and operational costs;
- US CDC provided US$ 750,000 in 2023 for emergency response; and
- WHO Contingency Fund for Emergencies provided US$ 17.4 million in 2022– 2024 for emergency response.

There are limited data on funding for cholera response in countries. For many years, stakeholders have highlighted that OCV has received disproportionately more funds than other areas. This is because of funding available from two large donors, namely Gavi and the BMGF.[36]

This imbalance on overall OCV funding is considered to be a particularly big issue, given that OCV will not offer long-term prevention (currently, two doses of OCV provide three years of protection). In comparison, safely managed water and sanitation services are the primary solution for prevention, but as is commonly known, the WASH sector has long been underfunded. This is partly because sustainable and effective WASH infrastructure developments require substantial funding and system-level change. It is also challenging to directly measure WASH developments for cholera, given the multifaceted nature of all WASH investments.

Despite the clear focus of the Roadmap on both outbreaks and prevention, outbreak response has attracted much more attention and funding. This is partly because there have been many more outbreaks than expected when the Roadmap was drafted and countries have been requesting outbreak support. It is also challenging to directly measure prevention-related funding for cholera, given that a number of investments relate to health-systems-wide investments rather than cholera-specific investments.

The country case studies have highlighted key gaps in the funding of country NCPs.

- In Kenya, the NCP was only partially costed. There was no official figure found on the current level of funding of the NCP and the estimated gap in funding. However, insufficient funding has been highlighted as a key weakness in the strengths, weaknesses, opportunities and threats analysis presented in the NCP across all pillars. Stakeholders unanimously recognized the high dependence on donor financing for cholera interventions (for outbreaks response and long-term interventions). As an example, funding for WASH 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 256 billion Kenyan shillings (US$ 2.23 billion) required.
- In Nigeria, the draft NCP has been costed and represents a positive step towards operationalization/implementation. However, there remains a significant gap in engagement with key funders and funding channels, and funding continues to be one of the biggest challenges.
- In Nepal, prevention and preparedness efforts are considered both costly and harder to generate funds for, with a need for dedicated resources for both responses and preparedness/prevention efforts.

Resources for the GTFCC. As noted in Section 1.1 on the evaluation object, there have been two estimates for the resource requirements (budget) for the GTFCC and CSP (from 2019 and 2024). Available data on funding for the GTFCC indicates that key donors for the Secretariat work over the years have included BMGF (US$ 2.2 million in 2022–2024), Gavi (US$ 4.4 million in 2022–2025), Swiss Agency for Development and Cooperation,

[36] This relates to funding available both to implement the Roadmap and for the work of the GTFCC.

US$ 1 million in 2021–2025), US CDC (US$ 1.9 million in 2022–2025), Wellcome Trust, UK Foreign, Commonwealth and Development Office and WHO (US$ 2 million in ad-hoc funding over the years). This translates to a rough total of US$ 7.5 million to US$ 9.5 million from donors in 2022–2024. While more complete annual information on GTFCC funding is not available, data indicate a mismatch between funding received from donors and financial resources required. For example, in 2024 the GTFCC Secretariat indicated that there was an annual budget gap of approximately US$ 1 million for personnel costs and US$ 200 000 to US$ 250 000 for activity costs. Furthermore, the funding for several positions has ended/is due to end between September 2024 and December 2025. In addition, the CSP has received Sw.fr. 8.49 million since 2020 from BMGF, Swiss Agency for Development and Cooperation, Wellcome Trust and UK Foreign, Commonwealth and Development Office. For the CSP, 40% of positions were at risk in 2024 due to completion of grants.[37]

Overall, the GTFCC has very limited funds available, in general due to declining donor interest in cholera in the face of other health issues. A significant portion of GTFCC Secretariat and CSP grant funding is coming to an end in 2024, with no further commitments from donors, putting the future functioning of the GTFCC crtitically at risk. As the GTFCC is approaching a funding cliff in 2025, the need for diversified and sustainable funding base is evident and urgent. This raises questions for the GTFCC in terms of (i) how additional funding could potentially be obtained and (ii) whether its ambitions need to be reduced given the available funds.

2.4. Effectiveness

The results assessment under this evaluation focuses on effectiveness.

There are two EQs under this evaluation criteria, covering progress against the Roadmap Axes (EQ6, Section 2.4.1 to 2.4.4) and factors driving progress (EQ7, Section 2.4.5).

5. What results have been achieved by the GTFCC partnership in the implementation of the Roadmap at the global and country level?

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

Effectiveness is assessed across the three strategic axes of the Roadmap, namely:

- Axis 1: Early detection and quick response to contain outbreaks;
- Axis 2: A multisectoral approach to prevent cholera in hotspots in endemic countries; and
- Axis 3: An effective mechanism of coordination for technical support, resource mobilization and partnership at the local and global level.

The assessment against Axes 1 and 2, which is focused on country level progress, is based on GTFCC and country documentation outlining areas of progress and gaps. It has also been supplemented by insights from stakeholder interviews and country case studies, where relevant. On Axis 3, which is about results achieved through the work of the GTFCC, this has largely been based on GTFCC documentation and supported by stakeholder interviews.

[37] Steering Committee, GTFCC, Meeting, 2024.

Support from the GTFCC on Axis 3 has primarily been provided through: (i) WGs through technical guidance and assistance, (ii) the Secretariat through provision of technical guidance and coordination; (iii) the CSP in the countries it has engaged with; (iv) the IRP through reviewing and providing suggestions on select country NCPs and (v) partners such as WHO, UNICEF, Gavi, US CDC, IFRC, Red Cross and Red Crescent societies, WaterAid, Solidarités Internationales, Action contre la Faim, etc. providing direct technical or implementation assistance. The assessment has focused on (i) to (iv) for the most part, noting that its scope does not extend to reviewing the cholera activities of all GTFCC partners.

Table 2.4 presents the key findings and their robustness rating. Each finding is then detailed in turn below.

Table 2.4. Summary findings for effectiveness

Summary finding on effectiveness: Despite progress made in key strategic areas of the Roadmap (with greater progress made in Axis 1 on outbreak response than Axis 2 on prevention), the effectiveness of Roadmap implementation has been limited overall. External factors, primarily conflict and climate change, and internal factors – notably funding shortfalls and importantly the lack of an operational plan including an M&E framework measuring differentiated results across axis and countries as well as the absence of a resource mobilization strategy – have affected the effectiveness of the GTFCC.		
Finding 4.1: The lack of an operational plan including an M&E framework measuring differentiated results across axis and countries has affected the effectiveness of the GTFCC. There are persistent issues with availability and quality of country level cholera data due to both capacity limitations and some reluctance to report cases.	Strong	Based on review of documentation, majority consultations and country case studies.
Finding 4.2. (Axis 1) Globally, progress on cholera outbreaks has followed a fluctuating trajectory, and cases and deaths have increased overall since the launch of the Roadmap.	Strong	Based on data in documentation and majority consultations
Finding 4.3. (Axis 1) There has been progress in several key implementation areas in support of outbreak response, notably the strengthening of integrated early warning surveillance systems, laboratory capacity and cholera reporting. Yet important gaps remain, in particular in relation to data quality and reporting mechanisms, while the global shortage of OCV has affected implementation.	Good	Based on review of documentation, country case studies and consultations.
Finding 4.4. (Axis 2) The identification of PAMIs has improved strategic targeting of cholera interventions in countries.	Strong	Based on review of documentation, majority consultations and country case studies.
Finding 4.5. (Axis 2) There have been efforts at country level to scale up the implementation of multisectoral interventions for preparedness and prevention of cholera across all key pillars including OCV, surveillance, laboratories, etc. However, progress has been slow. The delivery of OCV preventative vaccination has been particularly challenging due to the current global shortage of vaccines, and access to WASH remains limited due to severe underinvestment.	Good	Based on review of documentation, country case studies and consultations.
Finding 4.6. (Axis 3) Some countries have developed NCPs with GTFCC support. NCPs are considered a foundational framework for	Good	Based on stakeholder consultations, country case

a more strategic and holistic approach to cholera interventions across pillars. Yet there has been limited progress in the implementation of these NCPs.		studies and e-survey feedback.
Finding 4.7. (Axis 3) Despite efforts in advocacy and resource mobilization to keep cholera on the global health agenda and foster political commitment, both remain weak areas where progress is critical.	Strong	Based on document review, majority of stakeholder consultations and e-survey feedback.
Finding 4.8. (Axis 3) Progress has been made in cholera research with the benefit of dedicated funding for research. There is a need to ensure the GTFCC research agenda links well with country research agendas.	Good	Based on document review and stakeholder consultations.
Finding 4.9. (Axis 3) The GTFCC has successfully served as a forum to develop technical guidance and tools (including NCP guidelines, PAMIs, case management methodologies, multiannual OCV plans) through the WGs. This has helped align approaches between partners and countries, although there is scope for improving awareness at the country level.	Good	Based on stakeholder consultations, country case studies and e-survey feedback.
Finding 4.10. A range of external and internal factors has influenced the implementation of the Roadmap, notably conflicts and other political factors, the impact of climate change and funding shortfalls. The challenges with GTFCC functioning present an issue but also an opportunity for reform.	Strong	Based on document review, majority of stakeholder consultations, country case studies and e-survey feedback.
Review against ToC: There has been mixed progress in terms of having the right inputs and activities to support cholera outbreaks and prevention in countries. Outcomes on Axis 1 (outbreaks) have been furthered more than Axis 2 (prevention), reflecting a number of unrealized key assumptions (e.g. available funding and resources for cholera, political will); and materialized risks (e.g. health emergencies, conflict and climate change) have circumvented translation of outputs to outcomes and impacts.		

2.4.1. Progress against roadmap axes

Finding 4.1: The lack of an operational plan including an M&E framework measuring differentiated results across axis and countries has affected the effectiveness of the GTFCC. There are persistent issues with availability and quality of country level cholera data due to both capacity limitations and some reluctance to report cases.

A key challenge to assessing progress across the three axes is the lack of an operational plan and of a global detailed M&E framework with concomitant monitoring and reporting for the Roadmap.

- **The Roadmap only includes a high-level monitoring framework** with one indicator for each axis measured every five years (in Annex C of the Roadmap document), and this is not specific in terms of data sources. Efforts to develop an M&E framework for the Roadmap have been ongoing and an

assessment of GTFCC M&E processes was initiated in 2024 to strengthen reporting towards 2030.[38] The GTFCC has presented global figures *(23)* such as cases and deaths in publicly available dashboards *(23)*, global situation reports (SitReps *(22)* *(23)*) and an annual dashboard since 2000 *(24)*.

- **The frequency and quality of progress reporting has varied over time** due to a number of challenges with the GTFCC's M&E process, including clearly delineated responsibilities and coordination.[39] Information is scattered across GTFCC progress reports (specific progress reports were not available for 2017 and 2018), Steering Committee meeting reports (which cover a range of different topics), SitReps and General Assembly annual meeting reports and presentations.
- **There have been persistent challenges at country level due to issues of data accuracy and reluctance to report cases** for many years.[40] Reluctance to declare cases is related to a number of reasons, including political sensitivities (e.g. Nepal and Nigeria) with cholera viewed as a "disease of the poor" and its potential impact on the economy and tourism (due to illegal tourism and trade sanctions applied in cholera-affected countries). This extends to Roadmap indicators. There are capacity issues with data collection. As one e-survey respondent noted, "It seems to us that capacity-building in the fight against cholera is still inadequate. For example, as part of the monitoring of indicators in the global roadmap for the elimination of cholera, it has been observed that countries do not master these indicators, and some indicators are not well collected." Sections 2.4.2 and 2.4.3 provide more discussion on country level data challenges.

In addition to the sources mentioned above, the evaluation has reviewed key partner documents such as multi-country outbreak of cholera situation reports (these are referenced in the bibliography and country case study reports). Document review has been supplemented by feedback from stakeholder consultations and the e-survey responses. Country-specific progress and challenges have been captured through the country case studies. Despite the challenges with progress reporting, a review of the progress achieved across the three Roadmap axes is presented below, highlighting key challenges as well. Where feasible, the specific work of the GTFCC in support of the observed progress is highlighted.

2.4.2. Axis 1 – Early detection and outbreak response

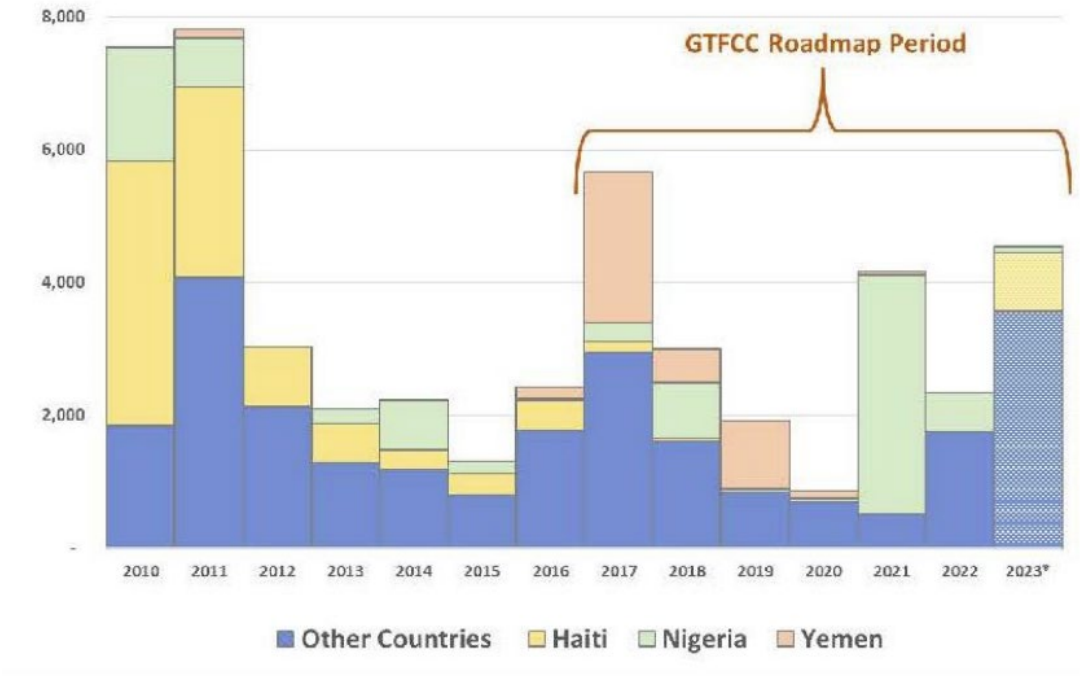
The Roadmap outlines a target to reduce cholera mortality by 90% by 2030, to eliminate cholera in as many as 20 countries and to prevent catastrophic outbreaks in fragile settings. Findings are presented on overall progress on cholera outbreaks in terms of data on the number of countries and number of reported cholera deaths and on progress on key implementation areas to support outbreak response.

[38] M&E, GTFCC, Working session, June 2024.
[39] M&E, GTFCC, Draft assessment report, May 2024.
[40] Under the International Health Regulations, notification of all cases of cholera is no longer mandatory. However, public health events involving cholera must always be assessed against the criteria provided in the regulations to determine whether there is a need for official notification.

Finding 4.2: Globally, progress on cholera outbreaks has followed a fluctuating trajectory, and cases and deaths have increased overall since the launch of the roadmap.

At the time of the Roadmap design in 2017, cholera was affecting about 47 countries worldwide and was responsible for about 2.9 million cases and 95 000 yearly reported deaths globally *(6)*. As can be seen from Fig. 11 below, the GTFCC reported a sharp decline in cholera mortality in the immediate years following the launch of the Roadmap until 2020, although this occurred in the context of a sharp increase in cholera reported deaths in 2017 (driven by reported deaths from Yemen), preceded by a downward trend since 2011 (due in part to significant reduction in reported cholera mortality from Haiti). Between 2020 and 2023, the GTFCC reported an increase in reported global cholera deaths (including a sharp increase from Nigeria in 2021). During a 2024 Steering Committee meeting, the GTFCC reported a 26% overall reduction in cholera mortality between 2017 and 2023, following the launch of the Roadmap.[41] However, there has been a recent rise in reported cholera deaths since 2020, and the number of countries managing outbreaks has increased from 29 in 2017 to 35 in 2023.[42]

Figure 11: Overview of reported cholera deaths 2010–2023[43,44]



Cholera deaths reported to WHO between 2010 and 2023

In addition, a presentation from the Secretariat in June 2023[45] highlights that of the 47 countries identified in the Roadmap, none have applied for the recognition of a cholera-free status by the GTFCC, but 11 (plus Zanzibar) have not reported a cholera outbreak in three years.

[41] Steering Committee, GTFCC, Secretariat presentation, June 2024.
[42] GTFCC,Data on number of countries with outbreaks per year, 2024.
[43] Steering Committee, GTFCC, Secretariat presentation, June 2024.
[44] Final data for 2023 are available and stand at 4007 deaths, reflecting a 29% decrease.
[45] Secretariat, GTFCC, Update: the GTFCC partnership "on the road" to 2023, 2023.

Finding 4.3: There has been progress in a number of key implementation areas in support of outbreak response, notably the strengthening of integrated early warning surveillance systems, laboratory capacity and cholera reporting. Yet important gaps remain in particular in relation to data quality and reporting mechanisms, while the global shortage of OCV has affected implementation.

The following implementation areas are discussed below: (i) early warning surveillance systems, laboratory capacity and data; (ii) OCV reactive mass campaigns; (iii) prepositioning of stocks of essential supplies; (iv) outbreak response through WASH and rapid health response and (v) preparedness of WASH and health systems.

Early warning surveillance systems, laboratory capacity and data

Overall, stakeholders highlighted the positive efforts made to strengthen integrated early warning surveillance systems and laboratory capacity, including the development of comprehensive surveillance strategies across many countries; an increase in cholera recognition and cholera reporting globally and better cholera testing and confirmation capacity (e.g. through the use of Rapid Diagnostic Tests (RDTs) and culture confirmation, promotion of molecular testing and strengthening of environmental surveillance) (including Democratic Republic of the Congo, Nigeria, Nepal) *(25)* *(26)*. Outbreak monitoring at the global level has also improved, for example through the compilation of comprehensive monthly SitReps and better information-sharing between the GTFCC and key partners such as WHO and the Global Outbreak Alert and Response Network operational partners *(27)*.[46]At country level, strengthening of surveillance systems and laboratory capacities was often cited as a positive externality from the COVID-19 pandemic, including aspects such as improved port health systems (e.g. as reported in Kenya), as well as strengthening of DHIS2 systems, electronic data recording and disease notification mechanism at local levels *(28)*. Respondents to the e-survey also noted that there have been improvements in the quality and quantity of laboratory surveillance data that has helped direct support for interventions. Given the progress in terms of global reporting on cholera, some of the increase in reporting of cases and deaths may be attributable to better surveillance.

This progress was also attributed to the GTFCC and partners who have helped to improve the availability and access to key technical guidelines and tools to support cholera surveillance and response activities, including tools to support better identification of PAMIs for cholera control and elimination and guidance to promote better alignment on standards for cholera surveillance (e.g. gradual transitioning from acute watery diarrhoea surveillance to cholera surveillance).This is further discussed under Finding 4.9 on technical guidance.

Despite these areas of progress, countries continue to face persisting challenges in surveillance, which hinder early reporting and response. In particular, stakeholders flag issues in data-reporting and data quality due to continuous methodological challenges (e.g. case definitions not well adhered to and limited laboratory confirmation) that limit the accuracy of cholera estimates; continued use of paper based/manual data-recording and reporting system at health facility level in many countries; non-adherence to standard case definition; and low timeliness and completeness of Integrated Disease Surveillance and Response reporting, amongst other reasons (e.g. a particularly notable issue reported in Nepal) *(28)*. Laboratory capacity and sample transportation continue to be a key area of weaknesses in countries especially at subnational level, which further delays outbreak detection (e.g. in the Democratic Republic of the Congo the stool culture sample collection rate stood

[46] Steering Committee, GTFCC, Meeting: Secretariat presentation, June 2024.

at 33% in 2024 (up to week 40), below the 50% target set by the National Multisectoral Plan for Cholera Elimination) *(29)*. In addition, stakeholders highlighted that whilst cholera reporting has increased overall, underreporting and no recognition of cholera (primarily due to political reasons) continues to be a challenge in many counties, especially in the WHO Asia region.

Box 2.5 provides key areas of progress and weakness flagged in the various country case studies.

Box 2.5. Areas of progress and weakness in outbreak response reported in country case studies

While a detailed review of these systems was not conducted as part of the country case studies, stakeholder feedback at the country level indicated severl **key areas of progress**.

- Surveillance systems, particularly since the COVID-19 pandemic (Democratic Republic of the Congo, Kenya, Nigeria) – e.g. in Democratic Republic of the Congo, robust surveillance efforts in 2023 resulted in the detection of 17 cholera outbreaks across various regions, with emphasis given to seven high-risk health zones, where continuous monitoring was maintained. The implementation of Integrated Outbreak Analytics and daily online reporting has also greatly strengthened real-time tracking for decision-making.
- implementation of an OCV vaccination campaign – as part of a multifaceted response, this has contributed to outbreak control (Haiti, Kenya, Nigeria).
- Case management (Nepal) and use of RDTs to support case detection (Democratic Republic of the Congo, Kenya, Nepal, Nigeria) – e.g. in Nepal, 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).
- Community-led responses and community health workers for early identification and notification (Haiti, Nepal).

A number of **key areas were identified as having made less progress**:

- Sample transportation systems (Democratic Republic of the Congo, Kenya, Nigeria).
- Laboratory network and capacity (Kenya) – laboratory diagnosis capacity has been lacking according to stakeholders and as reported in the recent outbreak After-Action Review. This is attributed to a lack of well-defined sample referral systems within the counties and national level for collecting, transporting and shipping outbreak samples to the 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 laboratory personnel leading to incorrect sampling and results, compounded by a shortage of laboratory staff due to staff turnover and budget constraints.
- Data quality and completeness, e.g. water quality, epidemiological data (Kenya, Nepal).

OCV reactive mass campaigns

The implementation of reactive large-scale mass vaccination campaigns with OCV has been a core strategy under Axis 1, facilitated by the GTFCC, to effectively stop disease transmission and curb outbreaks. In 2023, the GTFCC, its partners and ICG reported 28 reactive OCV campaigns delivered in 12 countries, and by mid-2024 a further

eight reactive campaigns were implemented in seven countries, targeting over 40 million people.[47] In the face of increasing cholera outbreaks, the GTFCC and its partners were able to adapt their approaches to ensure access to protective vaccines. This includes the unprecedented decision by the ICG in 2022 to limit all reactive OCV campaigns to one single dose instead of two, supported by the Strategic Advisory Group of Experts' recommendations on use of OCV, in light of the ongoing vaccine shortage and increasing country needs *(30) (31)*.

However, some stakeholders flagged countries' overreliance on OCV as a "silver bullet" to stop outbreaks and have warned about the limits of this strategy as more should be done to strengthen response mechanisms across all pillars, especially WASH. The current shortage of OCV supply (due to the imbalance between growing demand and the manufacturing capacity of the single manufacturer, EuBiologics) presents a critical risk to an OCV dependent response. The increase in unpredictable large-scale outbreaks led to a significant increase in demand for OCV for reactive campaigns. The GTFCC estimated that more OCV doses were requested for outbreak response between 2021 and 2023 than during the entire previous decade.[48] Despite the new ICG strategy and efforts from the supplier and partners, country demand continues to exceed available supply. This contributes to countries often receiving fewer doses than requested for their reactive campaigns.[49] In 2023, the GTFCC reported a 50 million dose gap for outbreaks reactive campaigns alone.[50]

In addition, the increase in reactive OCV demand has a knock-on effect on countries' capacity to implement preventative campaigns as explored further under Axis 2 below. In 2022, the GTFCC estimated that 57% of the 112 million OCV doses shipped to countries since 2013 had been dedicated to reactive campaigns.[51] The current single-dose strategy also offers a shorter protection (between 1 and 2 years) instead of 3 years with a double dose regimen *(32) (33) (34)*. This leaves less time for countries to recover in between outbreaks and strengthen their WASH and health systems as recommended. Box 2.6 describes country experiences for OCV from Kenya and Nigeria.

Box 2.6. Select country experience with OCV (reactive and preventative)

In Kenya, support from the OCV WG was said to have been instrumental to enable the country to submit its 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 in containing and curbing their last major outbreak. In addition, this OCV campaign was an example 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 (at national and county levels) was actively engaged in the planning and delivery of the campaign to integrate WASH activities such as WASH sensitization, RCCE and awareness-raising during vaccination activities.

[47] Steering Committee, GTFCC, Secretariat presentation, June 2024.
[48] Steering Committee, GTFCC, Meeting: Secretariat presentation, June 2024.
[49] Ibid.
[50] Secretariat, GTFCC,10th GTFCC general assembly. Towards the 2030 roadmap's goals: Where do we stand? Secretariat presentation, June 2023.
[51] Steering Committee, GTFCC, Secretariat presentation, June 2022.

Nigeria's experience with OCV highlights both success and challenges. In 2021 Nigeria successfully applied for OCV to conduct preventative vaccination campaigns after the country completed its hotspot mapping. The application submitted by Nigeria was used by key partners within the OCV pillar to provide training to other anglophone countries. However, despite the quality of the application, Nigeria only received 1 million out of the 9.96 million doses that were applied for and approved. Reactive campaigns have played a larger role in Nigeria's use of OCV, with it receiving 5.1 million doses in 2021 and 4.4 million doses in 2024 for outbreak response *(21)* *(22)*. However, due to misalignment in outbreak response approaches between the federal and state government, and what stakeholders described as vaccine hesitancy on the part of state government leadership, the 4.4 million doses supplied to respond to the Lagos State outbreak were not deployed in Lagos. The vaccines were ultimately redirected to contain later outbreaks in other regions of the country.

Prepositioning of stocks of essential supplies

Beyond vaccines, stakeholders report key challenges in pre-positioning of stocks and availability and distribution of essential cholera supplies, which hinders countries' responses. This includes oral rehydration salts, IV fluids, cholera kits and high test hypochlorite.[52] In 2022, WHO reported a global shortage in cholera kit supply as global stocks were depleted and suppliers were struggling to meet demand *(30)*. Some countries have also highlighted limited access to ORS due to weak distribution systems that cause frequent shortages and stock-outs, as well as the potential effect of the pandemic on ORS production costs and price due to pressures on global supply chains *(20)(35)* .

Outbreak response though WASH and health rapid response

There is mixed evidence of progress made for early detection and timely and effective case management of cholera including through the use of WASH and Health Rapid Response Teams for field investigation. Stakeholders highlighted the instrumental role of partners in supporting countries and attempting to improve the timeliness of responses. In many countries, implementing and technical partners are crucial to enable the implementation of cholera responses and complement countries capacity which can often be limited. This is especially the case in humanitarian and conflict-affected countries that have very high needs, weak governance systems and severe capacity and resource constraints (e.g. in Haiti). GTFCC and partners provide support across all pillars of cholera responses especially around case management by setting up dedicated health care facilities (cholera treatment centres) and cholera treatment units), training of health workers, deploying rapid response teams and providing treatment. They also contribute to implementing short-term WASH interventions as part of outbreak responses, such as distribution of point-of-use water treatment, strengthening of chlorination of community water supplies, monitoring of water quality in piped networks and distribution of soap to prevent disease spread.

In a number of countries, the GTFCC, through its internal structures such as the Secretariat, WGs and CSP, also contributes to supporting cholera responses, with this support varying from country to country (e.g. the

[52] Secretariat, GTFCC, GTFCC general assembly 2023; Secretariat presentation: Towards The 2030 Roadmap's Goals: Where Do We Stand? "023.

Secretariat and CSP has promoted a multi-sectoral response, WASH WG has promoted WASH as a key intervention in the cholera response. This includes by facilitating multisectoral coordination in countries, including health and WASH actors as part of national and partner-led response taskforces.

However, there have been challenges in outbreak coordination, especially in countries without an activated cluster (health and WASH clusters) *(36)* [53] and delays in mobilization and rapid responses after initial reporting in countries such as Malawi and other East African countries, leading to catastrophic outbreaks that could potentially have been avoided. Box 2.7 includes an example from Nepal where multisectoral coordination in outbreak response still warrants strengthening.

Box 2.7. In Nepal, surge response systems are in place and have strengthened over time, though timeliness and multi-sectoral coordination could be boosted

The need to strengthen surge capacity in Nepal through a more effective multisectoral coordination effort was raised by many stakeholders. This has reportedly improved over time and is reportedly more effective than other prevention and preparedness modes, but there are still some misalignments during response. As one stakeholder 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."**

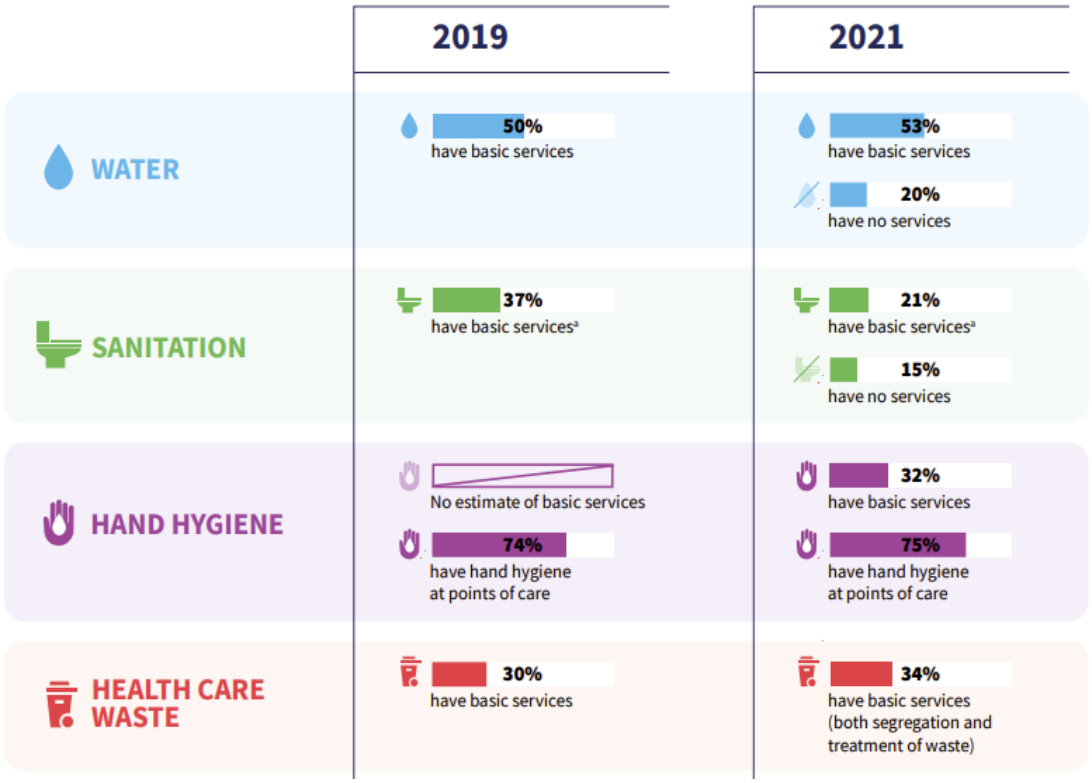
Preparedness of WASH and health systems

Some progress has been reported on efforts to improve health care facility infrastructure, including WASH in health care facilities, although this still remains insufficient. Countries have been increasingly taking action to improve WASH in health care facilities, especially through better monitoring, strengthening of health care waste and WASH standards and training of personnel in WASH and infection prevention and control [54]. However, progress is far off track as more than 1 billion people are still reported to visit health care facilities with inadequate or no WASH services. The situation is even more critical in the least developed countries where only 21% of health care facilities have basic sanitation services. Essential WASH infrastructure, alongside good infection prevention and control practices, is critical for providing quality care, avoiding further transmission of infectious disease through health care facilities, and effectively and efficiently delivering health services in emergencies. Despite a modest estimated cost for providing WASH services in health care facilities (about US$ 0.60 per person per year in least developed countries), financial investments for WASH on health care facilities have been limited. Out of 73 countries that provided data for the WHO global report on WASH in health care facilities, only 16% had undertaken national infrastructure improvements. Fig. 12 includes more details regarding the status of key WASH indicators in health care facilities in least developed countries.

[53] Currently there are 29 WHO Health Clusters, of which two are regional coordination mechanisms

[54] Currently there are 29 Health Clusters, of which two are regional coordination mechanisms (Pacific and Whole of Syria).

Figure 12: Status of key WASH indicators in health care facilities in least developed countries *(36)*



2.4.3. Axis 2 – Prevention

A number of findings are provided below on progress against Axis 2 on prevention.

Finding 4.4: The identification of PAMIs has improved strategic targeting of cholera interventions in countries.

The GTFCC has developed a number of resources to support countries' efforts in identifying PAMIs, including two technical guidance documents on PAMIs for cholera control and elimination *(37)* *(38)*. As of December 2024, the number of countries with a finalized Hotspot/PAMI identification performed following a GTFCC recommended method stood at 23 (see Box 2.8 for some updates from this evaluation's case study countries) *(39)*. Country stakeholders shared that the new GTFCC PAMI methodology provided a more holistic approach to identifying high-risk areas for cholera as it incorporates a comprehensive set of indicators, including epidemiologic and WASH data as well as contextual risks factors such as population density, presence of at-risk populations, vulnerability to extreme climate events, etc *(40)*.

Box 2.8. Recent country progress on PAMIs

In Kenya, GTFCC supported the government in implementing a PAMIs assessment in 2024 and enable the implementation of a targeted approach to effectively control and eliminate cholera in the most at-risk areas. Stakeholders were highly positive about the availability of this new PAMIs assessment, which in their

opinion offers a more comprehensive approach to identifying 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 better supports multisectoral interventions".

In **Nigeria**, the CSP organized workshops in November 2024 to launch PAMIs mapping that will update previous hotspot mapping. Stakeholders expressed significant enthusiasm for this initiative, as it will involve a broader range of stakeholders, 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 National Strategic Plan of Action on Choler Control (NSPACC) 2024–2028.

In **the Democratic Republic of the Congo**, the NCP 2023–2027 focuses on hotspot/PAMIs through a multisectoral approach. Stakeholders consider that this has facilitated outbreak response and positioning of resources: in six hotspot health zones in Haut Katanga for instance, an alert system has been established and supported with communication credits and internet modems. The inaccessibility of certain PAMI areas during the rainy season and poor communication routes limit access to remote populations. Stakeholders emphasized the need to convert one-time humanitarian assistance into long-term support in cholera hotspots and recommend the GTFCC deepen its collaboration with Democratic Republic of the Congo health zones and activate stronger advocacy for improved epidemic preparedness.

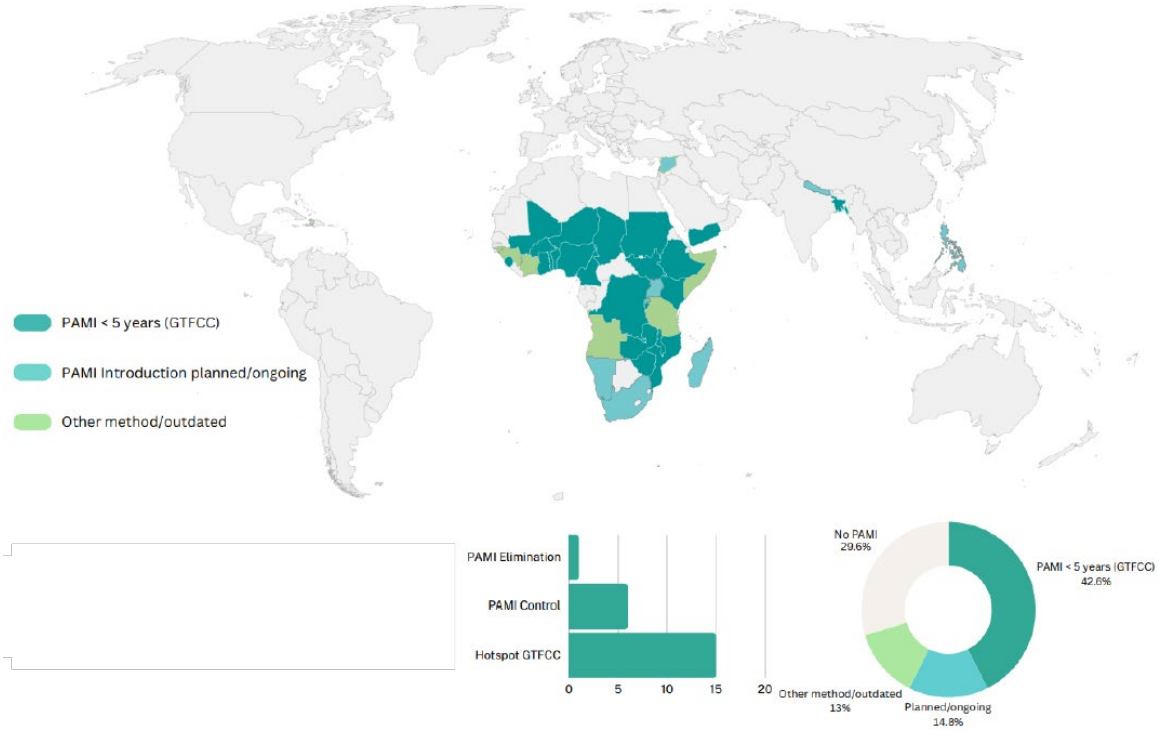
In **Nepal** the PAMI is currently in the final approval processes within the **Ministry of Health and Population**. Once approved, it will be shared with the GTFCC for final approval.

Somalia has a draft NCP, but a weakness is that it did not include hotspot or PAMI identification. In collaboration with the WHO and GTFCC, support is planned for a PAMIs assessment to be undertaken, and the expectations are that this will be very beneficial in addressing this gap and ensuring targeted, effective interventions.

However, some stakeholders interviewed highlighted some limitations in the implementation and communication of PAMIs, including ensuring that they are being used and taken into account in the WASH sector (while the WASH sector should be involved in PAMI identification). As one Kenyan country stakeholder said, "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".

Fig. 13 provides a status regarding progress of PAMI assessments globally. As can be seen, more progress has been made in African countries than Asian countries with regards to completing PAMIs.

Figure 13: PAMI identification process as of December 2024 *(39)*



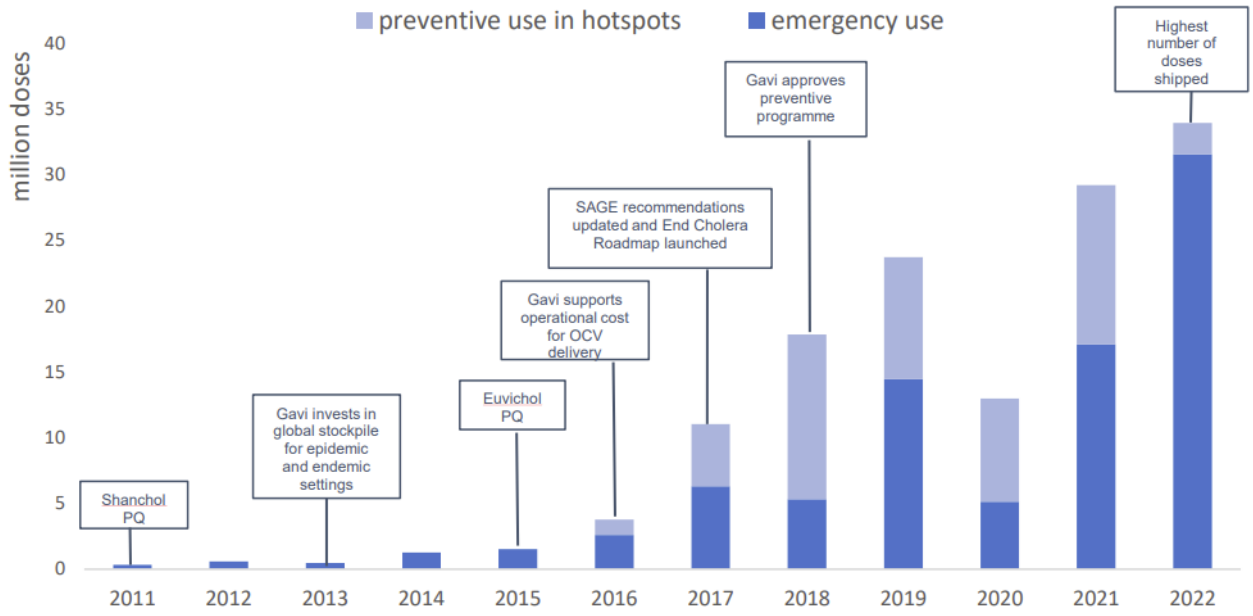
Finding 4.5: There have been efforts at country level to scale up the implementation of multisectoral interventions for the preparedness and prevention of cholera across all key pillars including OCV, surveillance, laboratories, etc. However, progress has been slow. The delivery of OCV preventative vaccination has been particularly challenging due to the current global shortage of vaccines, and access to wash remains limited due to severe underinvestment.

Preventative OCV vaccination

The annual supply of OCV has increased greatly since the creation of the stockpile (from 2.5 million doses in 2013 to 36 million currently in 2023).[55] However, over the recent years, demand for OCV has sharply increased, both in the number and size of requests, and OCV demand has greatly exceeded the available supply.[56] As noted above, most doses had to be prioritized for emergency response over preventative campaigns (in 2022, over 90% were allocated for outbreak control and emergencies *(41)* Due to high demand, there have been recurrent stock-outs of the vaccines, and no preventative vaccination campaigns have been implemented since December 2022.[57] Fig. 14 provides the trend in OCV supply in 2011–2022.

[55] OCV Temporary Commission, GTFCC,Final report June 2023, 2023.
[56] Ibid.
[57] Steering Committe, GTFCC,Meeting: Secretariat presentation, June 2024.

Figure 14: Trend in OCV supply 2011–2022 *(41)*



Despite the use of a single-dose regimen for reactive campaigns by the ICG since 2022 to slow the depletion of OCV, demand continues to surpass supply. In 2021 and 2022 the stockpile experienced severe shortages of doses because of increasing OCV demand from countries, and regular stock-outs continue to occur to this day.[58] The GTFCC confirmed that the emergency stockpile was completely depleted in January 2024 and this again in October 2024 *(27)*.[59]

To help address the increase in unpredictable large-scale outbreaks, the difficulty in forecasting prevention demand and limited availability of OCV supply, the GTFCC has been supporting countries' efforts, especially through the OCV WG, in strengthening planning for preventative OCV. This has included the provision of trainings to improve the quality of OCV requests (e.g. three regional workshops delivered in 2024 in Africa and South-East Asia, one in EMRO), creating supportive guidelines and providing technical assistance to develop OCV multiyear plans.[60] Despite these efforts, vaccine shortages continue to be an issue and are likely to continue at least in the short term. The limited OCV manufacturing capacity is also a key issue in addition to forecasting challenges. At the time of the Roadmap launch, there were three WHO prequalified OCVs, two of them available through the global stockpile (Euvichol from EuBiologics and Shanchol from Sanofi) *(6)*. In 2021, however, Sanofi decided to suspend its OCV production and quit the market, leaving only a single prequalified manufacturer, EuBiologics, to fulfil all OCV demands.[61] Efforts are ongoing by the GTFCC and partners to identify potential solutions to this issue as outlined in the Cholera Vaccine Market Shaping Roadmap *(41)*.

[58] OCV Temporary Commission, GTFCC, Final report June 2023, 2023.
[59] Steering Committe, GTFCC,Meeting: Secretariat presentation, March 2024.
[60] Steering Committe, GTFCC,Meeting: Secretariat presentation, June 2024.
[61] Steering Committee, GTFCC, Meeting, June 2021.

Surveillance and laboratory capacity

Survey respondents and interview stakeholders reported that support from the GTFCC has been useful to enable strengthening of routine surveillance and diagnostic and laboratory capacity in countries. The GTFCC (especially the Epidemiology WG and Laboratory WG) provided support in several areas.

- It strengthened surveillance capacity and systems, including by developing comprehensive surveillance guidance such as a technical note on environmental surveillance, the GTFCC method to assess cholera surveillance *(42)* to support identification of priority gaps where surveillance needs scaling up (including by linking priorities to improve surveillance to relevant parts of NCPs) and guidance for public health surveillance of cholera with updated recommendations on: (i) case and outbreak definitions, (ii) testing, including to expand the use of RDTs, (iii) minimum case-based data to be collected on suspected cholera cases, and new guidelines integrating considerations regarding additional transmission settings to enable "adaptive cholera surveillance" according to the prevailing epidemiological situation at the local level *(21)*.[62] Additional guidance and tools for surveillance data collection, reporting and analysis were also created as well as providing recommendations for the monitoring and evaluation of surveillance performance *(21)*.
- It improved diagnostic and laboratory capacity by providing capacity-building and training of trainers for laboratory staff, developed a series of laboratory fact sheets, job aids and minimum laboratory capacity standards and laboratory capacity assessments as well as support for the provision of cholera RDTs for faster cholera detection and advocated for increased testing and reporting of cholera cases, which has helped inform responses in countries and better track progress towards control and elimination *(21)*. They also helped develop a better testing strategy (strategic and expanded use of RDTs complemented by culture and polymerase chain reaction for outbreak detection and monitoring in different epidemiological settings) that have been adopted in countries.
- The GTFCC cholera app has also been cited as a very helpful tool, which respondents stated aids access to key resources.

However, stakeholders highlighted significant barriers that remain, including inconsistent funding for surveillance and laboratory systems strengthening, persisting issues with under reporting in many countries and issue of data quality. In some of the case study countries (e.g. Democratic Republic of the Congo, Nepal), coverage of diagnostic services has required strengthening (e.g. RDTs, culture and polymerase chain reaction, and technical and geographical diagnostic capacity and supplies remain limited. Laboratory capacity is especially challenging due to rapid turnover of laboratory personnel and loss of capacities especially in high-risk areas, as well as a lack of resources for laboratory supplies (RDTs, reagents) and equipment. 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.

[62] GTFCC, 11th GTFCC general assembly: The global cholera control effort: overview of progress made towards the 2030 targets Version of 19 June 2024, 2024. GTFCC, Assessment of cholera surveillance: interim guidance document 2024, 2024.

Box 2.9 describes Haiti's situation where efforts during outbreaks are then substantially scaled up putting prevention infrastructure at risk.

Box 2.9. Sustaining the response to cholera resurgence in an unstable political context: lessons learnt from Haiti.

After early progress towards cholera elimination in 2019–2022, 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. The insecurity has also led to a complex humanitarian crisis with massive population displacements as well as climate-related disasters (e.g. extreme flooding, landslides) further increasing vulnerability to cholera.

Stakeholders considered that the cholera response mechanisms strengthened during the 2010–2019 outbreak provided a strong foundation that helped the country respond to the recent outbreak beginning in 2022. This included embedding active response systems within communities through building on existing community health worker networks and recruiting and training additional community health workers. Mobile Rapid Response Teams (Emira) were also set up to provide decentralized and timely responses in affected communities based on the GTFCC recommended case-area targeted interventions strategy, a "game changer" according to a stakeholder**.** Another stakeholder said**, "Early detection and response in communities was crucial to provide timely live-saving treatment, implement key prevention activities, and ultimately stop the transmission of the disease."**

During the previous outbreak, the government and partners increased case management capacity by setting up additional cholera treatment centres and boosting trained health workers for cholera. However, case management capacity has been highly reduced in this new outbreak as the political instability and insecurity have caused many partners and national actors to leave the country, including trained health care workers and response staff. Many stakeholders raised the effect 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.

WASH

Overall, global progress towards SDG 6 on water and sanitation are behind and off track to meet the 2030 SDG timeline and targets, especially in low- and middle-income countries as a recent UN-Water report estimated that billions of people worldwide continue to lack access to safely managed drinking water sanitation and basic hygiene services *(2)*. The UN Water report highlights key statistics on global progress towards SDG 6:.

- Since 2015, coverage of safely managed drinking water services has only increased from 69% to 73%, with better progress in rural areas (from 56% to 62%) than urban areas (from 80% to 81%). As of 2024, an estimated 2.2 billion people (1 in 4 people globally) still lacked safely managed drinking water services in 2022, including 1.5 billion with basic services, 292 million with limited services, 296 million with unimproved services and 115 million drinking surface water, which increases the risk of contamination and transmission of disease such as cholera putting billions of people at risk. Disaggregated data reveal huge disparities in service between and within countries, including gender disparities as the burden of water carriage remains significantly heavier for women and girls. Access to water in key areas such as schools is also lacking as 33% of schools (447 million children) still lacked basic drinking water service in 2023 *(2)*.

- Coverage of safely managed sanitation services has also seen some minor progress (from 49% in 2015 to 57% in 2022), including a 10% increase in rural areas globally (from 36% to 46%) and a 5% increase in urban areas (from 60% to 65%). Globally, 3.5 billion people (or 2 out of 5 people around the world) still lacked safely managed sanitation in 2022, including 1.9 billion with basic services, 570 million with limited services, 545 million with unimproved services and 419 million practising open defecation. In 2023 78% of schools had a basic sanitation service, but 427 million children still lacked a basic sanitation service at their schools *(2)*.
- Coverage of basic hygiene services has increased from 67% to 75% globally since 2015, mainly in rural areas (from 53% to 65%) whilst coverage in urban areas has remaining largely unchanged, at 83%. In 2022, around 2 billion people (i.e. 1 in 4 people around the world) still lacked basic hygiene services, including 1.3 billion with limited services and 653 million with no facility. Around the world, 67% of schools had a basic hygiene service in 2023, while 646 million children lacked a basic hygiene service at their schools *(2).*
- Water quality monitoring remained a key challenge and remains a data gap globally on the contamination risk from water supplies across low- and middle-income countries. Domestic wastewater treatment data showed that households generated an estimated 268 billion cubic metres of wastewater globally in 2022, of which 42% was not safely treated. This represents a marginal increase of 2% since previous estimates in 2020. In many regions, domestic wastewater is not safely treated. This is due to a lack of household connections to sewers or septic tanks and insufficient treatment of sewered flows at urban wastewater treatment plants, as is the case in many low- and middle-income countries. Industrial wastewater treatment also remains insufficient globally, as recent data estimate that only 38% of industrial wastewater was reported as treated and only 27% was safely treated *(2)*.

The lack of disaggregated data limits the ability to track country-specific progress on WASH and better target safely managed WASH services in cholera-endemic areas and identified PAMIs (hotspots). The implementation of WASH service improvements is reliant on government- and partner-led activities and highly dependent on donor financing for service delivery and/or strengthening of existing services *(2)*. Countries have limited domestic financial resources to support safely managed service delivery across many cholera endemic settings *(2)*. A recent WHO report *(27)* also highlighted that global funding for WASH remains highly insufficient to meet current needs, let alone meet the increasing demands created by climate change and political instability. It flags that continuing levels of programming will not achieve SDG 6 by 2030 and that considerable scale-up is needed, which will require increased investment. For example, the 2020–2030 National Programme for Water Supply, Sanitation and Hygiene (Programme National Eau, Hygiène et Assainissement, PNEHA) in the Democratic Republic of the Congo has laid out investment requirements of US$ 8 billion to reach the ambitious access targets of 80% for urban water, 60% for rural water, 70% for sanitation and universal access in schools and health centres by 2030. This target has not yet been reached, and it is unlikely to be fully funded *(43)*.

Whilst the GTFCC highlights the need to improve WASH service coverage and use in cholera-endemic areas and PAMIs, advocacy efforts with key WASH donors have not succeeded in pivoting existing funding or targeting new funding to these sites *(20)(21)(44)* . The GTFCC has largely focused energy on producing guidelines for environmental surveillance – including water quality monitoring during cholera outbreaks – and convening meetings between WASH actors and other organizations to advocate for improvements to WASH services in affected countries *(20)(21)(44)*. As an example, Box 2.10 below highlights constraints to progress in WASH in Nepal.

Box 2.10. WASH in Nepal is challenged by insufficient political and policy focus, underfinancing and data gaps.

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%). Existing WASH infrastructure is vulnerable during heavy rains and floods, with further investment required to improve wastewater management system resilience and sustainability.
- The availability of comprehensive WASH data to plan and guide efforts is sub-optimal. For example, district level data on the proportion of households with handwashing stations and access to safe drinking water is not readily available. Data on open defecation reportedly far underestimate the extent of the practice. One stakeholder emphasised that, **"we are not getting detailed localized 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 is under way, with over 300 local municipal areas currently engaged. This data will provide household level data, support sharpening prioritization of WASH efforts and highlight potential cholera risks.
- 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 strategy, policy and regulatory framework and roles and responsibilities for WASH, though it does not explicitly mention cholera. 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.

In addition, some stakeholders in Kenya 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 NCP or had only informally come across it at a later stage. As such, whilst stakeholders were of the opinion that most partners' interventions are somewhat aligned to what is proposed in the NCP, they shared that a lack of involvement at design stage is a missed opportunity to have strong endorsement of the NCP across all partners and intentional alignment of their activities and priorities with the proposed approach in the NCP.

2.4.4. Axis 3 – Coordination

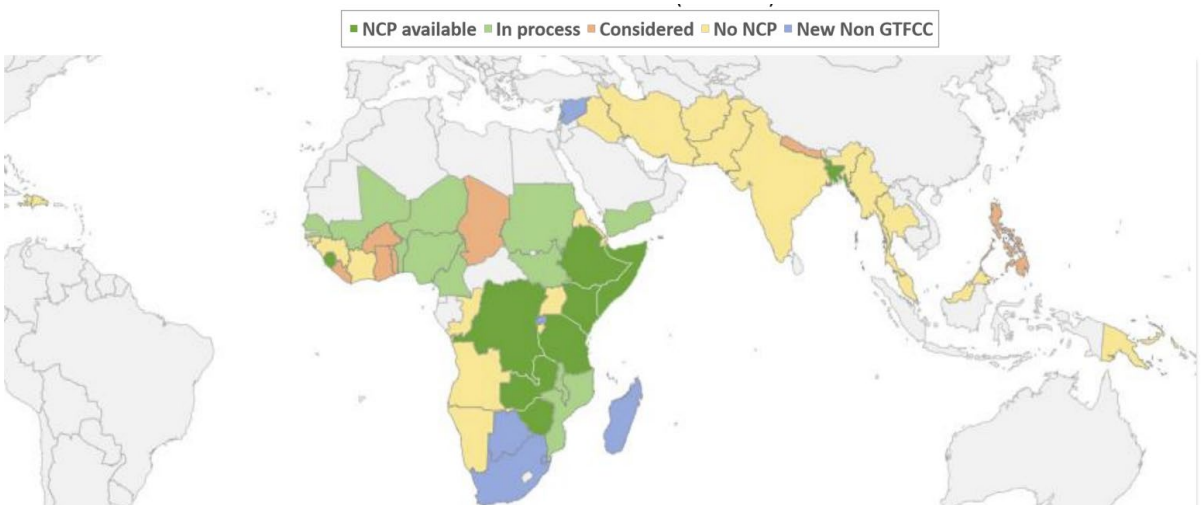
As per GTFCC documentation, Axis 3 focuses on (i) NCP development, (ii) advocacy and resource mobilization, (iii) research and (iv) coordination of the GTFCC and its internal structures (i.e. coordination of work between the Secretariat and CSP, coordination of IRP reviews, preparation of Steering Committee meetings, collaboration between the Secretariat, WGs and CSP and coordination of the network as a whole). These are discussed in turn but several of the previous findings have touched on a number of these issues from a relevance, coherence and efficiency perspective. This section provides some further findings from an effectiveness lens – i.e. what have been the observed results from the coordination and technical exchange, advocacy and resource mobilization

efforts and research activities of the GTFCC. These are based largely on GTFCC documentation and supported by stakeholder interviews.

Finding 4.6: some countries have developed NCPs with GTFCC support. NCPs are considered a foundational framework towards a more strategic and holistic approach for cholera interventions across pillars. Yet there has been limited progress in the implementation of these NCPs.

The **development of NCPs** is a core course of action recommended in the Roadmap to enable the implementation of Axis 2. In total, ten countries have finalized their NCPs with the support of the GTFCC as of 2024, eight were developing their NCPs, and seven were considering NCPs.[63] Fig. 15 shows the NCP status across countries, with African countries having more NCPs available than other regions.

Figure 15: GTFCC NCP status across countries[64]



The aim of these NCPs is to help "break the silos at national and global levels to implement integrated, multisectoral actions in cholera hotspots… by elevating cholera as a priority in affected countries *(6)*. The majority of stakeholders interviewed believe that the NCPs are very important to provide a foundational framework to enable a more strategic and holistic approach for cholera interventions across all pillars. In a number of countries reviewed as part of this evaluation, NCPs have been developed in a collaborative way with partners across relevant sectors, especially health and WASH (e.g. Democratic Republic of the Congo, Nigeria), which fosters strong buy-in and engagement across sectors and promotes a multisectoral approach to cholera implementation (see Box 2.11 and 2.12 on Nepal and Kenya's NCP development).

[63] Steering Committee, GTFCC, Meeting: Secretariat presentation June 2024. Details regarding how this support was delivered and by whom are not provided. However, based on country case studies, this support was reportedly provided by the Secretariat and CSP (the latter just in CSP countries), and the IRP also provided feedback on some draft NCPs.
[64] Steering Committee, GTFCC, Meeting: Secretariat presentation, June 2024.

Box 2.11. Nepal NCP development process

In Nepal, the recent NCP development process has enabled the deliberate consideration of a comprehensive Roadmap for the first time and has facilitated active engagement across stakeholder groups and sectors, which will take time and effort to operationalize – especially as the NCP is still seen very much seen as a "Health Plan" and is not "owned" by the WASH Ministry. The NCP has also helped to secure alignment for key cholera responses, such as OCV campaigns, which are seen as key priority in high-risk districts in the coming years. One stakeholder 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".**

Box 2.12. GTFCC support was considered instrumental in developing Kenya's 2022–2030 Kenya National Multisectoral Cholera Elimination Plan and other cholera response priorities.

Technical support by the IRP for the Kenya National Multisectoral Cholera Elimination Plan review was said to have been timely and helpful, especially to strengthen the NMCEP alignment with the Global Roadmap. Additionally, Secretariat coordination support during the IRP review process of the Cholera Elimination Plan (through coordinating biweekly meetings attended by GTFCC members, the WHO Country Office, Washington State University and ministry staff) was viewed as contributing to an efficient review process. Regular check-ins also helped to identify additional needs for further support. As one stakeholder said, "The Secretariat really helped to push the [Kenya National Multisectoral Cholera Elimination Plan] review process, especially during the COVID period."

With respect to Kenya's Cholera Elimination Plan, other relevant national plans (e.g. from the WASH sector) as well as county-level strategic plans are not explicitly aligned – suggesting there is scope for much greater integration and harmonization. For example, the 2023–2030 National Costed Kenya Rural Sanitation and Hygiene Roadmap, another comprehensive national strategy from the Ministry of Health that outlines national priorities for WASH in rural areas of the country, makes no reference to the Cholera Elimination Plan or to cholera. Some stakeholders shared that a lack of wider involvement at design stage was a missed opportunity to have both strong endorsement of the Cholera Elimination Plan across all partners and intentional alignment of their activities and priorities with the Plan.

However, whilst NCPs provide a good starting point, many stakeholders have also been asking "what's next", as many countries that have NCPs continue to be highly impacted by cholera outbreaks and make poor progress on preparedness and prevention interventions. There has been slow progress on the implementation on NCPs in most countries especially due to a lack of funding, particularly for preparedness interventions and effective WASH service delivery for prevention *(45)*. For example, a stakeholder pointed to ongoing challenges in the Democratic Republic of the Congo: "Whilst [the Democratic Republic of the Congo] has prepared 5-year cholera control plans three times, going back 15 years or more, the cholera context in the country remains largely unchanged". The same observation was made in Kenya, where it is unclear how the development of the new NCP supported by the GTFCC considered the challenges faced in the implementation of previous cholera plans and how to mitigate them. Across the country case studies for this evaluation, several challenges were noted with NCP implementation:

- **Lack of adequate funding:** In 2017, the GTFCC estimated that more than 80% of affected countries had insufficient financing to meet their WASH targets *(6)* . This trend continues to date as most stakeholders believe that resourcing for NCPs is inadequate, especially for WASH services. The GTFCC Secretariat has also continuously flagged insufficient funding for NCP implementation and/or cholera-related operations over the years *(45)* .[65] However, there are no data providing a holistic view of NCPs funding status to ascertain the funding gaps across countries and the difference between funding allocated to outbreak responses versus preparedness and prevention activities. Support for resource mobilization for NCPs is part of the GTFCC and CSP objectives, but remains challenging in view of national priorities, political commitment levels and limited funding options, which are suboptimal in some contexts.[66]
- **Limited focus outside of outbreaks and challenge in collaborating across health and other sectors in countries:** Despite the availability of NCPs, many stakeholders have flagged that investments in cholera interventions are mostly restricted to outbreaks, highlighting the limitation that while NCPs exist, they may not translate into sufficient attention and investments for health and WASH systems strengthening. In addition, many shared that cholera priorities often fail to be integrated into other country plans across relevant sectors. Whilst NCPs are created with high-level political endorsement across the ministries in the relevant sector, many stakeholders believed that NCPs remain mostly the responsibility of the ministries of health and health partners as other sector actors fall short in being accountable for progress made against the NCP.
- **Gaps in M&E:** There also are gaps in M&E and reporting mechanisms, which hinder oversight of progress across countries (as discussed above).

Finding 4.7: Despite efforts in advocacy and resource mobilization to keep cholera on the global health agenda and foster political commitment, both remain weak areas where progress is critical.

One of the key objectives of the GTFCC is "increasing the visibility of cholera and conducting advocacy and resource mobilization". The GTFCC (under the steering of the Secretariat) has worked to keep cholera on the global health agenda. In particular, it has managed to foster high-level political commitment across health ministries of Member States and global health leaders through its advocacy during high-level meetings, such as the World Health Assembly and its side events *(46)*.[67] This has, for example, contributed to the adoption of the 71st WHA resolution *(47)* in 2018 urging cholera-affected countries to implement the Ending Cholera Roadmap and asking global health actors such as WHO to reinforce leadership and coordination of global prevention and control efforts and increase capacity to support countries in the fight against the disease.[68] At the 2023 United Nations Water Conference on World Water Day, the GTFCC Steering Committee appealed to countries and the international community to take concrete action *(48)*.

But, over time, on account of both external factors – such as the prominence of other health issues (e.g. COVID-19) – and internal factors (limited resources and capacity in the Secretariat to coordinate and support further

[65] GTFCC, 11th GTFCC General Assembly: Overview of progress made towards the 2030 targets: Secretariat presentation, 2024.
[66] GTFCC, Progress report, September 2020–June 2021.
[67] Advocacy & Communications Task Team, GTFCC, 12-month workplan, 2023.
[68] Steering Committee, GTFCC, Terms of reference, 2019.

advocacy and resource mobilization work, limited reach of the Steering Committee, limited reach from the CSP's work, etc.), **limited progress has been made**. Some stakeholders have commented that the advocacy activities have been started but not pursued actively due to limited bandwidth within the GTFCC. Box 2.13 highlights recent progress through an Advocacy Task Team, which, the evaluators were informed during the interviews, has now also stalled.

Box 2.13. Work by the Advocacy Task Team

As detailed in KIIs, an Advocacy Task Team comprising a number of representatives from the CSP, Secretariat and select partners was established in 2022 to amplify GTFCC's efforts on advocacy. The Task Team sought to detail a results framework for the GTFCC, identify key progress areas and highlight key messages for advocacy purposes. A detailed workplan was also developed with priority objectives to fundraise for the GTFCC, political engagement and for activities at the country level, including increased emphasis on WASH, etc., with time frames and partner responsibility accorded to each. Some progress monitoring was also conducted in 2023.[69] Later in 2023, a meeting was held that recognized the gaps in the workplan and the need to re-think the advocacy approach. In 2024, the need for external consultants was reaffirmed in order to aid capacity of the GTFCC Secretariat and CSP in terms of advocacy and resource mobilization efforts. A renewed Advocacy Framework was developed with a very different approach from that developed in 2022. The renewed framework focused on policy dialogue, mapping and engaging donors, managing the GTFCC membership, updating the website and other communications management. Additional efforts are needed to implement the results framework and associated activities.

Multiple key informants highlighted significant weaknesses in the GTFCC's engagement of partners outside the health sector, which has limited its ability to drive high-level political commitment in other relevant decision-making forums, such as UNGA, COP, WASH forums, etc. Despite ongoing efforts by the GTFCC and its Advocacy Task Team, the majority of stakeholders believed that GTFCC advocacy remained too health-focused (e.g. overreliance on WHA) and fell short of enabling effective awareness-raising across other relevant sectors. There has also been a lack of consideration around how cholera could be tied to other frameworks or donor priorities. In general, cholera advocacy remains on the backfoot with one stakeholder stating, "Cholera is (one of) the biggest health emergency that no one ever hears about."

Linked to this, fundraising and resource mobilization for cholera have been key areas of weaknesses with resource mobilization for cholera and the GTFCC having reached critical and unsustainable levels (as discussed in several places in this report). Stakeholders highlighted the importance for the GTFCC to develop a comprehensive fundraising strategy to mobilize sufficient resources for cholera interventions at country level as well as financial resources for the GTFCC to operate as the main coordination mechanism for the Roadmap. The

[69] From a review of the progress monitoring tool, it appears that most progress assessment by the Task Team was judgement-based.

lack of such a strategy has led to engagement often being reactive with no strategy towards key events, therefore limiting resource mobilization.

Finding 4.8: Progress has been made in cholera research with the benefit of dedicated funding for research. There is a need to ensure the GTFCC research agenda links well with country research agendas.

There has been some progress on developing the research agendas within GTFCC; however, some have questioned its importance vis-à-vis other GTFCC priorities, especially in a resource-constrained environment. Therefore, the need to concentrate on country research agendas, which often focus on operational research, was highlighted in the e-survey and consultations.

The GTFCC's research workstream, launched in 2023 with funding from the Wellcome Trust, seeks to address critical gaps in cholera research, improve knowledge translation and support evidence-based decision-making at both global and country levels *(20)*. Its focus includes fostering collaboration within the cholera research ecosystem, enabling countries to integrate research findings into their NCPs and identifying and addressing research gaps through a structured agenda. The launch of the Cholera Research Tracker, an interactive online database featuring information on 62 research projects across 24 countries, further enhances these efforts *(20)*. The tracker enables stakeholders to identify trends, address gaps and promote collaboration in cholera research.

At the global level, a major initiative has been a scoping review to track progress against the global research agenda. As of June 2024, 12,000 articles published from 2017 had been screened, with 587 selected for inclusion in the final analysis for publication *(20)*. The findings are expected to provide a comprehensive overview of global cholera research, helping to identify gaps and align efforts with the GTFCC's objectives. Preliminary findings noted that Bangladesh is conducting more studies than any other country, with a strong focus on surveillance.

At the country level, the GTFCC research workstream has provided significant support for national research initiatives. In Zambia, a workshop in 2023 helped refine cholera research priorities to support the development of the country's NCP. The GTFCC also supported a pilot study on case-area targeted interventions in Zambia. In the Democratic Republic of the Congo, a scoping review identified evidence gaps in cholera control efforts, and the GTFCC research workstream has also provided support to develop a research database to incorporate evidence into activities of the country's NCP. Regional collaboration was further promoted through conferences in Mozambique and the Democratic Republic of the Congo, which facilitated the sharing of lessons learned. Notably, the CSP also promoted country-level research by hosting workshops in Kenya in 2024 focused on evidence for the use of OCV *(20)*.

Despite these achievements, there is room for more targeted improvement. A key challenge is a lack of resource mobilization and funding for locally led research *(20)*. In addition, the process for developing the research agenda has also faced limitations, such as the lack of systematic literature reviews and limited country-level representation during priority-setting. While the CSP has strengthened the engagement of country stakeholders, further efforts are needed to ensure the early involvement of country-level stakeholders in research initiatives to enhance uptake.

Finding 4.9: The GTFCC has successfully served as a forum to develop technical guidance and tools (including NCP guidelines, PAMIs, case management methodologies, the multiannual OCV plan) through the working groups. This has helped align approaches between partners and countries, although there is scope to improve awareness at the country level.

Overall, stakeholders consider that the GTFCC plays an important role in enhancing technical knowledge among partners, especially at the global level and improving at the country level. This derives particularly from the work developed by the WGs, including the WG chairs and WG focal points (who are WHO Cholera Programme staff) and members of WGs, and supported by the Secretariat.

Respondents highlighted the utility of the GTFCC's technical guidance, especially in terms of supporting countries with tools like the NCP guidelines, PAMIs, case management methodologies and the multiannual OCV plan. The web annexes contain a breakdown of key guidance documentation produced by the GTFCC.

The key points below, drawn from the WG updates section of the GTFCC's 11th Annual Meeting Report, highlight achievements and outputs related to technical guidance and support across WGs *(20)*.

- The Case Management WG has contributed to treatment for cholera, notably by developing guidance on antibiotic use in cholera treatment, which incorporates the risks associated with certain high-risk populations, such as the elderly, and enhancing data collection protocols through the development of a dedicated Cholera Case Report Form (a template providing support for standardizing reporting). This WG has also expanded on antibiotic use research, including efforts to model the impact of expanded antibiotic use on cholera transmission and undertaken a scoping review, which highlighted the need to improve access to treatment, quality of treatment and data collection. Furthermore, ORP (Oral Rehydration Point) guidance was developed, as well as a series of job aids. The WG is collaborating with key technical partners such as UNICEF to conduct a literature review and revise treatment guidelines for highly vulnerable populations, such as children with severe acute malnutrition.
- The Epidemiology WG has focused on advancing cholera surveillance, with key achievements including the publication of guidance for public health surveillance and the development of PAMI identification guidance in 2024. The interim recommendations published by this WG on metadata sets for regional and global cholera reporting directly supported cholera surveillance strengthening activities of the WHO cholera ncidence Management Support Team.
- The Laboratory WG has made progress in the development of technical guidance for cholera diagnostics, publishing surveillance guidelines that incorporated RDTs, culture and polymerase chain reaction used for outbreak detection and monitoring. In addition, practical tools and guidance for laboratories such as job aids fact sheets and laboratory forms were developed. The WG is also collaborating with key technical partners such as the CDC to develop materials to support training-of-trainers programmes in multiple priority countries on laboratory diagnostics.
- The OCV WG has seen considerable success in supporting countries in developing multiyear OCV vaccination plans and submit successful OCV requests for reactive vaccination campaigns. For example, in 2024 DRC's application for OCV was rejected. In response, WG partners collaborated closely with national stakeholders to support to address key issues in the application, which was subsequently approved. The WG supported three regional workshops in Africa and South-East Asia to provide training to representatives from 16 countries to improve the quality of OCV application requests (both outbreak response and preventative applications).
- The WASH WG has focused on integrating WASH measures into cholera prevention, utilizing global health platforms to conduct advocacy and raise the profile of cholera initiatives and publishing

guidance, including an environmental surveillance guidance document in partnership with the Laboratory WG. The WASH WG has co-hosted events and conducted presentations at the UN Water Conference and African Union to raise the profile of WASH initiatives.

In addition, the GTFCC website has been overhauled in recent years and now includes many resources across different subject areas and also a research database with information on ongoing research projects across different areas relevant for cholera. As part of the development of the Roadmap, the GTFCC developed a phone-based application containing technical information and practical documents to provide guidance and up-to-date information in cholera control *(49)* . An example of transversal work, the app contains technical information and practical documents from several pillars and supports monitoring the uptake of tools.

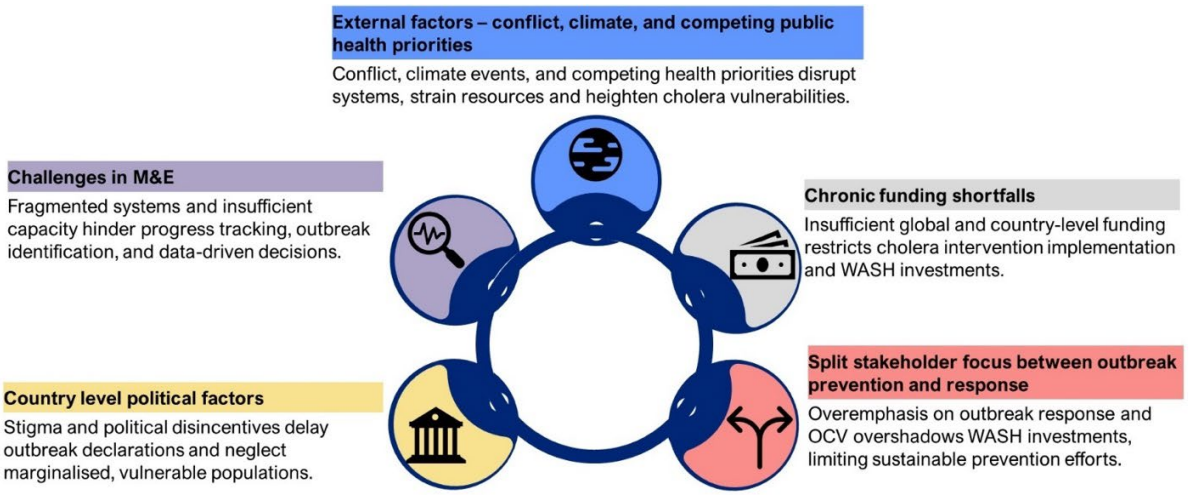
In general, the consultations with WGs at the global level provided reference to several different guidances and documentation produced by each WG. However, consultations with country -evel stakeholders indicated awareness and use of a select number of guidance documents, especially on NCP development and PAMI identification, as well as the GTFCC app, which were all noted to be beneficial by country stakeholders. The app was highlighted most often for its usefulness and has been appreciated by many stakeholders, including for its practical application (e.g. around aspects like case management). Many of the country stakeholders interviewed across the six country case studies were not aware of the longer list of GTFCC guidance documents and did not know how to access them. Given limited awareness of the GTFCC as well amongst certain country stakeholders, multiple avenues are used to share information at the global, regional and country levels in addition to the GTFCC website, which is being updated. The GTFCC Secretariat also disseminates tools and guidance through GTFCC mailing lists as well as to WHO regional and country-office presentations or at meetings or during trainings.

2.4.5. Factors and opportunities affecting roadmap implementation

Finding 4.10: A range of external and internal factors have influenced the implementation of the roadmap, notably conflicts and other political factors, impact of climate change and funding shortfalls. The challenges with GTFCC functioning present both an issue but also an opportunity for reform.

Fig. 16 presents the main key factors affecting the implementation of the Roadmap followed by a summary discussion of each factor based on the evaluators' analysis. This analysis refers to factors affecting progress on the outputs and outcomes in the ToC.

Figure 16: Factors affecting Roadmap implementation



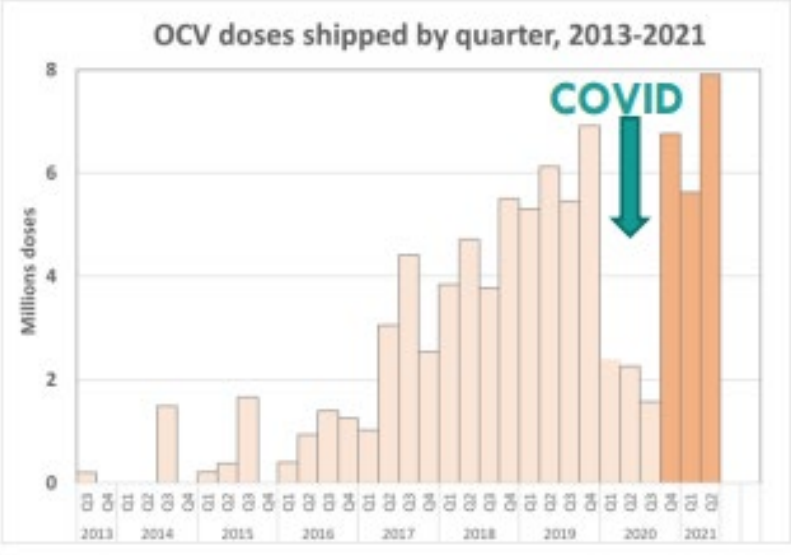
External factors – conflict, climate and competing public health priorities: The implementation of the Roadmap has been significantly affected by external factors including conflict, climate-related challenges and competing public health priorities. There has been a rise in conflict globally, including many conflicts that involve non-state actors such as political militias, gangs and international terrorist groups (such as in the Democratic Republic of the Congo, Haiti and Nigeria) as well as unresolved regional tensions that have led to a breakdown in state institutions and internal conflicts (e.g. Lebanon) *(50)* *(51)*. This rise in conflict has had a significant impact on cholera due to breakdown of governance, infrastructures and systems and an increase in displacement, poverty and malnutrition that augment population vulnerability and complicate the delivery of humanitarian aid and public health interventions. In 2024, the GTFCC estimated that of the 24 countries affected by cholera since January 2024, 46% were also impacted by acute or protracted conflict.[70] A recent study has also demonstrated that conflicts increased the risk of cholera in Nigeria by 3.6 times and in the Democratic Republic of the Congo by 2.6 times and estimated that 19.7% of cholera outbreaks in Nigeria and 12.3% of outbreaks in the Democratic Republic of the Congo in 1997–2020 were attributable to conflicts *(52)* .

The impact of climate-related events and natural disasters on cholera is increasingly evident in cholera outbreaks. Across multiple countries, extreme weather events such as cyclones (e.g. Malawi, Mozambique), floods (e.g. Bangladesh, Haiti, Kenya, Nigeria) and droughts (e.g. Horn of Africa) have increased the risks of cholera in communities and intensified transmission of cholera (environment to human, as well as human to human) by affecting water supplies (e.g. overflow of wastewater during floods, limited access to water during droughts) and exacerbating living conditions *(53)*. Natural disasters such as large earthquakes have also been associated with increased risk of cholera outbreaks due to population displacement, damage to sanitation and health infrastructures and limited access to clean water resources *(54)*. This was the case in Haiti, which experienced its first cholera outbreak in 2010, after a devastating earthquake that killed over 200 000 people and displaced over 1 million, an outbreak which lasted for almost a decade before ending in 2019.[71]

[70] Steering Committee, GTFCC,Meeting: Secretariat presentation, June 2024.
[71] CDC (2024). Office of Readiness and Response. Haiti Cholera Outbreak.

Finally, global and country-level stakeholders have highlighted the increasing number of competing priorities at global and country level, which have significantly undermined delivery of cholera interventions, especially preparedness and prevention efforts. Other priorities have often led to cholera efforts being sidelined and diverted attention away from cholera-specific interventions. This was demonstrated during the COVID-19 pandemic when countries had to cancel or postpone their OCV campaigns at the start of the pandemic, as resources shifted to tackle COVID-19.[72] Whilst countries were able to adapt rapidly and put in place strategies to maintain reactive OCV campaigns later with the support of the GTFCC, this impacted the number of doses shipped in 2020 (see Fig. 17 below).[73]

Figure 17: Early impact of COVID-19 on OCV 2013-2021[74]



Chronic funding shortfalls: As described in sections above, insufficient funding at both the global and country levels has severely constrained the implementation of cholera interventions. WHO's appeal for cholera has remained underfunded in recent years, as global attention and resources have been diverted to address other competing crises such as COVID-19.[75] OCV is strongly financed by Gavi and BMGF, and many stakeholders recognized this as a strength but also noted that a similar amount of funding needs to be available for other pillars. Global funding for WASH, a critical component of cholera prevention, has seen a significant decline as a proportion of overall aid investment in recent years *(55)*. A 2023 WaterAid report highlighted a 15% decline in aid to the water supply and sanitation sector between 2020 and 2021, compared to a 4% decline in energy, while reproductive health and education saw increased investments ranging from 2 to 11% *(55)*. At the country level, stakeholders consistently highlighted insufficient funding and resources as a major barrier to implementing the Roadmap. While acknowledging that public sector efforts towards cholera-focused interventions could be strengthened, they emphasized that governments in the Global South cannot shoulder the investment costs

[72] Steering Committee, GTFCC, Meeting, September 2020.
[73] Ibid.
[74] Secretariat, GTFCC, Progress report, 2021
[75] Steering Committee, GTFCC, Meeting: Secretariat presentation, June 2024.

alone and require support from international partners. In addition, limited funding for the GTFCC has significantly hindered its ability to support countries and deliver on its objectives as described above.

Split stakeholder focus between outbreak prevention and response: The dichotomy of funding and stakeholder focus between reactive outbreak response and long-term prevention, particularly regarding OCV and WASH, presents a significant challenge to comprehensive cholera control. The reliance on OCV as a "silver bullet" is exacerbated by limited vaccine supply, with only one manufacturer in the market, and a unique source of funding for reactive and preventative OCV. This bottleneck has created critical gaps in outbreak response and reduced the capacity for preventative campaigns. Reactive campaigns have dominated the allocation of OCV, with 100% of approved OCV requests in 2023 targeted towards reactive campaigns *(22)* . Stakeholders interviewed have raised concerns about the shorter-term protection offered by single-dose, reactive campaigns, leaving insufficient time to strengthen WASH systems before the next outbreak.

Many stakeholders also highlighted the disparity in support for WASH service delivery to endemic countries or hotspots, which continue to face significant funding and implementation gaps despite their importance. Effective WASH services often lack the financial backing and institutional prioritization required to address systematic issues, such as inadequate infrastructure and hygiene services. Many stakeholders stated that the GTFCC and its key partners' technical expertise in health care leads to a disproportionate emphasis on health responses to cholera, with WASH deprioritized and siloed. Stronger support for WASH and a more integrated approach to cholera control is required to make further progress towards cholera prevention and elimination.

Country-level political factors: At the country level, political factors pose significant challenges to cholera prevention and control efforts. Stakeholders highlighted that political officials are often reluctant to formally declare cholera outbreaks due to the stigma associated with the disease. Cholera is closely linked to poor hygiene standards and inadequate infrastructure, which can project an image of underdevelopment and reflect poorly on political and economic leadership. Furthermore, as cholera disproportionately affects marginalized and impoverished communities, the political cost of inaction remains low. These populations are often not politically influential, enabling leaders to deprioritize cholera response without significant repercussions, further exacerbating the cycle of neglect and delayed interventions. As a result, the question of commitment to invest to address cholera remains critical at country level.

Challenges in M&E: The lack of adequate M&E of the Roadmap has significantly impacted the GTFCC and countries' ability to track progress and use data to inform decision-making on cholera elimination efforts. A 2024 review by the GTFCC of the M&E framework for the Roadmap highlighted a disjointed approach to implementation, with unclear roles, fragmented responsibilities across stakeholders and limited accountability.[76] This has hindered the effective tracking of cholera outbreaks and evaluation of interventions.[77] A number of key informants corroborated these findings, noting that GTFCC-led M&E efforts are often spread across multiple stakeholders including GTFCC structures and partners and national ministries of health. This fragmentation has at times resulted in inconsistent data-reporting and a lack of certainty on progress.

While the GTFCC has supported the development of several M&E tools, including the Global Roadmap Monitoring Framework, the NCP interim guiding document for the development of NCPs, the GTFCC interim cholera regional and global reporting technical recommendations and the GTFCC OCV dashboard, their use is

[76] GTFCC, M&E framework assessment, 2024.
[77] Ibid.

not consistent among stakeholders *(56)*.[78] The OCV dashboard *(22)* is a strong example of how a well-designed and adequately resourced tool can support transparency and data-sharing and inform decision-making (recognizing the specific context of monitoring vaccines).

At the country level, stakeholders highlighted a lack of capacity (including resourcing and political commitment) to analyse and use available data for cholera planning and interventions. These factors have limited countries' ability to respond to outbreaks rapidly, making it difficult to identify and address emerging hotspots, leaving populations at increased risk from cholera. While Section 2.4.2 highlights notable progress in early warning surveillance systems, laboratory capacity and data-sharing, including improvements in cholera recognition and reporting, enhanced use of RDTs and better data-sharing through tools such as SitReps, challenges remain. In particular, stakeholders noted that there has been insufficient resourcing and funding directed towards M&E; greater political commitment is required at both the country and global level.

Challenges and opportunities with GTFCC: A number of challenges with the functioning of the GTFCC have been highlighted in the previous sections, including the lack of a strategy and workplan, a range of issues with different GTFCC structures, challenges with M&E, etc. However, overall, these challenges also present an opportunity for reform and improvement as per the range of recommendations provided in Section 4 of this report. The GTFCC has a long history of coordinating the cholera response, and given the Roadmap, significant strides in improving its country engagement, several high-quality technical guidance documents and an overall base for partner engagement, there is room to enhance the impact of the GTFCC.

Other opportunities: Despite the noted funding shortfalls, there is scope to improve resources for cholera by better integrating with other diseases and work on epidemic control and enhancing evidence-based advocacy and resource mobilization efforts, e.g. through investment cases. This is reflected in the range of recommendations provided in Section 4. There is also a good base for cholera responses across several countries, given the progress made on developing NCPs and cross-functional teams to coordinate cholera responses at the country level (as described in more detail in specific country case study reports). Several GTFCC partners are working actively at the country level, and there is an opportunity to enhance their coordination under the GTFCC umbrella by more impactful advocacy work through the GTFCC.

2.5. Sustainability

The evaluation criterion of sustainability examines the degree to which the GTFCC Roadmap and interventions have incorporated measures to ensure the long-term sustainability of cholera control efforts. Table 2.6 presents the key findings.

[78] Ibid.

Table 2.6. Summary findings for sustainability

Summary finding on sustainability Although sustainability of cholera response is a core objective of the GTFCC Roadmap, sustainability considerations are not fully embedded within GTFCC planning and activities, especially long-term WASH and funding for cholera. Limited progress on advocacy to increase the visibility of cholera and on resource mobilization poses a risk to overall sustainability.		
Finding 5.1: The Roadmap emphasizes sustainability including long-term WASH, capacity-building and government-led cholera response. Key aspects underpinning sustainability remain insufficiently embedded in GTFCC planning and activities, notably WASH, advocacy and resource mobilization. Overall funding for the cholera response and the GTFCC itself is at a critical level and may compromise sustainability of progress made to control cholera, particularly given the risks of impending funding shortfalls.	Limited	Based on review of the Roadmap, and majority of stakeholder consultations, country case studies and e-survey feedback. Limited quantitative data to support finding.
Review against ToC: A review of the GTFCC ToC indicates that one of the key assumptions for results, namely "adequate funding and human resources available", has not yet been borne out in practice.		

7. What steps has the GTFCC taken to ensure the sustainability of its interventions under the Roadmap?

Sustainability is essential in health and development, and it requires long-term planning and the strengthening of institutions and systems to foster durable improvements in health outcomes.

To address the question of sustainability, evaluators considered two main areas. Firstly, the extent to which the Roadmap promoted sustainable cholera interventions, with specific emphasis on WASH, capacity-building and NCPs. Secondly, the extent to which steps have been taken by the GTFCC to ensure the sustainability of progress in terms of financial, programmatic and environmental considerations, drawing on data from stakeholder consultations, country case studies and e-survey responses.

Finding 5.1 The roadmap emphasizes sustainability including long-term wash, capacity-building and government-led cholera response. Key aspects underpinning sustainability remain insufficiently embedded in GTFCC planning and activities, notably wash, advocacy and resource mobilization. Overall funding for the cholera response and the GTFCC itself is at a critical level and may compromise sustainability of progress made to control cholera, particularly given the risks of impending funding shortfalls.

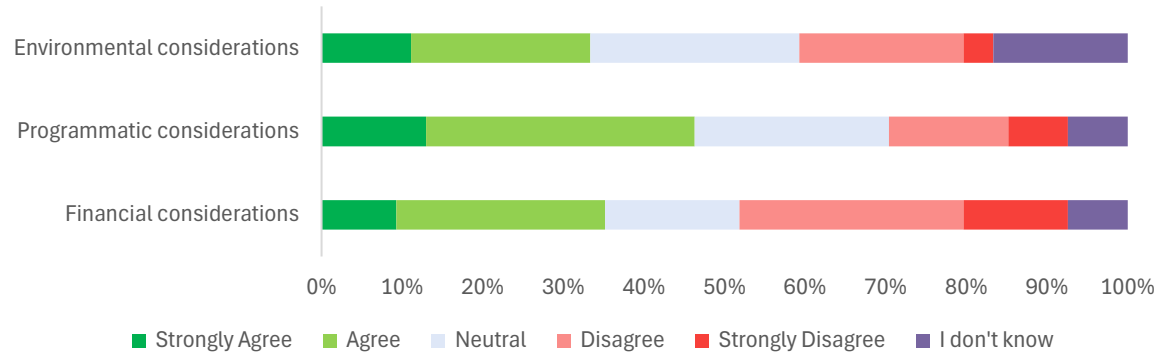
The GTFCC Roadmap emphasizes a sustainable approach towards cholera responses by advocating for multisectoral, long-term interventions targeting the root cause of transmission. Key elements include promoting sustainable WASH infrastructure development and accessibility, capacity-building and institutionalizing government ownership of cholera response through NCPs. The GTFCC Roadmap advocates for the development of infrastructure to provide access to safe drinking water, sanitation and hygiene facilities in areas vulnerable to cholera outbreaks. Furthermore, the Roadmap acknowledges that countries impacted by conflict and political instability face significant challenges in establishing sustainable WASH services, with these fragile settings requiring a response that is more focused on achievable and immediate mortality reduction, rather than

elimination. On capacity development, the GTFCC Roadmap incorporates a dual approach to strengthening health care systems at the country level. This approach as outlined in the document involves building local capacity to respond to cholera outbreaks through the provision of comprehensive training for health sector staff while also ensuring the availability of essential resources, such as cholera diagnostics and therapeutics. NCPs, featured as a component of cholera response in the Roadmap, are policies developed with a broad coalition of stakeholders but are ultimately government-owned and led. This approach embeds cholera control within national priorities, providing a platform for long-term sustainability *(6)*.

However, despite the Roadmap's incorporation of long-term WASH, capacity-building and government-led cholera response, stakeholder feedback consistently questioned the extent to which sustainability considerations were embedded within GTFCC planning and activities. Several stakeholders interviewed noted that sustainability did not appear to be a core component of the GTFCC's operational model, with some expressing the view that the Task Force's engagement with some key aspects underpinning sustainability were insufficient in practice, namely WASH, advocacy and resource mobilization.

Concerns regarding financial sustainability were raised in terms of cholera implementation efforts and funding for the GTFCC itself, particularly regarding the risks of impending funding shortfalls and the potential effect on maintaining cholera control progress. This feedback was reflected in the e-survey results. Fig. 18 below shows responses from global, regional and multi-country stakeholders when asked whether the GTFCC Roadmap and interventions adequately considered environmental, programmatic and financial considerations. Only 46% of respondents agreed that adequate programmatic sustainability considerations were applied, with fewer than 40% of respondents agreeing with regard to environmental and financial considerations.

Figure 18: E-survey responses from global, regional and/or multi-country stakeholders on the adequacy of sustainability considerations in the GTFCC Roadmap and interventions (n=54)



Overall, while the GTFCC Roadmap outlines a framework for sustainable cholera control through multisectoral interventions and government-led responses, stakeholder feedback indicates a gap between these intended strategies and practical implementation. Box 2.14 provides examples regarding sustainability in country case studies.

Box 2.14. Areas of progress and challenges with regards to sustainability in country case studies

Overall, findings from country case studies highlighted financial sustainability to be the biggest concern at the country level. In terms of programmatic and environmental sustainability, the following aspects were found:

Programmatic sustainability

- **Democratic Republic of the Congo**: Some partner organizations contribute to sustainable surveillance and treatment systems, not only for cholera but also for other epidemics. For instance, the **Case-area targeted intervention (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 programme management.
- **Haiti**: The challenging political context limits long-term planning, hampering programmatic sustainability.
- **Kenya**: An **example** of good practice **that stakeholders highlighted is the use of community- and other health promoters to sustain interventions**. This includes **RCCE and behaviour change in communities beyond outbreak responses**.
- **Nepal**: Sustained advocacy was recognized to be important, and two key advocacy areas commonly highlighted were: (i) advocacy to high-level government officials to maintain cholera as a priority issue and (ii) advocacy to increase and maintain domestic and international financing for NCP implementation**.** Gaps in multisectoral coordination, particularly across the spectrum of prevention, preparedness and response, were seen to threaten sustainability.
- **Nigeria:** 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.
- **Somalia:** 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.

Environmental sustainability

- **Haiti**: 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.[79]

[79] UNICEF and DINEPA (2024). Haiti WASH sector emergency briefing.

2.6. Gender, equity and human rights

This evaluation criterion is focused on assessing the extent to which GER considerations have been included in the GTFCC Roadmap and corresponding implementation activities. Table 6 presents the key findings.

Table 6: Summary findings for GER

Summary finding on GER The Roadmap addresses economic inequities in cholera response but does not address other aspects of GER, such as gender and human rights, to the same extent. There is a need for stronger, more explicit engagement with GER principles to better target the most vulnerable populations.		
Finding 6.1: While the Roadmap explicitly highlights the correlation between poverty and increased risk, it does not incorporate a specific emphasis on gender and human-rights considerations. There have been examples of progress at country level in addressing geographical and economic inequities, but there is room for stronger, more explicit engagement with GER (i.e. more disaggregated data by gender, more explicit and systematic integration in monitoring frameworks and implementation strategies).	Limited	Based on overall limited generalizability of findings based on the review of the Roadmap, country-level document review and the majority of stakeholder, e-survey and country case study feedback.

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

Finding 6.1. While the roadmap explicitly highlights the correlation between poverty and increased risk, it does not incorporate a specific emphasis on gender and human-rights considerations. There have been examples of progress at country level in addressing geographical and economic inequities, but there is room for stronger, more explicit engagement with ger (i.e. more disaggregated data by gender, more explicit and systematic integration in monitoring frameworks and implementation strategies).

Engaging with, and addressing, GER concerns is crucial across all health initiatives, both within cholera response efforts and in broader health contexts. Incorporating GER considerations into initiatives facilitates the development of more inclusive, equitable and responsive interventions that better meet the needs of all individuals, particularly those who face structural barriers. In the case of cholera, equity considerations, particularly economic factors, are inherently relevant as the disease disproportionately impacts the poorest and most vulnerable communities *(57)*.

In support of the review of this EQ, evaluators examined (i) the extent to which GER concerns were reflected in the GTFCC Roadmap and (ii) its implementation at the global and country levels, including within country case

study countries. This included evaluating the extent to which data collection and analysis have incorporated disaggregated data based on age, gender, equity, disability, IDP status and geographical location, and whether such data are used to support prevention and response policies. This document and data review was supplemented by stakeholder consultations and e-survey responses, which helped triangulate findings and strengthen conclusions.

Firstly, in terms of a review of the Roadmap, it proposes mitigations to key risks arising from unexpected events that increase the risk of cholera, such as conflict or natural disasters. These include developing a robust monitoring system based on indicators that can trigger increased support from the GTFCC in response to heightened risks, such as health system disruption or an increase in the number of IDPs. It also highlights the systematic use of OCV for refugees and other displaced population in high-risk areas *(6)*. While these measures demonstrate awareness of equity considerations for vulnerable populations, the Roadmap does not include a direct plan for the implementation of these proposed high-level, risk mitigation strategies.

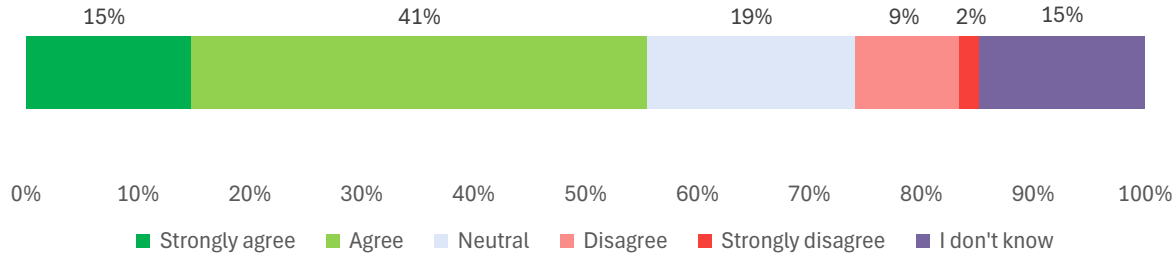
The GTFCC Roadmap explicitly identifies and acknowledges the vulnerability of impoverished communities to cholera, highlighting the correlation between poverty and increased risk *(6)*. The Roadmap's multisectoral approach to cholera prevention and control, coupled with a strategic focus on PAMIs (originally referred to in the Roadmap as hotspots), aligns closely with GER principles by prioritizing areas most affected by socioeconomic disparities. Notably, PAMIs are areas that face recurrent outbreaks, with high cholera burdens and limited access to health care and adequate WASH services. The Roadmap lays out a strategy to address these areas through a combination of OCV and WASH interventions. While OCV serves as an immediate response to disrupt transmission cycles, it aims to allow the necessary time to implement long-term WASH solutions in these underserved areas, advancing GER objectives by addressing both immediate health needs and foundational inequities in water and sanitation access.

However, while the Roadmap more directly engages with issues of economic inequity, it does not incorporate a specific emphasis on gender and human rights considerations. The Roadmap frequently references poverty, access and economic inequities, aligning with its focus on addressing the vulnerabilities of impoverished communities, but mentions of other GER-related dimensions are sparse. For example, gender is only mentioned once, in the context of social benefits from WASH investments, and human rights also appears just once, in a reference to access to water and sanitation*(6)*. The roadmap also makes reference to refugees and displaced people twice, while discussing the imperative of cross-border surveillance and a systematic approach to OCV use for people in high-cholera-risk areas *(6)*. Terms specifically addressing disability are absent from the document*(6)*. Findings based on this document review indicate that the Roadmap more directly engages with the implicit link between poverty and cholera than other components of GER, which is generally appropriate given the population groups most affected by cholera, but there is room for some amendments and a more explicit effort towards inclusion of other vulnerable groups.

That analysis was further supported by information collected through stakeholder consultations, including with regards to implementation of the Roadmap. Stakeholders noted that there was no strong emphasis on gender or other components of equity either within the Roadmap or its implementation. Some stakeholders expressed the view that gender and human rights concerns should be further explored, suggesting that these aspects could open avenues for new partnerships. As one stakeholder noted, "Cholera is the existence of lost human rights. Why is that not spoken about more?". Several stakeholders noted that analysis of data is not often undertaken to understand gender-related factors driving susceptibility to cholera. An exception in the country case studies is North-Kivu in the Democratic Republic of the Congo, where this such an analysis was in fact undertaken and highlighted contrasting drivers of gender-related factors that increase risks of being infected with cholera *(58)*. Survey feedback on the integration of GER considerations in the Roadmap was mixed. While only about half

(56%) of respondents agreed that GER was adequately considered, a significant portion either remained neutral, disagreed or lacked sufficient information to respond. Taken together, these insights point to the need for a more explicit approach towards incorporating GER principles in the GTFCC strategy and implementation. Fig. 19 below provides the survey results.

Figure 19: E-survey responses from global, regional and/or multi-country stakeholders on the adequacy of GER considerations by the Global Roadmap and cholera interventions (n=54)



The evaluators also reviewed country-level documents to assess progress in the integration of GER considerations into cholera prevention and response efforts. This review included government-produced cholera outbreak reports from the Democratic Republic of the Congo, Nepal, Nigeria and Somalia and was supplemented by a review of cholera outbreak reports produced by international technical partners for Haiti and Kenya *(59)*, *(60)*, *(61)*, *(62)*, *(63)*, *(64)* . Additionally, NCPs from the Democratic Republic of the Congo, Haiti, Kenya, Nigeria and Somalia were examined to evaluate the extent to which GER principles have been incorporated into strategic frameworks and cholera response programmes *(65)*, *(66)*, *(67)*, *(68)* .[80] The following findings are based on these documents.

The review demonstrated that government-produced outbreak reports consistently disaggregated data by age, gender and geographical distribution, enabling a crucial understanding of cholera's impact across these dimensions. However, other critical GER considerations, such as disability status or identification as an IDP or refugee, were absent from the government-produced reports reviewed. In contrast, the Kenya cholera outbreak report produced by the IFRC captured data focused on people with disabilities and IDP status. Key stakeholders interviewed as part of the Kenya case study stated that collaborations with partners such as the United Nations Refugee Agency and Internation Organization for Migration were essential for reaching underserved populations, including IDPs and residents of informal settlements. Nomadic populations were also identified as a vulnerable group. This inter-agency cooperation has supported GER considerations by leveraging disaggregated data from the Kenya Health Information System to guide local implementation activities. In Haiti, intersecting vulnerabilities, such as rurality, insecurity and malnutrition, have significantly compounded cholera risks *(69)*, *(70)*.Recent outbreaks disproportionately affected rural households with inadequate WASH services and regions isolated by insecurity. Children were also disproportionately impacted, accounting for two in five cholera cases in 2022 *(71)*, *(72)*.

A review of country NCPs demonstrated variability in their incorporation of GER principles. Somalia's roadmap references gender equity and social inclusion on multiple occasions, emphasizing the role of women in WASH interventions. While Kenya's NCP does not directly engage with issues of gender, it does directly include people with disabilities as part of its WASH objectives. Haiti and Nigeria's plans both acknowledge health and access to

[80] Federal Republic of Nigeria, National strategic plan of action on cholera control 2024-2028 (draft), 2024.

water and sanitation as a human right but other references to GER principles within the frameworks are limited. Similarly, the NCP of the Democratic Republic of the Congo does not explicitly address gender or human rights principles within its cholera response framework.

Overall, the country-level analysis suggests that while progress has been made in addressing geographical and economic inequities, there is room for improvement in the systematic integration of GER principles. Strengthening the inclusion of gender, disability and other equity dimensions in data collection, policy frameworks and implementation strategies would help to ensure that cholera interventions are inclusive, equitable and responsive to the needs of all affected populations.

3. Conclusions

Since the adoption of the GTFCC Roadmap in 2017, the global situation of cholera as a public health issue has worsened, with a changing epidemiology in recent years affected by climate change and several countries facing multifaceted crises of conflict, floods, droughts and political instability. Globally, the number of cholera-related deaths has declined more slowly than anticipated – by 26% over the past six years from 2017 to 2023,[81] although there has been a fluctuating trend with sharp declines following an outbreak and sharp rises with the next outbreak. During this time frame, the number of countries managing outbreaks has increased from 29 in 2017 to 35 countries in 2023.[82] Yet the cholera response remains underfunded globally and at country level, and political traction and donor interest in cholera remain much lower than desired, especially outside of outbreaks.

In this context, the GTFCC has a relevant and important role to play in furthering country engagement and response to cholera in a dynamic and complex environment. With a growing member base and range of support over the past few years, the GTFCC has successfully supported countries with NCPs, PAMIs, cholera data-sharing and a range of technical guidelines alongside overall improvements in partner coordination at the global level.

In such a complex environment, there is a need for the GTFCC to build on these gains and adapt its approach and governance structures to address challenges. A concerted effort is required to refine the Roadmap operational priorities to 2030, strengthen governance and collaboration with WASH and other sectors to enhance the GTFCC value added and contribution, including through heightening advocacy and resource mobilization efforts.

The following six conclusions apply, based on the range of findings across the assessment by OECD DAC evaluation criteria.

Relevance

Conclusion 1: The GTFCC Global Cholera Roadmap to 2030 continues to be a relevant overarching strategic framework to guide multisectoral cholera responses worldwide, balancing global and national actions, and response and prevention. Noting the ambitious targets of the Roadmap visàvis the overall SDG agenda 2030, there is a need for a lower-level prioritized set of actions to guide operationalization of the Roadmap, determine contributions of GTFCC partners and address global challenges in the context of resource constraints. The relevance of the GTFCC model of country engagement has evolved considerably since 2017, and there is a continuing demand to strengthen country engagement in a feasible way that considers available/potential resources.

The GTFCC Roadmap represents a first-time overarching multisectoral approach, which emphasizes the urgency to end cholera. The approach has struck a balance between global and national actions and incorporated both

[81] Steering Committee, GTFCC, Meeting: Secretariat presentation, June 2024.
[82] GTFCC, Data on number of countries with outbreaks per year, 2024.

elements of prevention and outbreak response. Its validity is affirmed by a number of countries that have modelled their NCPs on the Roadmap.

Yet the Roadmap objectives form an ambitious and broad framework and need to be prioritized to drive the operationalization of the Roadmap until 2030 in response to the evolving external environment and funding constraints to determine partners contributions and interventions. In the absence of such an action plan, the clarity and visibility of GTFCC priorities and approaches (including the balance between outbreak response and prevention efforts as well as different pillars, especially OCV versus WASH) to implement the Roadmap and partners' roles and responsibilities therein remain limited.

The GTFCC country engagement efforts have evolved considerably since 2017, through partners working directly at country level, the work of the WGs and particularly with the creation of the CSP and IRP. There has also been increased participation in the GTFCC annual assembly. However, there is a demand for expanding country engagement even further in a feasible way that considers available and potential resources.

Coherence

Conclusion 2: Overall, the GTFCC has strengthened coherence externally, promoting greater partner alignment and coordination, particularly at global level but less so at the regional and country levels. Nevertheless, the focus has positively tipped in the direction of greater country engagement. Within the GTFCC, partners' roles and responsibilities in the implementation of the Roadmap need clarifying. Partners have also been less aligned on the relative prioritization of outbreak versus preventative responses in general and OCV versus WASH in particular. There is a need to engage with WASH (especially non-humanitarian WASH) actors and wider development partners (e.g. bilateral donors and multilateral development banks), the private sector, regional bodies and country representatives beyond health ministries.

The GTFCC has been commended for bringing stakeholders together who are working on cholera; this partner engagement is considered to have helped to galvanize cholera efforts. Although the GTFCC partner engagement model is considered a strength, there is a need for a strategic action plan to implement the Roadmap with clearly defined roles and responsibilities for partners to maximize their engagement and contribution. Some key stakeholder groups have not yet been extensively engaged with the GTFCC, notably WASH partners and multilateral development banks as well as others including country representatives beyond health ministries.

Overall, partner engagement has been more effective at the global level than at regional and country levels. While some GTFCC partners provide support to GTFCC activities at regional level, including WHO, Africa CDC and others, enhancing engagement with regional partners (e.g. the African Union, African Development Bank, South Asian Association for Regional Cooperation, presents a key opportunity to address cholera, particularly given cross-border transmission.

At the country level, coordination is often less structured than at the global level, and there is scope to enhance multi-stakeholder engagement. In general, country engagement is supported by GTFCC partners. GTFCC structures have engaged primarily with health ministries with a smaller focus on other relevant ministries, such as those responsible for water, sanitation and/or emergencies.

Efficiency

Conclusion 3: Despite some improvements in the functioning of the GTFCC governance model since 2017, the overall efficiency of its mechanisms and core structures has been variable. There is a need to clarify the roles and responsibilities of GTFCC core structures (e.g. Steering Committee, Secretariat) and strengthen coordination among WGs. The limited availability of resources has affected the functioning of GTFCC structures (especially the Secretariat, the CSP and some WGs such as the WASH WG) and created funding imbalances between outbreak response and prevention and between OCV and WASH. There is an urgent need for a diversified and sustainable funding base for the GTFCC.

While the GTFCC has sought to define the terms of reference of its various structures, there is room to enhance the functioning of its core governing structures by clarifying roles and responsibilities, given that it is a network hosted by WHO and not a free-standing legal entity. In light of the latter, the **Steering Committee** mandate and the extent of its role in strategic direction and oversight needs clarifying, including its role in decision-making for the GTFCC. The overall efficiency of the Steering Committee could be enhanced by streamlining its meetings and expanding membership with regards to WASH, development partners and additional country stakeholders. The role of the **Secretariat** is central in terms of driving and coordinating GTFCC activities, but there are challenges in relation to partners' lack of alignment on the extent of agency taken on by the Secretariat and the separation of responsibilities with the WHO Cholera Programme. The limited availability of financial resources has also impacted overall efficiency.

The GTFCC **WGs** are important structures for partner engagement and technical exchanges. The WGs generally function efficiently despite disparity in WGs resourcing levels and partner engagement. There is a need for enhanced communication and cross-Working Group coherence of workplans and priorities for greater efficiency.

The creation of the **CSP** has provided multisectoral support to countries; it is generally fit for purpose and working well. Yet its reach is limited to a small group of countries, and gaps remain in terms of support for NCP implementation. In addition, the CSP faces a significant sustainability risk given limited funding. The **IRP** was another structure set up to review country NCPs. There is a need to improve its efficiency, as currently there is limited awareness of its role, lack of engagement and considerable delays in its review work.

Effectiveness

Conclusion 4: Overall effectiveness of the GTFCC roadmap implementation towards achieving its goals by 2030 has been mixed. There has been progress in some key strategic priorities, including early warning surveillance systems, laboratory capacity, cholera reporting, the development of technical guidance and tools and, in a growing number of countries, the development of PAMIs and NCPs, which have yet to be implemented.

Persisting challenges remain with key aspects concerning the quality and availability of country-level cholera data, the shortage of OCV supply and advocacy and resource mobilization. External factors have affected implementation, with the imperative being to address the resurgence of outbreaks and the overall shortfall of funding for cholera, in particular for prevention. Within prevention, progress regarding WASH for cholera has remained slow. The operationalization of the Roadmap has also been challenging due to the absence of a costed

strategic action plan and an M&E framework measuring differentiated results across axes and countries as well as the lack of a resource mobilization strategy.

There has been progress on **Axis 1** in some key implementation areas in support of outbreak response, but important gaps remain. In particular, there was notable progress to strengthen integrated early warning surveillance systems, laboratory capacity and cholera reporting. However, countries continue to face persistent challenges in surveillance, and stakeholders have flagged several issues with data-reporting and data quality due to methodological challenges (e.g. case definitions not well adhered to and limited laboratory confirmation). Overall, the data collection and collation and reporting mechanisms need further strengthening. OCV reactive mass campaigns have been a core strategy under Axis 1, and the ICG decision to limit doses has helped to manage the manufacturing challenges, but in 2023 the GTFCC reported a significant doses gap for outbreak reactive campaigns alone,[83] and preventative vaccine demand was not met.

Progress on **Axis 2** has been mixed. PAMI identifications have progressed, and NCPs targeted to PAMI have been developed but not implemented in several countries or not consistently across sectors. Delivery of preventative OCV vaccination has been particularly challenging due to a global shortage of vaccines and limited manufacturing capacity, and, importantly, while there has been some progress in access to WASH globally, especially in rural areas, this remains limited as investments in WASH services continue to be highly insufficient, including in cholera hotspots.

Across the two axes, outbreak response has received more attention and funding, with prevention efforts lagging. Within the GTFCC, partners are less aligned on the relative prioritization of outbreak versus preventative responses in general and OCV versus WASH in particular. The various outbreaks have warranted a greater emphasis on outbreak response. Partners focusing on longer term prevention and WASH have noted that they think this emphasis on outbreak response has been at the expense of adequate efforts on long-term prevention aspects. Other challenges perpetuating this dichotomy are greater funding available for OCV (particularly through Gavi) than WASH and GTFCC members being more health and emergency-focused and less engaged with WASH actors (especially non-humanitarian WASH actors) and wider development partners (e.g. bilateral donors and multilateral development banks). The lack of an overarching GTFCC strategy/workplan has also created a degree of conflict and lack of clarity amongst partners on the relative prioritization of these aspects.

Sustainability

Conclusion 5: Overall sustainability of gains in cholera control is vulnerable, particularly in view of impending funding shortfalls. Sustainability is central to the Roadmap, which promotes multisectoral, long-term interventions, sustainable WASH infrastructure development, capacity-building and government ownership through NCPs. However, implementation has not been fully embedded in Roadmap operations. In particular, advocacy to raise the visibility of cholera in global health and resource mobilization efforts urgently need reinforcing.

[83] Secretariat, GTFCC, 10th GTFCC General Assembly. Presentation: Towards the 2030 roadmap's goals: Where do we stand? June 2023.

The GTFCC has worked to keep cholera on the agenda and contributed to the 71st WHA resolution in 2018 urging cholera-affected countries to implement the Ending Cholera Roadmap and asking global health actors such as WHO to reinforce leadership and coordination of global prevention and control efforts and increase capacity to support countries in the fight against the disease. However, over time, both external factors such as the prominence of other health issues (e.g. COVID-19) and internal factors (limited resources and capacity in the Secretariat to further advocacy and resource mobilization work, limited reach of the Steering Committee in this regard, limited engagement by the CSP) have kept advocacy and resource mobilization weak areas with limited progress. In general, cholera advocacy remains on the backfoot, and fundraising and resource mobilization for cholera and the GTFCC have reached critical and unsustainably low levels. The GTFCC needs a communication strategy to convey its value proposition and a comprehensive fundraising strategy to mobilize sufficient resources for cholera interventions at country level as well as financial resources for the GTFCC to operate as the main coordination mechanism for the Roadmap.

Gender, equity and human rights

Conclusion 6: Equity considerations are essential to addressing cholera, which primarily affects poorer communities; the Roadmap directly addresses economic inequalities in cholera response. However, it does not address other aspects of GER, including gender and human rights, to the same extent. There is room for stronger, more explicit engagement with GER principles.

4. Recommendations

This section of the report provides recommendations derived from evaluation findings and conclusions. Each recommendation features sub-recommendations that provide more detail alongside a rationale (i.e. linkage to the conclusion), indicative time frame and relevant stakeholders implicated by each recommendation.

Recommendation 1: To effectively implement the roadmap through 2030, develop a strategic action plan with prioritized objectives, a results framework, costed workplan, budget and clearly defined stakeholder roles.

Sub-recommendations

i. Review priority objectives to 2030 (as well as activities and outcomes), ensuring an appropriate balance across outbreak response and prevention and OCV and WASH, and integration with other disease/epidemic control efforts;

ii. Develop a results framework, including specifying partners' contributions;

iii. Develop a prioritized costed workplan to 2030, taking into account priorities and prospective resource availability.

Rationale	**Conclusions 1 and 2**
Indicative time frame and relevant stakeholders	Next 6 months GTFCC Secretariat in consultation with partners and Steering Committee.

Recommendation 2: Enhance engagement of GTFCC partners at country and regional levels to maximize results at country level.

Sub-recommendations:

i. Increase focus on and priority for country-level work building on progress in developing country NCPs. Identify barriers and address implementation challenges through more specific approaches and greater integration with other disease/ epidemic control and health systems strengthening efforts. Continue to engage with countries to identify WG priorities and increase dissemination and use of WG products among countries

ii. Strengthen and build on the CSP approach, by 1) identifying and sourcing funding to capacitate the CSP and 2) clarifying the scope and role of the CSP.

iii. Explore regional approaches to facilitate greater coverage of countries and strengthen cross-border coordination for cholera responses. Enhance engagement with regional partners, including GTFCC members and networks, as well as regional meetings and South to South exchange and learning.

Rationale	Conclusion 2
Indicative time frame and relevant stakeholders	Next 12 months GTFCC Secretariat, CSP in consultation with partners, Steering Committee

Recommendation 3: Clarify roles and responsibilities of GTFCC core structures to improve partner engagement and ownership and facilitate decision-making.

Sub-recommendations:

i. Steering Committee: 1) clarify its decision-making role in line with WHO hosting approaches and rules and clarify expectations on strategic direction and oversight; and 2) consider expanding and diversifying its composition (notably from WASH and country stakeholders) without making it too large.

ii. Secretariat: in addition to overall coordination of GTFCC, 1) reinforce its role in relation to implementing the Roadmap strategic action plan (see Recommendation 1), with partners taking on additional roles and responsibilities in areas where they have specific capacity/comparative advantage; and 2) clarify its role vis-à-vis the WHO Cholera Programme and dedicate an FTE for the GTFCC Secretariat.

iii. Working Groups: 1) strengthen systematic cross-WG coordination of priorities, workplans and exchange; 2) consider the need for technical subcommittees (or equivalent) to further specific areas building on members' motivation and available resources; and 3) reassess the need to operationalize the RCCE WG.

iv. The IRP: Assess continuing need for the IRP in light of challenges met and limited availability of resources and/or measures to improve timeliness of IRP support.

v. General Assembly: Expand partner engagement within the GTFCC by increasing 1) the contribution and role of WASH and development partners; 2) participation of countries, for example by holding some General Assembly meetings in cholera-affected countries; and 3) involvement of multiple sectors.

Rationale	Conclusion 3
Indicative time frame and relevant stakeholders	Next 6 months Steering Committee, Secretariat, specific GTFCC structures

Recommendation 4: Enhance communication, advocacy and resource mobilization for cholera at the global, regional and country levels to support roadmap implementation, GTFCC structures and multisectoral integrated approaches.

Sub-recommendations:

i. Develop a communication and advocacy plan based on the strategic action plan (see Recommendation 1), to raise the profile of cholera and identify new opportunities in connection with 1) efforts to reduce the stigma of cholera to facilitate more timely and transparent sharing of data by countries; 2) issues of climate change, WASH and pandemic preparedness and response; and 3) leveraging partnerships' platforms.

ii. Develop a resource mobilization strategy identifying key priorities linked to the operational plan (see Recommendation 1), targeting high-profile international efforts and positioning cholera in integrated approaches and joint resource mobilization efforts in connection with health and climate change and WASH/development.

iii. Explore innovative resourcing strategies, including the use of models to mobilize small grants for local partners to advocate at country level *(73)*[84] and nontraditional approaches for partner support at global, country and regional levels (e.g. secondments, other in-kind support, leveraging partners' communication and/or resource mobilization teams).

Rationale	**Conclusion 4 and 5**
Indicative time frame and relevant stakeholders	Urgently for resource mobilization for the structures of the GTFCC Secretariat, Steering Committee, CSP

Recommendation 5: Increase engagement, integration and alignment with wash interventions and programmes highlighting priority wash areas in the roadmap and cholera integration in wash investments at national and subnational levels.

Sub-recommendations:

i. Strengthen the WASH WG, including by expanding its membership to partners who are familiar with and can influence policy-making in cholera-affected countries and at the global level (e.g., World Bank, African Development Bank Group, UN Water, etc.), and by integrating into the WG workplan. Where possible, engage WASH in other WGs.

[84] Unitaid and FIND funded small grants to support COVID-19 related advocacy that had a substantial reach across multiple countries and leveraged local capacities and networks.

ii. Adopt a more holistic/integrated approach to WASH (relevant to multiple disease control efforts), increase linkages with WASH activities at country, regional and global level and support the transition from "emergency" WASH to more of a long-term WASH focus by strengthening engagement with other organizations' WASH frameworks and with relevant events/initiatives (e.g. UN System-wide Strategy for Water and Sanitation)

Rationale	Conclusion 2
Indicative time frame and relevant stakeholders	Next 12 months Secretariat, WASH WG, Steering Committee

Recommendation 6: Reinforce monitoring and evaluation (M&E) for implementing the global roadmap and continue efforts to strengthen country-level data collection and collation frameworks.

Sub-recommendations:

i. Develop a robust M&E framework (further to Recommendation 1) to assess progress on the Global Roadmap, clarifying roles and responsibilities in data collection and use; conduct periodic progress reviews and integration of lessons into re-prioritization and expand reporting.

ii. Continue to expand initiatives to enhance country capacity to report on cholera; monitor and evaluate cholera responses.

iii. Enhance and support collection of disaggregated data at the country level to further address GER concerns.

iv. Emphasize the need to facilitate more timely and transparent sharing of data by countries to focus advocacy efforts to reduce stigma of cholera (see Recommendation 4).

Rationale	Conclusion 4 and 6
Indicative time frame and relevant stakeholders	Next 12 months GTFCC Secretariat (M&E of the Roadmap) and Epidemiology WG, Steering Committee

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