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1. Introduction – Welcome by K. Fukuda

In 2011, the WHA formally asked the WHO DG to revitalize the Global Task Force on Cholera Control (GTFCC). It has been active during much of previous 20 years and was instrumental in developing consensus and guidance, especially on activities related to Africa.

However, there is a need for change:

- Cholera remains a major cause of infectious disease whose estimated burden of 3 to 5 million cases worldwide per year falls disproportionately on the poorer & more vulnerable populations; consequently, GTFCC is needed.
- Resolution WHA 64.15 requested WHO DG to revitalize GTFCC and improve collaboration and coordination among relevant WHO Departments at HQ and in the regions, and among other relevant stakeholders.
- Effective public health principles and interventions that can reduce cholera morbidity and mortality and its social and economic consequences are known, but are not being adequately implemented. They will not be implemented without ongoing increased advocacy and multi-sectoral participation especially with Ministries of Health and International Partners.
- On the vaccine side, we are entering into the era of safe, effective and potentially affordable oral cholera vaccines; member states now need assistance in using this new tool. Steps are underway to establish an oral cholera vaccine stockpile:
  - Discussions are underway with 5 potential donors (EU, USAID and three private foundations)
  - Vaccine tender in process
  - Vaccine contract expected to be awarded by mid-May
  - Monitoring and Evaluation framework finalized
  - Working group formed to develop field guidance and implementation protocols for monitoring and evaluating the use of OCVs in outbreak response.

This meeting gathers recognized experts on cholera control activities from within and outside WHO. All levels of WHO and WHO regional offices are firmly committed to the process. This first working group meeting will enable us to get a clear vision of the relevant stakeholders and frame directions for the revitalized task force. The Agenda for the meeting is Annex 1 and the List of Participants is Annex 2.
2. Revitalizing the Global Task Force on Cholera Control (GTFCC)

Background of the revitalization process – A. Hinman

The WHA resolution 64.15 of 2011 requested the WHO DG:

- To strengthen and enhance measures to ensure that the Organization continues to respond expeditiously and effectively to the needs of the countries affected by or at risk of outbreaks of cholera;
- To revitalize the Global Task Force on Cholera Control and to strengthen WHO’s work in this area, including improved collaboration and coordination among relevant WHO departments and other relevant stakeholders.

A 1-year grant from The Bill & Melinda Gates Foundation to The Task Force for Global Health to work with WHO has started the revitalization process of GTFCC.

Helping WHO to revitalize the Global Task Force on Cholera Control (GTFCC) as a means for harnessing the expertise, resources, and advocacy of the entire range of stakeholders will improve prevention and control of cholera around the world.

The revitalized GTFCC is expected to:

- Support and increase WHO’s capacity to strengthen national, regional, and global cholera control programs by providing technical guidance and optimizing support of key stakeholders;
- Strengthen technical assistance for critical activities such as surveillance, and increase use of existing and new interventions;
- Provide leadership in raising awareness about the continuing burden of cholera, the urgency of fully implementing available interventions and the need for resources.

Major activities

The major activities of the first year will lead to the relaunch of the GTFCC. They include:

- Establish a working group (this group)
- Carry out stakeholder analysis (SA)
- Based on SA, draft recommendations and proposal on goal, strategies, membership, structure, and management of GTFCC
- Obtain approval from WHO DG on the revitalization proposal
- Relaunch the GTFCC and appoint members
- Seek funding for ongoing operations

A second phase, over two years, will focus on seeking support of GTFCC for its first 2 years and ideally, a broad consortium of long-term donors can be identified.

Objectives of the meeting

The objectives of the Working Group meeting, on March 18-19, 2013 include:

- Agree on Working Group governance
- Identify and proceed with stakeholder analysis
- Frame considerations for the GTFCC
3. Background on GTFCC – W. Perea

Initial mandate and objectives of the GTFCC in 1991

Created in 1991 following resolution WHA 44.6, the initial GTFCC aimed at Coordinating the World Health Organization’s global action in relation to cholera control, in cooperation with the regional offices and several WHO departments at Headquarters level.

To reduce mortality and morbidity associated with cholera and to reduce the social and economic consequences of cholera through:

- Intensified cooperation in national control activities;
- Enhanced information exchange;
- Review and revise policy;
- Intensified research efforts;
- Mobilize financial resources;
- Activate a global technical resource network.

Structure and members

The GTFCC was initially composed of 6 WHO staff members. It included also one liaison staff member from UNICEF. See figure 1 below. It carried out internal coordination from all levels of WHO i.e. Country offices, Regional Offices and Headquarters

![Figure 1. Structure of the initial GTFCC](image-url)
Historical landmarks
The GTFCC has been through three distinct periods in terms of activities and outcomes (see Figure 2).

**1991-1992**
- Cholera re-emerges in Latin America & Africa
- WHA 44.6 Resolution leading to a GTFCC (1991)
- AFRO Initiative for CC (1992)

**1993-1999**
- Cholera re-emergence in Africa (Moz, DRC, Horn of Africa)
- Interregional meetings in AFRO & EMRO
- Cholera Control Guidelines (1993)
- 1st WHO OCV (1999) recommendations

**2000-2008**
- 2000-04 Decrease in cholera cases
- 2005-07 steady increase
- Water & Sanitation
- OCV meeting (2002)

**2009-2012**
- Major Epios in Zbu, Som, Yen
- Cholera introduced in Haiti (2010)
- WHA 64.15 Reivitalization of the GTFCC (2011)
- UN Task Force on Cholera in Haiti

Figure 2. the GTFCC over the past 20 years.

From 1991 to 2000
- Cross-sectional within the Organization: includes various division and departments
- Several international/interregional meetings
- Key Stakeholders participate on an ad-hoc basis

From 2001 to 2008
- Essentially composed of Cholera Program Staff
- Close interaction with WaSH and Vaccine Units
- Coordination with stakeholders “according to needs perceived”

From 2009 to 2011
- Re-activation of the GTFCC to strengthen internal coordination
- 9 HQ Departments initially represented - 7 meetings held
- Overridden by Haiti epidemic + WHO re-structuring
Main activities and key deliverables:

- Development of norms and guidelines
- Development and maintenance of a global database – country profiles and annual data reviews
- Direct country support on preparedness and response
  - Swiss Disaster Relief network (1996-?)
  - Coordination of major outbreak responses through GOARN
  - Interagency Diarrheal kit
  - Technical backup to regional initiatives, meetings and workshops
- Shaping vaccine policy
  - WHO position paper: 2010

Human and financial resources

WHO human and financial resources over the past 20 years on cholera are the following:

- Human resources: cholera focal point with 1-3 professional staff and 1 assistant
- Financial resources:
  - 2004-2005 ~USD $250,000 (total, not annual)
  - 2008-2011 ~USD $500,000 (total, not annual)

Conclusions on the initial GTFCC

- Internal rather than Global
- Stakeholders involved on an ad-hoc basis
- Institutional technical group rather than a TF
- GTFCC activities are embedded in the Cholera Control Program
- Overall responsibility has traditionally rested with the technical focal point
- Chronically understaffed and under-resourced
- No clear mechanism for accountability
- International attention driven by media-hype crisis
4. **WHO activities in cholera control and prevention at HQ level**

Activities in cholera control and prevention are spread across 3 main clusters at WHO HQ (see Annex 3. WHO organizational chart on cholera activities):

- **Health Security and Environment (HSE) including:**
  - The department of Pandemic and Epidemic Diseases (PED) which deals with stockpile, support to the GTFcc, risk assessment and surveillance; also public health;
  - The Protection of the Human Environment (PHE) dealing with environment has WaSH capacities;
  - Global Capacities and Response in charge of IHR implementation, logistics and the GOARN secretariat.
- **Polio Emergencies and Country Collaboration (PEC) and its Surge and Crisis Support team** dealing with humanitarian emergency risk management (EMR) for flood disasters or political crisis.
- **Family, women’s and children’s Health: maternal and child health (FWC)** with its unit on Immunization and Research (IVR), part of Immunization, Vaccines, and Biologicals (IVB).

Currently, cholera activities are fragmented within WHO. These activities are not just limited to outbreaks but focus on how to help countries in a sustainable development perspective.

5. **Discussion on current landscape of cholera - participants**

**Definition of endemic and epidemic cholera and under-reporting issues**

There is need for better definition of endemic/epidemic cholera. Responses are more generally focused on epidemic outbreaks than to the endemic situation. In addressing cholera challenges, the GTF should look at both epidemic and endemic cholera.

Cholera still carries a strong stigma for affected populations, in some instances even worse than HIV/AIDS. Additionally, because of potential impacts on trade and travel, countries under-report cholera cases, reporting instead “acute watery diarrhoea”, if anything.

**Advocacy**

There is no strong lobby for cholera. As it is a disease affecting mainly poor countries, few developed countries are investing in cholera prevention and control. Business and investment cases have to be built to strengthen advocacy which remains non-existing.

6. **Considerations in drafting a charter – M. Rosenberg**

**Need for collaborative approach in public health**

Public health faces unique challenges that can benefit from a collaborative approach;

- **Broad geographic scope** – disease and injuries have no borders; we live in a connected world, a global community.
- **Complexity of the problems** – requiring creative collaboration drawing on diverse talent, perspective and expertise.
• **Health cannot be addressed in isolation** – Political, social and economic sectors must be involved to have an impact on health.
• **Low levels of funding for public health and poverty in the countries we work with** – coming together helps us pool the resources we have and use them efficiently.

Collaboration is needed to do something together that is not possible independently. **Collaboration helps achieve outcomes by:**

- Encouraging implementation of joint programs
- Making the commitments of participating organizations and people visible
- Promoting policy changes
- Enabling information exchange and networking
- Supporting professionals who are addressing difficult problems
- Mobilizing support

Regardless, the focus should be on the desired result, not just the process of collaboration

**Essential elements of successful collaboration**

**Pathway towards a successful collaboration:**

- Set the goal, robust strategy, clear organizational structure (who will do what?), synergistic membership (more complex than within one institution)
- Shared leadership – a mediator, an advocate
- Trust, transparency, how do people get along
- Effective project management
- Wrap it up once goal is achieved.

**Barriers to collaboration include:**

- Cultures;
- Conflicting goals;
- Confusion in terms of roles and responsibilities,
- Control—attempts to control the outcomes and proceedings
- Capabilities,
- Competition between organizations,
- Costs (donor does not always realize the cost of overcoming obstacles to make it work).

For the GTFCC to be successful, it needs to focus on compassion and less on threat avoidance as cholera will not be seen as a threat by donor countries.
Discussion on specific issues in cholera collaborations - participants

**Collaboration with WaSH**

Collaboration with WaSH remains an challenge. Projects supporting access to clean water at households level are the main focus at WHO level. This should be related to national and/or regional programs. The GTFCC should try its best to coordinate with WaSH. The GTFCC should be an opportunity to collaborate more effectively with UNICEF on WaSH activities.

**Example of the UN clusters**

The cluster approach seems useful in terms of emergency preparedness and response where WHO and UNICEF actually talk to each other and collaborate in non-emergency response modes. This represents a way to work collaboratively on issues where emergency preparedness needs to take place. At country level, there are increasing numbers of meetings where multi-sectoral partners are coming together e.g. in Kenya.

**Leadership in collaborations**

Collaboration synergies have to begin internally within WHO if WHO is to coordinate the external partners. The leadership, management style, and procedures can motivate people to collaborate. Whether people function as silos or in a collaborative way, depends on their incentives for working together. This is the management of complexities. For example WaSH group at WHO is part of network led by UNICEF. There are networks of networks. The GTFCC could work as a network, working with and managing other networks.
Country implementation

At country level, cholera control strategy is lacking. The GTFCC could help every country develop a national strategy. Most country plans are reactive plans and not preventive ones.

The Kenya experience in developing a national plan for cholera was pulled together from experience from many public health areas. Lessons from this successful experience are that the lack of available resources could be addressed by national mobilization, in this case lobbying the parliament.

Some indicators to convince decision-makers can be helpful such as, for example, the infectious disease cost calculator from the University of Pittsburgh. Calculating how much is it costing the country today, in health care costs and death costs; targets not only ministry of health but other ministries as well.

Evolution of global health landscape

Evolution of the global health landscape is that as much as there is a demand for evidence-based decisions, many other factors influence decision-making. It is a combination of evidence, ideologies, egos (both individual and institutional) that are driving global partnerships especially in public health.

4-5 years ago resources were not as constrained as nowadays. There is a general trend in public health donors where the donors who were previously pushing for health sector wide approaches, now have very vertical approach. This is reflected in the need for clear business case, value for money, and accountability for dollars spent.

7. Stakeholder analysis – A. Hinman

Methodology and preliminary feedback

The questionnaire - basis for the stakeholder analysis - has been developed by the project team in advance of the meeting. Prior to this Working Group meeting, the questionnaire was pre-tested on 8 Working Group members and 3 other external persons with extensive expertise in cholera control and prevention.

Preliminary results of interviews are presented in Annex 4. To sum up:

- 11 interviews were conducted over phone
- They last an average of 45 minutes
- All participants had read questionnaire and thought about the questions
- Overall, pilot went fairly smoothly
- Analysis/interpretation of results will be challenging – mix of quantitative and qualitative information
Revision of the questionnaire - participants
Extensive discussion of the questionnaire – question by question – resulted in many suggestions for changes that ultimately (after the meeting) resulted in a revised questionnaire (Annex 5) for the remainder of the interviews.

Revisions addressed goal, objectives, and strategies for GTFCC as well as options for structure, management, and membership

8. Work group members vision of the revitalized GTFCC - participants
Working Group members were asked to provide their vision of a revitalized GTFCC. The following points were recurrent:

Possible functions of the GTFCC

- Deal with technical aspects of cholera
- Revise norms and guidelines
- Develop research agenda
- Stimulate improvements
- Integrate surveillance
- Improve case management
- Improve implementation of WaSH;
- Wider use of vaccine
- Strengthen national capacity and training
- Mobilize resources.

Participants shared the view that prominent features of the revitalized GTFCC would be:

- **Enhanced collaboration and partnership** at all level and in between sectors.
- Strong emphasis on the **mobilization and advocacy** with creative approach.
- **Cholera as a public health problem with a broad, cross-sectoral approach** including: development and human rights issues.
- Need to build on a **shared leadership**.

Visions on the **structure/governance** addressed:

- Degree of independence from WHO
- Forum or a broader group of stakeholders consulted on a regular basis
- Specific working groups
- Small core group
9. Key considerations for the GTFCC – Goals, objectives, & strategies

- These issues were discussed by the Work Group in the context of revising the questionnaire and the revised questionnaire reflects the options considered.
- Results from the Stakeholder analysis will guide development of the Work Group’s recommendations to the WHODG.

Discussion on goals - participants

Principles of the goal statement:

- ambitious
- measurable
- measure of equity built in
- reduction of cases and deaths
- outcome focus (not process focus)

Different potential goals were discussed:

- **Elimination of cholera as a public health threat:**
  Such a goal may be premature, but progressive targets can be effective.

- **Reduction of the burden of cholera to the maximum level possible**
  This would rely on a strategy ensuring optimal use of available interventions, development and rapid implementation of new interventions.

- **No more cholera deaths:** “Eliminate cholera deaths”
  Objective is to narrow the equity gap.

Next set of MDGs are likely to focus on equity. Some targets have been reached, but equity has worsened. The World Bank has identified elimination of extreme poverty in 20 years. Cholera as a marker for extreme poverty would be a natural fit. The need for an aspirational goal was emphasized.

Discussion on objectives and strategies - participants

Several objectives were discussed:

- **Optimal use of available tools** and development of adequate indicators to monitor progress
- Convene the various stakeholders to revise and ensure guidelines and norms are up to date (WHO has adopted the GRADE approach so updating the 1993 guidelines will be a 1-2 year process)
- **Increase public awareness of cholera** and priority given to cholera not only during outbreaks but also on endemic settings;
- Need to respond better to outbreaks with increased preparedness at country level (national plans for instance);
- Keep attention on development of water and sanitation;
- Facilitate research in priority areas where there are research needs;
- Publish a yearly review of cholera with a wide distribution worldwide;
- Develop a global plan to control cholera and estimate resource needs and potential donors
- Strengthen WHO support to GTFCC;
- Map the presence, prevalence of epidemic and endemic cholera around the world.
10. Options for structure, management & members – participants

- These issues were discussed by the Working Group in the context of revising the questionnaire and the revised questionnaire reflects the options considered
- Results from the Stakeholder analysis will guide development of the Working Group’s recommendations to the WHO DG

Discussions on management
- Need for strong project management with an adequate workplan not duplicating activities of other partners
- Mapping what currently exists in order to best demonstrate added value of new projects
- Develop effective communication plans
- Develop set of rules (SOPs) and write down the goal, strategy, structure, membership, management in a charter at the beginning.
- Pay attention to management of conflicts of interest within the decision making.
- SOPs on decision-making: majority vote or by consensus. For instance, GAVI goes by consensus, SAGE and ACIP take votes.

Discussion on budget
- Need to look at broad range of donors
- Budget estimate for the first year has to be done
- Some low-hanging fruit that would help to establish the credibility of the GTFCC
11. Work plan, roles and responsibilities – A. Hinman, W. Perea, and participants

Roles and Responsibilities
- WG will finalize proposal to relaunch the TF with budget etc by mid-July
- End of June, circulate around WHO for review and approval by end of July.
- End date of grant is end of October 2013. Target end point is to have members of the GTFCC appointed.
- One page concept note will be needed asap to approach additional donors (in addition to Gates)

Project Team action points
- WHO will circulate the stakeholder roster within 24 hours
- A revised questionnaire will be circulated by end of week
- Follow up communication by telephone/email once in April, once in May
- Second face to face meeting to be held in June (adjacent to Coalition meeting in Bethesda)
- Draft summary record of meeting within 2 weeks
- WG will move forward with ideas to draft the structure/management etc – within one month
- Finalized questionnaire to be circulated to WG within 3 weeks

WG action points
- Return comments on stakeholder roster by end of next week – columns, names, additions
- Revise and resend with proposed categorization within 10 days after
- Provide feedback on revised questionnaires – within one week of receipt with deadline specified.
- Continue to participate and provide advice, with expected participation in June and in teleconferences. WHO will invite participation in at least one of the interviews.
- Provide final endorsement on the list of interviewees.
- Begin to brainstorm potential donors and send details of any worth pursuing – foundations etc.
Annex 1. Agenda

Revitalization of the Global Task Force on Cholera Control
Working Group Meeting
March 18 and 19th 2013 – Chavannes de Bogis, Geneva

MAIN OBJECTIVES

- **Agree on working group governance**
  - **Outcomes:** Terms of reference; roles and responsibilities; work plan, and time line
- **Identify and proceed with the stakeholder analysis**
  - **Outcomes:** Identify, categorize, and map stakeholders
- **Framing considerations for the GTFCC – context to analyze the stakeholder analysis and clarify which option or combination of options can address the findings.**
  - **Outcomes:** Considerations for GTFCC key elements

*Day 1 - Monday March 18th – Co-chairs Alan R. Hinman/William Perea*

8.30       Registration
9.00 – 10:00  1. Welcome and group introductions – (Keiji Fukuda)
10:00 – 11:00 Presentation of the revitalization process
           Background on the project – (A. Hinman)
           Background on the GTFCC - (W. Perea)
11:00 – 11.30 Coffee break
11.30 – 12.30 Considerations in drafting a charter – (M. Rosenberg)
           Key elements of a charter
           Understanding key factors for success
12.30 – 13.30 Lunch
13.30 – 15:00 Stakeholder analysis (A. Hinman)
           Discussion of interview questions
           Presentation of preliminary results
           GTFCC stakeholders
15:00 – 15:30 Coffee Break
15:30 – 17:00 Identification and categorization of stakeholders
Day 2 - Tuesday March 19th - Co-chairs Alan R. Hinman/William Perea

9.00 – 9:15  Recap of Day 1 and Introduction of Day 2 program
9.15 – 10:30  Framing considerations

  Presentations from the participants (5mins) on their vision for the future GTFCC

10:30 – 11:00  Coffee break
11:00 -12:30  Key considerations for GTFCC Goal, objectives & strategies
12:30 – 13.30  Lunch break
13.30 – 14:30  Recap key considerations
  Options for structure, management & members
14:30 – 15:30  Work plan
  Roles & responsibilities
15:30 – 16:00  Coffee break
16:00 -17:00  Finalizing the work plan and timeline
17.00  Wrap-up and closure of the meeting
Annex 2. List of Participants

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Annex 3. Organizational chart of WHO HQ activities in cholera control and prevention
Annex 4. Preliminary results of the stakeholders analysis

- 8 Working Group members and 3 non-members interviewed by telephone
- Interviews averaged 45 minutes

Results by questions

Q3. 6 had participated in GTFCC meetings, 5 had not

Q5. Whether initial objectives were met – range of views but most felt they had been only partially met

Q6. Objectives generally felt to be still relevant but in need of some modification

Q7. What WHO has done well – range of views but outbreak response mentioned by several as was development of guidelines

Q8. What WHO has not done so well – range of views with interagency coordination mentioned by several

Q9. Current unmet needs – many things mentioned with integration of OCV into response mentioned by several

Q10. Needs best met by WHO – several things mentioned with incorporation of OCV and revisions of guidelines/policies mentioned by several

Needs best addressed by other partners – several things mentioned with WaSH and UNICEF mentioned by several

Former Q9. Adequacy of a GTFCC to strengthen cholera control and prevention – all feel it is necessary but some felt it was not sufficient

Former Q10. GTFCC should have both technical and advocacy functions

Q13. What revitalized GTFCC should accomplish – range of views without clear pattern

Q14. Measuring progress of GTFCC – range of views with mix of process and outcome indicators mentioned

Q15. How GTFCC could provide maximal support to countries – range of view with several mentioning TA and training

   How GTFCC could provide maximal support to research institutions – range of views with setting research agenda and translating research findings into policy/practice mentioned by several
How GTFCC could provide maximal support to TA providers – range of views with coordination and harmonization of guidelines mentioned by several

How GTFCC could provide maximal support to donors - range of views with coordination and advocacy mentioned by several

Q19. Membership in GTFCC should be mix of WHO staff and from outside

Q20. Membership in GTFCC should include all of the categories mentioned

Q21. Optimal size of GTFCC – 10-19

Q22. Chair of GTFCC – range of views with co-chair (WHO/non-WHO) mentioned by several

Former Q18. GTFCC should issue recommendations as advice to WHO DG, rather than independently

Q23. WHO should provide support/secretariat

Q24. GTFCC should meet twice a year

Q25. GTFCC member selection – range of views with most favoring an open nomination process with selection by an ad hoc committee (perhaps with subsequent appointment by WHO DG

Q22. Governance process – range of views with several indicating that Chair/Vice-Chair should be elected by GTFCC members

Q23. Other thoughts – wide range to be summarized/synthesized when interviews are completed.
Annex 5. Revised questionnaire

BACKGROUND

Following the adoption of Resolution WHA 44.6 in 1991, the Global Task Force on Cholera Control (GTFCC) was established to reduce mortality and morbidity associated with cholera, and to reduce the social and economic consequences of cholera. Initially the Task Force comprised only WHO staff, with a liaison from UNICEF. Six principal components of the Task Force’s efforts were:

- Intensify cooperation in national cholera control activities
- Enhance information exchange
- Review and revise policy
- Intensify research efforts
- Mobilize financial resources
- Activate a global technical resource network

To date, the Task Force has provided technical advice and support for cholera control and prevention at country level; training of health professionals at national, regional and international levels in prevention, preparedness and response of diarrheal disease outbreaks; and the dissemination of information on cholera and other epidemic prone enteric diseases to health professionals and the general public. Some of the important accomplishments of the Task Force include development of the following publications:

- First steps for managing an outbreak of acute diarrhoea
- Acute diarrhoeal diseases in complex emergencies: critical step
- Cholera outbreak: assessing the outbreak response and improving preparedness
- Cholera vaccine in complex emergencies
- Oral cholera vaccines in mass immunization campaigns.

Over time, the Task Force expanded to include representatives of other organizations. However, both the Task Force and cholera efforts in general were chronically under-resourced, both in terms of human and financial resources. As a result, it became unable to meet demands placed on it in a timely manner. One of our tasks will be to understand the factors that impeded the Task Force’s ability to optimally carry out its functions, factors such as:

- cholera was not viewed as a priority by international agencies, particularly after successful control of cholera in South America
- Emergence of competing priorities such as SARS and pandemic influenza
- Increasing attention to integrated, rather than topic-specific, approaches
- Global economic distress.
1/ Your involvement in cholera prevention and control

1. What is your (or your institution’s) current role in global cholera prevention and control efforts?

2. Have you had previous experience with professional partnerships and collaborative work groups in global health? If yes, please
   • explain what kind of partnership and what was your role?
   • What lessons did you learn from your experience?

3. What has been your prior personal experience with the Global Task Force on Cholera Control (GTFCC)?
   • Member
   • Participant
   • Observer
   • No prior experience

4. How would you differentiate between the Global Task Force on Cholera Control and WHO’s cholera program?
   • Totally distinct
   • Some overlap
   • One and the same
   • Don’t know/unsure

2/ Current needs and priorities in cholera prevention and control

The initial objectives set forth in 1991 for the GTFCC in supporting improved prevention and control of cholera were to:
   • Enhance global information exchange
   • Review and revise policies on cholera control and prevention
   • Activate a global technical resource network
   • Intensify assistance to national control activities
   • Intensify research efforts
   • Mobilize financial resources

5. How well do you think these objectives were met?

6. Should they be modified and, if so, how?

7. What has WHO done particularly well in cholera prevention and control?

8. What has it not done so well?
9. What are the top three priorities in terms of unmet needs in cholera control and prevention at the global level?
   • Comprehensive guidelines
   • Better coordination
   • Improved methods and tools for interventions
   • Support/training in implementing interventions
   • Better case management
   • Effective implementation of WaSH
   • Wide use of OCV (in all places where appropriate)
   • Resource mobilization
   • Establishing a research agenda
   • Other (please specify)

10. Which institution or organization do you to think is best placed to address each of these priorities?

11. What are the top three priorities in terms of unmet needs in cholera control and prevention at the national level?
   • Comprehensive guidelines
   • Better coordination
   • Improved methods and tools for interventions
   • Support/training in implementing interventions
   • Better case management
   • Effective implementation of WaSH
   • Wide use of OCV (in all places where appropriate)
   • Resource mobilization
   • Establishing a research agenda
   • Other (please specify)

12. Which institution or organization is best placed to address each of these priorities?

3/ GTFCC priorities and activities

The World Health Assembly has called for revitalization of the GTFCC and for improved collaboration and coordination among relevant WHO departments and other relevant stakeholders.

13. What do you think are the 3 most important things a revitalized GTFCC should do to enhance cholera prevention and control?
   • Support coordination of WHO activities
   • Coordination of all stakeholders
   • Development of comprehensive guidelines, norms and policies
   • Development of research agenda
   • Resource mobilization
14. How should its progress be measured?

15. GTFCC outputs could be of relevance to a range of stakeholders. How can the GTFCC support the cholera control efforts made by:
   - Countries
   - Research institutions
   - Technical assistance providers
   - Donors
   - Others (please specify)

16. How do you think the following stakeholders can support efforts made by the GTFCC?
   - Countries
   - Research institutions
   - Technical assistance providers
   - Donors
   - Others (please specify)

4/ GTFCC governance and composition

17. Do you think the revitalized GTFCC should remain an internal WHO coordination mechanism or should it address external organizations as well?
   - Internal WHO coordination mechanism
   - Address external organizations as well

Several task force models exist with different structure and governance components. Three examples are shown below.

<table>
<thead>
<tr>
<th>Type</th>
<th>SAGE (The Strategic Advisory Group of Experts on Immunization)</th>
<th>GPEI (global polio eradication initiative)</th>
<th>Stop TB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date of creation</strong></td>
<td>Expert Advisory Group</td>
<td>Global public-private Partnership started as an inter-agency partnership</td>
<td>Public-Private Partnership</td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td>Advise the WHO DG on immunization-related strategies</td>
<td>Implementation of nation-based activities among key partners to eradicate polio</td>
<td>Implementation of tuberculosis control in countries and alignment of actors worldwide in the fight against TB</td>
</tr>
<tr>
<td><strong>Strategy</strong></td>
<td>SAGE and WHO set the agenda and priorities</td>
<td>Strategic directions determined by WHA resolutions, following reports from the technical</td>
<td>Coordinating board sets strategic directions</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Stop TB Partnership Operational Strategy 2013-2015</td>
</tr>
<tr>
<td><strong>Responsibilities</strong></td>
<td>No regulatory or executive decisions</td>
<td>Oversight and accountability of the Polio Oversight Board (POB=heads of core partners) IMB is responsible for evaluation of progress</td>
<td>Decision body: Coordinating Board; Secretariat acts on behalf of coordinating board</td>
</tr>
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<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Structure</strong></td>
<td>• SAGE members (15)</td>
<td>• Polio oversight board (POB)</td>
<td>• Coordinating board (34 members) WHO-hosted Secretariat</td>
</tr>
<tr>
<td></td>
<td>• WHO secretariat</td>
<td>• Independent monitoring board (IMB) since 2010 (8 members)</td>
<td>• Partners’ forum (~1,000)</td>
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<tr>
<td></td>
<td>• Time-limited</td>
<td>• Technical groups and committees for strategic guidance</td>
<td>• Working groups (7)</td>
</tr>
<tr>
<td></td>
<td>SAGE technical working groups (9</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>currently)</td>
<td></td>
<td></td>
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<tr>
<td><strong>Membership</strong></td>
<td>• Members: 15 individual serving in</td>
<td>• 4 spearhead partners: WHO, UNICEF, CDC, Rotary International</td>
<td>• International organizations, countries, financial donors private and public; governmental or non-governmental organizations other entities with interest in TB</td>
</tr>
<tr>
<td></td>
<td>their personal capacity</td>
<td>• National governments</td>
<td></td>
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<tr>
<td></td>
<td>• WHO secretariat</td>
<td>• Other partners</td>
<td></td>
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<tr>
<td></td>
<td>• Observers upon Secretariat</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>invitation (GAVI, UNICEF, plus other)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nomination process for the board/decision body</strong></td>
<td>Nominated by the WHO IVB director in consultation with other stakeholders Appointed by WHO DG</td>
<td>POB: Senior officers (heads) from WHO, UNICEF, CDC and Rotary and lately BMGF</td>
<td>By consultation upon nomination by partners according to the following composition:</td>
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<td>• 4 representatives from high burden countries,</td>
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<td></td>
<td></td>
<td>• 3 representatives, one from each of WHO, the World Bank and the GFATM ,</td>
<td></td>
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<td></td>
<td></td>
<td>• 1 representative of another international organization,</td>
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<tr>
<td></td>
<td></td>
<td>• 6 regional representatives</td>
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<td></td>
<td>• 7 Working Group Chairpersons</td>
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<td>• 5 representatives of financial donors,</td>
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<td>• 1 representative of Foundations,</td>
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<td></td>
<td></td>
<td>• 3 representatives of NGOs and technical agencies, including The Union and CDC</td>
<td></td>
</tr>
</tbody>
</table>

Meeting report- Working group on the revitalization of the Global Task Force for Cholera Control
<table>
<thead>
<tr>
<th>Secretariat</th>
<th>WHO staff</th>
<th>No secretariat as such, specific programmes in each organization accountable for its activities</th>
<th>Half WHO staff, half seconded by partners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Secretariat</td>
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<tr>
<td>Frequency of meetings</td>
<td>Twice a year (adjusted if needed)</td>
<td>Quarterly for the POB and IMB</td>
<td>Coordinating board: At least 2 a year Global forum: 1 every 3 years</td>
</tr>
</tbody>
</table>

18. Which of the above models would be most appropriate for GTFCC?
- SAGE-like
- GPEI-like
- Stop TB-like
- Other (please specify)

19. From your perspective, how should the core/coordinating group be composed?
- Exclusively WHO staff
- Exclusively from outside WHO
- A mix of WHO staff and from outside

20. What would be the most important types of member to include outside WHO?
- Affected countries
- Other UN agencies
- Research institutions
- Researchers/individual experts
- Non-governmental organizations
- Donors
- Others (please specify)

21. What do you think might be the optimal size of GTFCC?
- <5
- 5 – 9
- 10 - 14
- 15 – 19
- ≥20
22. Should the Chair of the GTFCC be?
   • WHO staff member
   • Non-WHO staff member

23. Should support/secretariat functions for GTFCC be provided by?
   • WHO
   • Another body/agency (if so, who)

24. How often should GTFCC meet in person? Additional (virtual) meetings could also be arranged
   • Once a year
   • Twice a year
   • Three times a year
   • Other (please specify)

25. How should initial members of GTFCC be selected?
   • nominated by WHO program staff
   • nominated by GTFCC Work Group
   • Open nomination process
   • Other (please specify)

26. After initial establishment of GTFCC, how should members be selected?
   • Nominated by WHO program staff
   • Nominated by GTFCC members
   • Open nomination process
   • Other (please specify)

27. Do you think members should be appointed on
   • an individual basis
   • on behalf of their institutions
   • a mix of both?

5/ Other comments

28. What are you willing to do to help revitalize GTFCC? What can you/your institution contribute or bring to the GTFCC?
29. Where do you think the GTFCC should get support/resources from? How should the GTF sustain itself?
30. Are there specific types of advocacy GTFCC should carry out?
31. Are there any other thoughts you would like to share?