Revitalizing the Global Task Force on Cholera Control (GTFCC)

Report of the second meeting of a Task Force for Global Health/WHO Working Group
Geneva, Switzerland 12–13 September 2013
CONTENTS

Executive summary ................................................................................................................. 1

1. Opening session .................................................................................................................... 2

2. Review and revision of the Working Group Report and GTFCC TORS ......................... 5
   2.1 Goal .............................................................................................................................. 5
   2.2 Strategies .................................................................................................................... 5
   2.3 Structure ...................................................................................................................... 7
   2.4 Membership ............................................................................................................... 7
   2.5 Management ............................................................................................................... 8
   2.6 Priorities ..................................................................................................................... 9

3. Presentation of the revised GTFCC TORs to senior WHO staff ...................................... 10

4. Discussion of inputs received from senior WHO staff ..................................................... 13

5. Closing session .................................................................................................................... 13
   5.1 Financial considerations for the GTFCC and its Secretariat ....................................... 14
   5.2 Next steps for the GTFCC revitalization process ......................................................... 14

Annex 1: Meeting Agenda .................................................................................................... 15

Annex 2: List of Participants ................................................................................................. 18
Executive summary

The second meeting of the Task Force for Global Health/WHO Working Group for Revitalizing the Global Task Force on Cholera Control (GTFCC) was held in Geneva on 12–13 September 2013. On behalf of WHO, Dr Sylvie Briand welcomed the members of the Working Group and expressed her thanks for all of its hard work in bringing the process of revitalizing the GTFCC to this point. As the first phase of its intended two-phase programme of work approached completion, it was clear that the development of the revised GTFCC Terms of Reference (TORs) and associated materials represented a real advance.

The key objectives of the second meeting were:

- to finalize the proposed goal, strategies, structure, membership, management and priorities of the GTFCC;
- to finalize the corresponding GTFCC TORs;
- to develop a preliminary roster of GTFCC members;
- to present the outcome proposals to relevant senior WHO staff;
- to discuss the financial needs of the GTFCC and potential approaches for obtaining financial support;
- to set out the next steps for the Working Group and for the GTFCC Secretariat.

During detailed discussions the previously developed Working Group Report was reviewed and revised by meeting participants. Corresponding changes were then made to the proposed GTFCC TORs. In relation to early GTFCC priorities, a number of actions were identified that had the potential to bring about a mix of both rapid and longer-term improvements in cholera prevention and control activities worldwide.

During discussion with senior WHO staff clarification was sought from the Working Group on whether the proposed TORs were attempting to shape an advisory group or an institutional entity to implement actions or both. Senior WHO staff indicated that the GTFCC would need to be either an advisory group or an institutional entity, but could not be both. Further inputs were provided to the Working Group in order to help finalize the process of TOR revision and to clearly establish the primary goal, strategies, structure, membership and management aspects of the revitalized GTFCC.

Discussion was also held on the likely financial needs of the GTFCC and a proposed outline of costs and related requirements were presented. It was considered likely that a minimum of one full-time executive with one half-time administrative staff would be required, with current total budgetary estimates being of the order of US$ 1 million per annum.

The Working Group agreed that efforts should be maintained in light of the significant progress made to date and the high level of willingness and commitment shown by Working Group members and by WHO. In support of this, it was indicated that WHO would consider convening another Working Group meeting, should this be required, to maintain the momentum generated and to facilitate the next steps that now needed to be taken.
1. Opening session

The meeting was opened by the Chair, Dr Alan Hinman (Task Force for Global Health). After welcoming the participants, Dr Hinman briefly reviewed the upcoming agenda items and then invited Dr Sylvie Briand (Director, HSE/PED) to address the meeting.

Dr Briand welcomed the members of the Working Group and expressed her thanks for all of its hard work in bringing the process of revitalizing the GTFCC to this point. It was clear that the development of the current GTFCC TORs and associated materials represented a real advance, and had resulted from a greatly accelerated process that was now close to achieving the desired revitalization aims. Within WHO, the issue of cholera had relevance for a wide range of WHO departments and there was a strong commitment to strengthening efforts to address it. WHO technical units and activities now co-existed alongside a broader coordinating WHO Cholera Action Group that was still in its early phases. Dr Briand felt that this Working Group meeting itself would provide a good forum for highlighting the importance of improved coordination and synergy-building efforts at country, regional and headquarters level, particularly as senior representatives of WHO departments and Regions were scheduled to attend.

In terms of complementing the work of WHO by identifying and meeting unmet needs, Dr Briand indicated that a revitalized GTFCC had the potential to bring together and hear from more of the key parties (such as water and sanitation agencies) needed to achieve results and avoid duplication. At the same time, a revitalized GTFCC could significantly raise the profile of cholera as a public health concern, and help the relevant WHO departments to advocate for greater recognition of its importance. This is a broad issue requiring a broad response – and WHO Member States have unequivocally signalled the need for renewed action in this area. Cholera is an old disease but there have been new developments, such as vaccine development, and this issue requires and warrants more attention and action based upon multi-organizational and multisectoral approaches. As a result of these and other considerations, the GTFCC revitalization process being undertaken by this Working Group was very much welcomed.

An update of WHO cholera programme activities was then presented by Dr William Perea (Coordinator, HSE/PED/CED). Current activity areas included strengthening the coordination of global and regional cholera-control efforts (Box 1) and improving mechanisms and tools for cholera outbreak risk assessment, preparedness and response. Efforts were also being made to develop evidence-based recommendations for the use of oral cholera vaccine (OCV), and to strengthen the capacity of countries for cholera prevention, preparedness and response activities. The WHO cholera programme also liaised with other WHO departments and units, including through the provision of technical support and other collaborative activities (Box 1).

Dr Perea emphasized that this range of WHO activities was intended to be illustrative rather than comprehensive, and nor did it constitute a global or WHO-wide cholera “strategy”. However, it was hoped that initiatives such as the establishment of the WHO Cholera Action Group would help to assuage concerns about the degree of internal coordination of WHO activities in this area. Although the primary focus of the action group was currently on information exchange and coordination, there was the potential for its role to expand and develop subject to approval from the Director-General of WHO.

Dr Perea then invited WHO colleagues to add to the items covered in his presentation. Dr Mamunur Malik (Medical Officer, EM/RGO/DCD/CSR) highlighted a number of country-level initiatives carried out in the WHO Eastern Mediterranean Region. These included EPI-related activities; training courses; a pre-emptive OCV campaign in South Sudan in collaboration with MSF; the provision of assistance to countries in developing cholera-preparedness plans; the use of GIS
technology to locate disease hotspots; and advocating the importance of cholera, for example in scientific papers and meetings. Dr Sylvain Aldighieri (Senior Advisor, PAHO/AMRO) then highlighted the detection of cholera clusters in South America in the context of the main Pan American Health Organization (PAHO) priorities of eradicating cholera in Hispaniola through the use of vaccination, and an ongoing focus on IHR-related issues in the Caribbean. Regarding internal coordination, PAHO now had a new senior leadership and reorganized structure with the result that most cholera programmes were now located within a single department. Vaccine stockpile activities had also been initiated, and work started on strengthening outbreak response as part of the widely shared emergency risk management (ERM) framework. Although the importance of these and other coordination issues were recognized in the context of the United Nations cluster approach, significant challenges remain when many agencies are involved – as was demonstrated recently in Haiti. Although the mandate at regional office level was mainly to work with WHO country offices, coordination at all three levels – national, regional and global – was key.

Box 1: WHO cholera coordination activities

At global and regional level

• re-organization and revitalization of the GTFCC;
• progressive steps towards increased collaboration, for example with UNICEF, MSF, IFRC, ECHO, academia (for example, Imperial College, Boston University) and the Coalition for Cholera Prevention and Control;
• increased coordination of cholera-control activities between WHO headquarters and regional offices.

Within WHO

• establishment of a WHO Cholera Action Group for the improved coordination of WHO activities;
• collaboration with PHE on a household water treatment intervention project in the Lake Chad Basin;
• collaboration with IVB on a cholera-eradication project in Zanzibar;
• collaboration with EMRO and ERM on joint risk assessments of cholera in the Syrian humanitarian crisis;
• collaboration with the HIS cluster on the assessment and prequalification of rapid diagnostic tests.

The need to strengthen national plans and interventions in endemic as well as epidemic settings was then emphasized by meeting participants. WHO planning and activities covered both endemic and outbreak aspects with the aim of decreasing disease burden. However, in line with its mandate, there was a bias in the WHO focus towards outbreak situations. In practice, it could sometimes be difficult to distinguish between epidemic and endemic cholera. Nevertheless, the work of a number of WHO departments directly impacted upon endemic situations. Addressing both aspects would be needed rather than a switch of emphasis to endemic situations – in Africa, for example, epidemics were often the drivers and addressing these would be the key to endemic control. It was then suggested that one specific activity for the revitalized GTFCC could be advising on the need for improved surveillance mechanisms and tools, for example, a revised case definition and other potential surveillance enhancements. This could potentially help to address gaps such as surveillance information shortfalls and related issues. However, as data were available and their
limits known, the real need may be to better manage current data and improve information sharing among partners rather than significantly revising current surveillance processes.

Another prime GTFCC role – and a stated aim in the revised TORs – would be to strengthen the coordination of cholera activities through improved communication of the broad range of activities of partner agencies, and of the progress made at national and regional levels. Despite efforts by WHO to establish and contribute to broader partnerships and other initiatives (for example, through the work of the vaccine monitoring and evaluation working group) and to synergize efforts, it was apparent that awareness of some of the WHO activities outlined above was not universal, even among meeting participants. Conversely, WHO had experienced situations in which potentially overlapping efforts were found to be under way. An example was also given of delayed collaboration in the production of a major academic review paper, indicating a lack of comprehensive mutual awareness of activities across different sectors and organizations. Although the scope and breadth of WHO cholera activities were welcomed, improving awareness and coordination in order to avoid duplication clearly remains a priority.

In response to concerns that such a broad programme of WHO departmental activities could be seen as ambitious in light of current staffing levels and other resources, it was emphasized that rather than been viewed as an agenda, the activities outlined might be better viewed as part of a process of reaching out to a range of implementing partners. Rather than attempt to arrive at a core set of WHO departmental priorities separate from but complementary to GTFCC activities it may be far better to emulate the Stop TB Partnership model in which working groups are assembled in each of the main activity areas – not to complement WHO activities but to work collaboratively with WHO. This potential mechanism was already incorporated into the revised GTFCC TORs should that be the recommended approach.

The issue of advocacy to help mobilize resources against cholera was raised and linked to disease reporting by countries. It was noted that countries still avoid declaring cholera outbreaks due to the associated stigma and potential for adverse economic consequences, including the closing of borders and the banning of food imports. It was highlighted that the international community had a role to play in supporting IHR activities and discouraging over-reaction by neighbouring countries. In addition, the stigma and economic impact of declaring could be taken into account in GAVI cost-effectiveness estimates. As the economic costs of declaring an outbreak are not currently incorporated into such estimates, vaccination may be more cost effective than is currently realized.

The opening session concluded with a presentation by Dr Hinman who outlined the GTFCC revitalization process to date. After setting the process in its historical context, Dr Hinman outlined the key features of the GTFCC to date. It was clear that from its inception in 1991 a number of weaknesses had been incorporated into the original approach that had undermined the efforts made to date. The GTFCC revitalization project initiated in 2012 was now approaching the end of Phase 1 which had included the First Meeting of GTFCC Working Group; the conducting of a stakeholder analysis and associated teleconferences to discuss its results; and the production of the Working Group Report and draft GTCC TORs which were now the subject of this Second Meeting of the GTFCC Working Group. Dr Hinman then outlined the key objectives of the meeting which were:

- to finalize the proposed goal, strategies, structure, membership, management and priorities of the GTFCC;
- to finalize the corresponding GTFCC TORs;
- to develop a preliminary roster of GTFCC members;
- to present the outcome proposals to relevant senior WHO staff;
• to discuss the financial needs of the GTFCC and potential approaches for obtaining financial support;
• to set out the next steps for the Working Group and for the GTFCC Secretariat.

Three existing initiatives – the Strategic Advisory Group of Experts on Immunization (SAGE), the Stop TB Partnership and the Global Polio Eradication Initiative (GPEI) – had previously been put forward to illustrate the characteristics of different approaches. One potentially contentious issue could be deciding upon the optimal role of the GTFCC. During the stakeholder analysis, differing views had been expressed on whether the GTFCC should act solely as an internal WHO advisory body or also address external agencies. A majority of respondents had indicated that it should be both. It was clear that discussions were now needed to clarify these and other issues.

2. Review and revision of the Working Group Report and GTFCC TORs

During detailed discussions the following sections of the Working Group Report – which corresponded to each of the sections of the proposed GTFCC TORs – were reviewed and revised by meeting participants.

2.1 Goal

The emerging consensus from the stakeholder consultation was that the implicit goal of any revitalized GTFCC should be to reduce the burden of cholera in endemic countries through improved collaboration and coordination. Following group inputs the following broader wording was proposed:

The goal of the GTFCC is to harness the potential of collective action to reduce the burden of cholera in countries that are affected by, or at risk of, cholera.

In order to gain international recognition and attention, it was suggested that there would be major advantages if a relevant time-limited target could be included in the next set of international development goals post 2015. It was further felt that a cholera-related target would not only facilitate cross-sector collaboration between health systems, provision of safe water initiatives and communication for development agencies but would fit very well with the criteria proposed by the Secretary-General’s High-Level Panel of Eminent Persons on the Post-2015 Development Agenda for selecting future goals. It was felt that the combination of the recent WHA resolution and the inclusion of a cholera target in the post-MDG agenda would provide a powerful impetus for driving international action against cholera. The proposed encapsulation “Stop cholera transmission; end cholera deaths” was positively received with reservations expressed only about the feasibility of stopping all transmission. The following alternative phrase was suggested: Prevent cholera transmission – End cholera deaths.

2.2 Strategies

A recurring theme of discussion in this area was the need to clarify the precise activities to be undertaken by the GTFCC and to clarify the working relationship between it and WHO. WHO would listen to and be influenced by the outcome of GTFCC work and where appropriate adopt its advice in respect to WHO processes. One example put forward of a potentially highly beneficial GTFCC activity was the facilitating of multisectoral evaluations of national plans. The GTFCC could then evolve into a more action-centred group or a mechanism for guiding actions by its member organizations. However, as the GTFCC would not be a formal WHO advisory group (such
as SAGE) any implication of developing binding “recommendations” to WHO or other agencies would need to be avoided. In relation to the six strategies proposed in the draft GTFCC TORs the following issues arose:

**Strategy 1:** Advise and support the design and implementation of a WHO strategy for cholera control and serve as the primary coordination point for cholera-related activities among WHO and other partner entities (e.g., UNICEF, IFRCS, NGOs).

There was a need to better emphasize “consensus” as achieving this would increase the likelihood of any GTFCC-coordinated strategy being adopted. Developing such a strategy based on working groups with broad and fair representation and leadership would strengthen its acceptability and for this reason should be referred to as a “global health strategy” which could eventually be endorsed by WHO rather than a “WHO strategy” per se.

**Strategy 2:** Recommend norms and guidelines developed and approved in accordance with WHO procedures and standards.

There was a need to clarify the issue of the GTFCC “recommending norms and guidelines” as this was already a recognized process within WHO. The term “approved in accordance with” in relation to WHO procedures and standards was also considered problematic and the suggestion made that it might be better phrased as “global procedures and standards”. Explicit mention was then added of “operational manuals”.

**Strategy 3:** Strengthen country capacity by supporting universal implementation of proven effective and cost-effective interventions to prevent and control cholera.

The term “universal” was queried as it could be construed as meaning everywhere rather than “everywhere where appropriate”. In addition, although the GTFCC could recommend the strengthening of country capacity, it was difficult to see a path for bringing this about. The view was also expressed that strengthening country capacity and supporting the implementation of approved approaches were two separate undertakings. Further clarity was needed in the likely function of the GTFCC from the national perspective, specifically in relation to the issue of “monitoring” cholera activities versus providing guidance to countries on this. It was suggested that GTFCC functions could include identifying good practices for inclusion in national plans and the provision of “how-to” guidance to support and facilitate the monitoring of implementation. It was pointed out however that implementation was a bottleneck and the notion of monitoring (or at least “reviewing”) it needed to be incorporated without duplicating the work of WHO in this area. Given that few cost-effectiveness studies had been conducted to date the term was deleted.

**Strategy 4:** Coordinate advocacy and resource mobilization activities to enlist additional support for cholera prevention and control at country, regional, and global levels.

It was suggested that in relation to advocacy and resource-mobilization activities that “coordinate” may not be the correct term for the role of the GTFCC and this was changed to “facilitate”. The phrase “enlist additional support for” was then shortened to “support”. It was also suggested that the issue of funding might usefully be explicitly mentioned in any final revision of the wording.

**Strategy 5:** Serve as the primary forum for collecting, integrating, and disseminating data, information, and knowledge about cholera prevention and control (knowledge management).

The term “serve as the primary forum for” was amended to “serve as a global platform for” to emphasize the distinct but complementary role of its activities which may involve the provision of
advice outside WHO activity areas. It was pointed out that the purpose of the GTFCC in this activity area must be made clear and the terms “collecting” and “knowledge management” were deleted. One potential advantage of a distinct but complementary body would lie in its greater flexibility and speed in knowledge integration and dissemination.

**Strategy 6: Develop a research agenda for cholera prevention and control.**

This was highlighted as an important issue given the need for cutting-edge technologies and implementation approaches. A slightly expanded wording was then proposed to better capture the essence of what was required. Although the GTFCC would probably have insufficient funds to directly sponsor research it could identify and advocate for pressing research priorities. It was pointed out that research was also about encouraging countries to develop their own innovative approaches to cholera control rather than simply relying upon the findings of external researchers. This was particularly important as situations varied widely and local research was the key to tailored innovation, with a need for emerging good ideas to be documented. Although global funding bodies did not generally support research a revitalized GTFCC could support advocacy efforts for funding or convene working groups to address research priorities.

2.3 Structure

Although no changes were proposed with respect to the overall GTFCC structure and member categories, it was suggested that the appointment terms be adjusted to allow for the reappointment of members and to make permanent the terms of at least some institutional members. It was also clarified that the stakeholder analysis had indicated support for an approach based upon an elected external Chair supported by a WHO Secretariat and a membership of 15 – though the view was expressed that this figure should not be regarded as an absolute cap. It was further suggested that any hybrid structure should be kept flexible, without too many restrictions or boundaries that might raise legal issues.

2.4 Membership

Discussion centred on the composition of the membership and on the need to structure in both institutional “buy-in” and independence. An attempt was made to list the categories of organizations that would need to be represented, along with specific organizations. It was recognized that if all potential organizational representatives were accommodated then the scope for individual membership may be limited. The list of potential members that incorporated all the required elements of key institutional representation and technical expertise was long and the membership limit would be a constraint. A preliminary matrix was developed which included international and regional organizations, national agencies from affected countries, development agencies, the academic sector, nongovernmental organizations, and humanitarian and cooperation agency representatives. Donors were currently incorporated as observers. An attempt was made to outline the selection criteria for individual candidates and a number of individuals provisionally listed.

Further discussion took place on the optimal composition of the GTFCC membership. It was suggested that adding a World Bank representative might raise the profile of cholera within the development community. Given the previous WHO internal coordination role of the GTFCC it was also suggested that a WHO Cholera Action Group representative might usefully be added.

Some concern was expressed at the current wording which appeared to imply that the Director-General of WHO would have the power to approve and even veto the representatives of external agencies. In addition, there had been related criticism of the heavy WHO representation within the
current GTFCC. Reassurance was given that the vetoing of any proposed member would only be entertained on grounds of a perceived conflict of interest arising from a completed DOI. Furthermore, the intention was that after its initial launch under Working Group guidance – including the proposing of the initial Chair – it would be the GTFCC itself that would decide on its membership and its proposals would be very unlikely to be overruled. Nor would members face being constrained or deselected for expressing forthright and even critical views – especially since the electing of a non-WHO Chair was part of the current TOR text. Discussion also took place on the need for the Chair to serve in an individual capacity rather than as an institutional representative.

As institutions were very likely to put forward their own candidates for GTFCC membership, there was a need to be very clear about its precise nature and role. In line with the current TORs the intention was to develop a “hybrid” between an implementing body and an advisory committee. A very clear description of what the GTFCC was intended to be was required, which should be kept both simple and flexible at the outset to avoid issues caused by over-proscribing. WHO LEG would at some point be involved in the process of precisely delineating its formal role. In relation to the current TOR text it was suggested that another bullet point be added to cover termination of membership upon an individual leaving an institution. In terms of the roles and responsibilities of GTFCC members it was felt that, given the hybrid approach envisaged, the term “solely” should be deleted from its advisory function. In addition, the text was revised to better reflect the full range of intended roles and responsibilities. The text was then further amended to make clear that the GTFCC would facilitate and support the coordination of cholera activities rather than coordinate them directly.

2.5 Management

Clarification was requested on the key issues of the functioning of a revitalized GTFCC and its relationship to its WHO Secretariat. It was emphasized that the GTFCC was not intended to be a management body, and it was indicated that the primary focus would be on the development and provision of guidance. In this role, the convening of working groups would be a key mechanism for generating and mobilizing expertise and resources, and for increasing both the deliberations and operations of the GTFCC. In order to make this approach feasible, GTFCC funding recommendations would need to be expanded. It was suggested that the GTFCC could extend to become an implementing body with a corresponding need to monitor the degree of implementation of activities but this was not a unanimous view.

In terms of WHO Secretariat support, it was pointed out that SAGE had one full-time person but that this was a well-resourced and established initiative. The Stop TB Partnership had a secretariat drawn from WHO and other agencies. It was suggested, given the ambitious proposed programme of work, that a full-time person should be requested. This might also strengthen resource mobilization and help to avoid the mistakes of the past in relation to under-staffing and under-resourcing. To avoid placing an unrealistic burden on the WHO department, it was therefore suggested that explicit mention be made of the role of WHO as the Secretariat and of the corresponding need for adequate resources and support. It was agreed that the TORs be amended to include the need for one full-time executive (FTE) as part of a package of administrative, logistical and financial support that would be required for a revitalized GTFCC.

Another key managerial issue was the monitoring of GTFCC progress. Following stakeholder recommendations and inputs, a range of potential process, output and outcome indicators had now been identified. A suggestion was also made to adjust the text to allow for meetings of the GTFCC outside the proposed biannual approach in order to respond to emerging situations.
2.6 Priorities

In advance of the GTFCC setting its priorities, a number of potentially key issues were put forward for consideration and revision. It was agreed that well-coordinated efforts by the GTFCC and its Secretariat to secure sustainable financing would be an ongoing programmatic element and thus both an immediate and longer-term priority. Setting out a clear plan in this area would also have an iterative effect on future plans and priorities. Possible sources of funding included World Bank grants, for example via a World Bank “cholera trust fund”. It was noted that both USAID and DFID had also been supportive of cholera activities in the past.

The updating of the 1993 WHO Guidelines for Cholera Control was another identified priority and meeting participants discussed how this might be achieved. As WHO had now adopted the GRADE guideline-development process, addressing specific aspects of the guidelines (for example, case management) or selective interim updating in the light of recent advances (such as vaccine development) would not be feasible. Further discussions centred on the potential utility of distinguishing between guideline development and the development of practical “manuals” and on other alternative approaches to the publication of current guidance.

The development of an investment and human-rights case to raise the profile of cholera as a global priority was viewed as another potentially important activity. It was pointed out that these are separate undertakings as developing an investment case was a distinct financial activity. Developing the human-rights basis for action could be an important complementary GTFCC activity. This case would very likely be strengthened if it also encompassed broader humanitarian issues such as poverty eradication. Synergistically linking cholera to the MDG goal of safer water and integrating this into the post-2015 MDGs was also likely to bring benefits even if there was realistically no time to now advocate for the explicit mention of the disease in the revised goals.

A proposed resource-mobilization function was considered to be more involved. The GTFCC would require its own account and a clear sense of intent. Although sourcing funding in this under-resourced area was vital, existing bodies such as the Coalition for Cholera Prevention and Control might be a better starting point. This also raised the broader issue of the need to clarify the relationship between the GTFCC and the Coalition for Cholera Prevention and Control as any perception of competition would probably be counterproductive in the current global aid context.

It was also concluded that given the large gaps that currently exist in awareness of cholera interventions and of the effective actions that can be taken, a focus on general advocacy would be a clear potential GTFCC strength. This could be supported by efforts to develop a persuasive investment case to stimulate resource mobilization by other agencies. This would avoid the duplication of resource-mobilization activities by other initiatives already under way, and might facilitate a gradual process of mutually beneficial merging.

Other activities with the potential to yield relatively rapid results were suggested, including the publication of an editorial in the peer-reviewed scientific press and the convening of a broad Partners’ Forum to bring together multiple sectors and institutes. The latter might however be expensive, and a focus on rapid returns might even be misplaced given the long-term nature of cholera activities. However, if resources were available then an early GTFCC stakeholder meeting could be held to review the current cholera situation and associated national plans (including the use of indicators), review best approaches, highlight previous advocacy and other successes and failures, develop guidance on vaccine use and initiate the process of developing the research agenda. After further consideration the following potential activities were identified:

- develop the human rights and humanitarian case for cholera;
• plan and develop an approach to combat the stigma associated with cholera reporting, and document improved reporting;
• review national multisectoral plans to identify the major components and best practices that could be recommended to countries and regions;
• collate and evaluate information on the indicators and methods used by countries to assess the effectiveness of cholera programmes and interventions, and thus identify best practices;
• develop a research agenda and budget proposal for operational research in affected countries;
• revise the GTFCC website;
• convene a Partners’ Forum or stakeholder meeting;
• provide a coordination platform to provide technical guidance and “map” a coordinated response during emerging events;
• demonstrate the impact of such improved coordination and response, for example the timely delivery of vaccine during an epidemic.

It was recognized that, taken together, this programme of priorities was ambitious but could make a significant contribution to current efforts if implemented, for example by stimulating national cholera programmes. There was also recognition however that although such a programme implied that the GTFCC would have a large workforce, the reality was that information and resources would originate from its membership organizations and partners. In addition, the lack of explicit mention in the TORs of the need to support the WHO cholera programme by bringing in external resources and partners was highlighted.

3. Presentation of the revised GTFCC TORs to senior WHO staff

Dr Perea opened the session by observing that the convening of this second meeting of the Working Group and the level of seniority of session participants were clear indications that the revitalization of cholera activities was very much a priority activity for WHO. Since the re-emergence of cholera in Latin America and Africa in 1991 the history of cholera activities, at global and regional levels particularly, has been mixed. In 2011, resolution WHA 64.15 requested the WHO Director-General, among other actions:

   to revitalize the Global Task Force on Cholera Control [GTFCC] and to strengthen WHO’s work in this area, including improved collaboration and coordination among relevant WHO departments and other relevant stakeholders.

Dr Hinman then presented the consolidated outcome of the Working Group deliberations on each of the individual sections of the proposed GTFCC TORs. Finalizing of the parallel revision of the more expansive Working Group Report which accompanied the TORs was ongoing and would be completed very shortly to reflect the inputs of meeting participants. Dr Hinman then invited comments on the revised TORs.

Dr Daniel Lopez-Acuna (Advisor to Director-General, DGO) indicated that it was not clear whether the TORs were attempting to shape an advisory group or an institutional entity to implement actions. This “hybrid” approach had created a limbo of understanding and there was a need for clarification. The GTFCC should also probably be solely an institutional membership vehicle, especially as the incorporation of individual membership would potentially be highly problematic.
In response, Dr Hinman indicated that a view had been taken that a body consisting solely of institutional members might preclude the incorporation of representatives with the required technical expertise and skills. Although it was to be hoped that institutional representatives were experts this was not guaranteed as the nomination of individuals would be made by each institute in question. Dr Perea further commented that although individuals had been generally envisaged to be academics, the notion of “academia” as an institution was understood to be problematic.

Dr Keiji Fukuda (Assistant Director-General, HSE) reiterated the view that the proposed TORs were a source of some confusion. The essential issue appeared to be whether the GTFCC was to be a global coalition of implementing agencies or an advisory body to the Director-General of WHO – this issue was at the heart of the matter. Dr Fukuda alluded to a World Bank/FAO initiative that was based upon intermediate TORs. Although there were some theoretical advantages in terms of the flexibility of such an approach, the central weakness was that countries would want to know with what authority the group acted and would require reassurances about its neutrality and other characteristics. WHO was thus very careful in setting the rules under which advisory bodies, coalitions and other initiatives operated. The development of an intermediate approach involving the selection of specific individuals would raise a number of issues.

Dr Hinman clarified that the hybrid approach had arisen directly from the results of the stakeholder analysis which had indicated a need to go beyond the technical and advisory nature of the previous GTFCC model. It had been envisaged that initially recommendations would be developed – in accordance with WHO standards – and that further activities would subsequently be added.

Dr Maria Neira (Director, HSE/PHE) suggested that one potential solution would be to remove the current strategy 2 wording as the revitalized GTFCC would not be allowed to “develop” or update guidelines. These processes were undertaken only under strict WHO guidance which governed the precise role of advisory groups such as SAGE. Dr Neira also felt that the fully stated goal sounded weak and expressed a preference for the more emphatic term: “Stop cholera transmission – End cholera deaths” as a more ambitious and inspirational mission statement, and also suggested that the category heading “Strategies” was confusing in the context of the TORs.

Dr Fukuda reiterated that the hybrid model under consideration was difficult to understand – and potentially confusing for WHO Member States attending the World Health Assembly. The nature of any revitalized GTFCC would require clear explanation. In reality, both advisory groups and task forces can play key roles in many organizations and WHO itself used task forces to amplify its effectiveness in areas such as advocacy, often in quite flexible ways depending upon the relevant WHO processes and standards. If this was clearly the proposed approach then it would be possible to proceed.

Dr Lopez-Acuna further clarified that if the revitalized GTFCC was to be primarily a collective for implementation then it must be institutionally based. If it was to be an advisory body then it would require individual experts. However, it cannot be both. If the priority remains the development of a task force for amplifying advocacy, supporting and coordinating actions and strengthening related activities then this would be fine but processes for the development of normative guidance are already in place within WHO. Dr Lopez-Acuna then put forward the example of the recently proposed WHO-led Interagency Task Force on the Prevention and Control of Noncommunicable Diseases in which the institutional membership for delivering the governing body strategy is in place.

Dr Perea expressed his thanks for the inputs received and sought confirmation of his understanding that the GTFCC should now be geared towards becoming a collective body for implementation with a purely institutional membership. Dr Fukuda provided the example of WHO activities in relation to
polio in which a clearly institutional and non-advisory body coordinated efforts with WHO using its own international experts as advisors. A suggestion was made by Dr Hinman that having institutional members who were also likely to be cholera experts might solve the current membership issue. It was felt however that this would not resolve the issue of the hybrid nature of the proposed activities of the revitalized GTFCC. Once a decision had been made on the precise role of the body it was likely that everything else would follow in respect of its TORs, including the membership aspects. Dr Lopez-Acuna suggested that further adjustment of the current TORs, including the membership section, would be needed. While expressing his understanding of the good intentions behind the proposed revitalized GTFCC, Dr Kazuaki Miyagishima (Director, HSE/FOS) also expressed his concern that the proposed mix of functions would risk early dysfunction. Positioning it one way or another and then developing whichever relevant TORs are already in place was likely to be required to avoid the task force “falling between two stools”. Dr Miyagishima also clarified that institutional experts do not need to complete a WHO DOI and that their membership does not normally revolve.

Dr Mark Rosenberg (Task Force for Global Health) drew attention both to the recent resolution WHA 64.15 calling for a revitalized GTFCC and to the recent findings of the stakeholder analysis which had indicated that the previous GTFCC incarnation had not proved to be effective. Starting from a purely “functional” perspective had led to the development of the hybrid approach as this was thought to provide the best chance of success. Dr Rosenberg suggested that the revitalized GTFCC could perhaps follow on a smaller scale the approach used in the Stop TB Partnership, which itself could be viewed as an existing hybrid approach. It was also possible that any hybrid approach would evolve over time and its role become clearer.

Dr Lopez-Acuna acknowledged that there was a need for each of the roles currently incorporated into the TORs but not within the same entity. An expert group was needed but alongside a separate coalition for coordinating and strengthening the implementation of activities. Although WHO could not accommodate the hybrid process as proposed, complementary processes would be feasible. In any case, the hosting of a process modelled upon the clearly Member State mandated Stop TB Partnership was not an option.

Dr Hinman then highlighted the already-existing Coalition for Cholera Prevention and Control and indicated that the potential merging of this initiative with the GTFCC might be considered in due course. In this approach the GTFCC could begin as an advisory body working on technical issues (including cholera guideline updating) and then merge with the coalition. Although establishing good WHO connections with the coalition would be a key aim, several senior WHO representatives reiterated the need to delineate all the separate groups in line with earlier inputs. Dr Isabelle Nuttall (Director, HSE/GCR) indicated that a schematic of all the different organizations currently working in this area might be helpful in avoiding overlap and demonstrating the distinct role of each. The SAGE advisory model was again raised as a potential fit for the approach to be taken as this mechanism provides advice based upon good institutional representation. Dr Mohamed-Mahmoud Hacen (Association Mauritanienne de Santé) observed that the feedback received to this point appeared to be unanimous, and would need to be accommodated in the revised GTFCC TORs.

Dr Fukuda indicated that what was needed was becoming clearer and that the meeting appeared to be getting nearer to resolving the issues that had been raised. In terms of revitalizing WHO effectiveness in this area the question of what needed to be accomplished must now be answered. Although it could not be everything mixed up, there were options and there was a strong prospect of either an advisory group, task force or the seeds of a longer-term coalition process developing, with the expertise needed to move this along available in the Working Group.
4. Discussion of inputs received from senior WHO staff

Given that the hybrid model was not likely to proceed through WHO processes, it was suggested that follow-up discussions be held – perhaps directly with directors – to further increase clarity. The way forward was not felt to be unequivocally clear and no consensus appeared to have been reached. One opinion seemed to be to maintain the WHO Cholera Action Group as it is and to instigate a technical advisory group (TAG). The alternative position was for the GTFCC TORs to be adjusted in such a way as to allow it to function either as a task force of agencies or as a broader external coalition in coordinating and supporting the cholera activities of WHO and other partners. It was suggested that the TORs would need substantial revision if the intention was to develop a TAG. Less revision would be needed for outlining the move to a coalition or task force.

Some confusion was expressed over the prospect of pursuing either the TAG or coalition options. The World Health Assembly specifically called for a revitalized GTFCC and neither a TAG nor an external coalition seemed to address this or to be responsive to stakeholder inputs which indicated a desire for a mechanism through which external partners could come together and work with WHO. The view was expressed that what was required was indeed a non-WHO mechanism for improved coordination closer to the original notion of a revitalized GTFCC. Although the Working Group had listened to stakeholder concerns it was accepted that WHO would not adopt the hybrid solution first arrived at – thus the current impasse.

Whichever approach was decided upon it would likely be beneficial to keep senior WHO staff fully informed through early and regular updates. This had been done to a certain extent but the updates provided were perhaps of insufficient detail. In addition, it was only now that the group had felt prepared with regard to the proposed terms of the revised TORs. Issues which still remained included the contentious issue of individual members. It was again suggested that a switch to solely institutional members, perhaps with individuals invited as observers and adjustments made in the language used to describe their involvement, may provide a solution. In addition, removing the explicit guideline-development function would still allow a revitalized GTFCC to become a key mover in setting a guideline-revision process in motion and to advise on its course, without positioning it as the primary developer of such guidelines. There was some agreement that progress in these and other areas should now be possible in terms of further adjusting the TORs once the major characteristics of the envisaged body had been decided upon.

Given the imminent 31 October 2013 deadline for completion of Phase 1 of the revitalization process it was felt that a request for clear and unified senior-level feedback should be promptly initiated. A suggestion was made to prepare an email to be immediately sent to the Assistant Director-General, HSE requesting clear guidance on how WHO wished to proceed. Without clear consensus the group risked another late setback. It was agreed that a joint Chair and Co-Chair email be sent immediately on behalf of the Working Group indicating that the guidance received required clarification while setting out the three main options which now remained namely: (i) a TAG; (ii) a revitalized GTFCC in which partners were brought together and which would recommend guideline revision or other needs as required but would not develop them, and which would be based upon institutional membership with technical working groups used as a resource; and (iii) a broader TAG/GTFCC external coalition.

After presenting the email draft and inviting comments from meeting participants the Chair sent the final agreed-upon version to the Assistant Director-General, HSE.
5. Closing session

5.1 Financial considerations for the GTFCC and its Secretariat

Discussion was held on the likely financial needs of the revitalized GTFCC with Dr Hinman providing a proposed outline of costs and related requirements and Ms Anaïs Legand (WHO/PED) providing an illustrative financial matrix. It was likely that a minimum of one full-time executive (FTE) with one half-time administrative staff would be required, with current total budgetary estimates being of the order of US$ 1 million per annum.

It would also be important to clearly distinguish between the finances and requirements of the GTFCC and of its partner agencies, with a clear need for a dedicated project fund. As some potential funding sources (such as the Bill & Melinda Gates Foundation) did not generally support secretariats, the case would need to be made that the GTFCC was more than this. Once the precise priority activities had been identified they could be used to demonstrate a focus on concrete outcomes. Potential sources of finance included USAID and other bilateral donors; individual countries (for example, Australia and Japan); and development agencies such as NORAD, CIDA (Canada) and SIDA (Sweden). In addition, the industry sector could be approached and the benefits of financing cholera prevention and control activities highlighted, for example to adversely affected oil companies, import/export companies or vaccine companies. In this context, workforce outbreaks could be responded to by approaching the industry concerned. Caution would however be needed, specifically in relation to pharmaceutical sector funding, as there are DOI issues. Reservations were also expressed over the notion of an institutional GTFCC membership fee.

5.2 Next steps for the GTFCC revitalization process

It was decided that detailed consideration of GTFCC membership should be set aside until the clarification requested from WHO had been received. A follow-up meeting with the Assistant Director-General, HSE had now been scheduled for this purpose and it was suggested that the communication sent by the Working Group be used as the basis of discussion.

It was agreed that prior to the 31 October 2013 deadline for Phase 1 activities that the revision process for both the GTFCC TORs and associated Working Group Report should be completed, and that a proposed membership list developed. As the membership was now likely to be institutional in nature the provisional institutional candidate categories previously discussed were used as the basis for further refinement and a more comprehensive list produced during further group discussion.

Following 31 October 2013 it was suggested that funding be sought for Phase 2 of the revitalization project from potential donors including the Bill & Melinda Gates Foundation. During Phase 2 funding for the GTFCC itself would be sought and its work supported by the Working Group during the first two years. Ideally, a broad consortium of long-term donors would be identified.

The Working Group agreed that efforts needed to be maintained given the progress made so far and the high level of willingness and commitment shown by all Working Group members. In support of this it was announced that WHO might be willing to arrange another Working Group meeting to maintain the momentum generated.
Annex 1: Meeting Agenda

Second Meeting of the Task Force for Global Health/WHO Work Group
Revitalizing the Global Task Force on Cholera Control (GTFCC)
12-13 September 2013

Meeting Objectives:
1. Finalize recommended goal, strategies, structure, membership, management, and priorities for GTFCC;
2. Finalize recommended Terms of Reference (TOR) for GTFCC;
3. Develop roster of proposed members of GTFCC;
4. Present proposals to relevant WHO Department Heads;
5. Discuss financial needs to support GTFCC and approaches to obtain financial support; and
6. Clarify next steps for the Working Group and GTFCC Secretariat

Thursday 12 September

9:00 – 10:45 Opening session
The opening session will set the stage for the remainder of the meeting and ensure participants are at a common level of understanding.

9:00 Welcome and Introductions; review of agenda
William Perea and Alan Hinman

9:15 Importance of cholera to WHO
Sylvie Briand

9:45 Current WHO activities in cholera
William Perea

10:15 Progress in the revitalization project; critical issues still to be decided
Alan Hinman
- Goal statement
- Should the GTFCC continue to do internal coordination of WHO units as well as convene external partners? If so, how should this happen? How do we separate the role of the GTFCC from the role of the WHO program?
- How do we set priorities? Do we start many areas at once or do we begin with a small number of priorities and then expand in time? Do we go for some quick wins to gain support for the GTFCC?
- Who should be represented on the GTFCC?
- How will the work of the GTFCC be supported?

10:45 Coffee break

11.00 – 13.00 Session 1. Discussion of Work Group Report
In this session we will review in detail, discuss, and finalize individual sections of the WG Report and Recommendations.

11:15 Goals
11:30 Strategies

13:00 Lunch
14:00 – 15:45 Session 1. cont.
14:00 Structure, Membership, Management
15:00 Priorities
15:45 Coffee break

16:15 – 17:30 Session 2. Discussion of terms of reference for the GTFCC
In this session we will review in detail, discuss, and finalize individual sections of the TOR
17:30 Adjourn
19:00 Dinner

Friday 13 September

9:00 – 10:45 Session 3. Finalization of the proposal
In this session we will review and finalize the revised WG report and proposed TOR. Then we will discuss proposed membership of GTFCC.
9:00 Review/finalization of report and TOR
10:00 Proposed membership of GTFCC
• Up to 3 members from WHO
• Countries affected by or at risk for cholera
• Governmental bodies/control programs
• International agencies, e.g., UNICEF
• Relevant areas of expertise: WASH, diarrheal diseases, research, biologics, humanitarian logistics
• Donors—as observers?
10:45 Coffee break

11:00 - 12:00 Session 4. Presentation/discussion with WHO Cluster and Department Directors
In this session we will present a summary of our recommendations and TOR to relevant WHO Department Heads and seek their buy-in

• Health Security and Environment Cluster (HSE), Keiji Fukuda
• Public Health and Environment Department (HSE/PHE), Maria Neira
• Global Capacities, Alert and Response Department (HSE/GCR), Isabelle Nuttall
• Food Safety, Zoonoses and Foodborne Diseases Department (HSE/FOS), Kazuaki Miyagishima
• Emergency Risk Management and Humanitarian Response Department (PEC/ERM), Richard Brennan
• Immunization, Vaccines and Biologicals Department (FWC/IVB), Jean-Marie Okwo-Bele
• Office of the Director-General (DGO), Daniel Lopez Acuna –in charge of partnerships

12:00 Lunch
13:00 - 15:30 Session 5. Future of the GTFCC
The final session will address the future –
- How do we integrate the feedback from the Directors into our Report and TOR?
- How do we accommodate feedback from Keiji’s office, ODG, and Legal office?
- What are financial needs of GTFCC and its Secretariat? Where will the funds be found? What are future activities of the Working Group and the GTFCC Secretariat? How will the report be transmitted to Keiji/DG?

13:00 Discussion of financial needs – how will GTFCC be supported?
15:00 Coffee break
15:30 Wrap-up and next steps for Working Group and GTFCC Secretariat
17:00 Closure of the meeting and thanks to the work group.
Annex 2: List of Participants

Working Group Members

Dr Sylvain Aldighieri
Senior Advisor
IHR, Alert & Response and Epidemic Disease
Pan American Health Organization PAHO/WHO
Washington, DC
United Stated of America

Dr Mohamed-Mahmoud Hacen
Président
Association Mauritanienne de Santé Publique
Nouakchott
Mauritanie

Dr Alan Hinman
Director of Programs
Center for Vaccine Equity
Task Force for Global Health
Decatur
United Stated of America

Dr Mamunur Malik
Medical officer
Surveillance, Forecasting & Responses
WHO EMRO
Cairo
Egypt

Dr William Perea
Coordinator
Control of Epidemic Diseases (HSE/PED/CED)
World Health Organization (WHO)
Geneva
Switzerland

Dr Firdausi Qadri
Director
Centre for Vaccine Sciences
International Centre for Diarrhoeal Diseases Research (ICDDR,B)
Dhaka
Bangladesh

Dr Mark Rosenberg
Task Force for Global Health
Decatur
United Stated of America
Dr David Sack
Department of International Health
John Hopkins University
Baltimore
United Stated of America
Phone: +1 443 2878795
Email: dsack@jhsph.edu

Dr Pascal Villeneuve
Representative
UNICEF Bangladesh
Dhaka
Bangladesh
Phone: +880 2 885 2266 ext.7001
Email: pvilleneuve@unicef.org.bd

Dr Zabulon Yoti
Medical officer
Disease Prevention and Control Cluster
WHO Regional Office for Africa
Brazzaville
Congo
Phone: +47 241 39 915
Email: yotiz@afro.who.int

WHO Senior Staff
Dr Richard Brennan
Director
Emergency Risk Management and Humanitarian Response (PEC/ERM)
World Health Organization (WHO)
Geneva
Switzerland
Phone: +41 22 79 12603
Email: brennanr@who.int

Dr Sylvie Briand
Director
Pandemic and Epidemic Diseases (HSE/PED)
World Health Organization (WHO)
Geneva
Switzerland
Phone: +41 22 79 12372
Email: briands@who.int

Dr Keiji Fukuda
Assistant Director-General
Health Security and Environment (HSE)
World Health Organization (WHO)
Geneva
Switzerland
Phone: +41 22 79 13871
Email: FukudaK@who.int

Dr Daniel Lopez Acuna
Advisor to Director General
Office of the Director-General (DGO)
World Health Organization (WHO)
Geneva
Switzerland
Phone: +41 22 79 15868
Email: lopezacunad@who.int
Dr Kazuaki Miyagishima
Director
Food Safety, Zoonoses and Foodborne Diseases
World Health Organization (WHO)
Geneva
Switzerland
Phone: +41 22 79 12773
Email: miyagishimak@who.int

Dr Maria Neira
Director
Public Health and Environment (HSE/PHE)
World Health Organization (WHO)
Geneva
Switzerland
Phone: +41 22 79 15526
Email: NeiraM@who.int

Dr Isabelle Nuttall
Director
Global Capacities Alert and Response (HSE/GCR)
World Health Organization (WHO)
Geneva
Switzerland
Phone: +41 22 79 13861
Email: nuttalli@who.int

Dr Jean-Marie Okwo-Bele
Director
Immunization, Vaccines and Biologicals (FWC/IVB)
World Health Organization (WHO)
Geneva
Switzerland
Phone: +41 22 79 12779
Email: okwobelej@who.int

Project Team
Ms Samantha Kluglein
Associate director, Programmes
Center for Vaccine Equity
Task Force for Global Health
Decatur
United Stated of America
Phone: +1 404 592 1444
Email: skluglein@taskforce.org

Ms Anaïs Legand
Technical officer
Pandemic and Epidemic Diseases (HSE/PED)
World Health Organization (WHO)
Geneva
Switzerland
Phone: +41 22 79 14266
Email: leganda@who.int

Rapporteur
Dr Anthony Waddell
Rapporteur
United Kingdom
Phone: +44 1207 233 695
Email: tony.waddell@virgin.net