GLOBAL TASK FORCE ON
CHOLERA CONTROL

FRAMEWORK FOR THE DEVELOPMENT AND MONITORING OF A MULTISECTORAL NATIONAL CHOLERA PLAN

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Abbreviations and acronyms

C4D – Communication for Development
CHW – community health worker
CTC – cholera treatment centre
GTFCC – Global Task Force on Cholera Control
IPC – infection prevention and control
M&E – monitoring and evaluation
NCP – national cholera plans for control or elimination
O&M – operations and maintenance
OCV – oral cholera vaccine
ORP – oral rehydration point
RDT – rapid diagnostic test
SDGs – Sustainable Development Goals
SOP – standard operating procedure
WASH – water, sanitation and hygiene
WHO – World Health Organization

Introduction and overview

The Global Task Force on Cholera Control (GTFCC) has launched *Ending Cholera: A Global Roadmap to 2030* (*Global Roadmap*), an initiative that aims to **reduce global cholera deaths by 90 per cent and eliminate the disease in at least 20 countries by 2030.**

Cholera elimination vs control

Elimination of cholera in countries is defined as any country that reports no confirmed cases with evidence of local transmission for at least three consecutive years and has a well-functioning epidemiological and laboratory surveillance system able to detect and confirm cases.

Control is defined as a reduction in the incidence, prevalence, morbidity or mortality of an infectious disease to a locally acceptable level (e.g. no cholera deaths).

Source: *GTFCC's Interim Guidance Document on Cholera Surveillance*.

Achieving these global objectives requires effective implementation at the country level through a multisectoral cholera coordination mechanism that aligns government and national actors, GTFCC partners and key stakeholders towards a shared strategy and common practices along three axes:

1. Ensuring early **detection and response** to contain outbreaks;

2. Adopting a **multisectoral approach** to prevent and control cholera in hotspots;

3. Establishing **effective coordination mechanisms** for technical support, resource mobilization and collaboration at national and global levels.

Multisectoral cholera control activities are organized around **six pillars**: (i) coordination; (ii) surveillance; (iii) case management; (iv) oral cholera vaccine (OCV); (v) water, sanitation and hygiene (WASH); and (vi) community engagement. The three axes lay out the dimensions by which these activities should be developed within the *Global Roadmap*.

Country engagement

The implementation of the *Global Roadmap* at the country level **is driven by national government institutions and affected communities, with the support of GTFCC partners**. National cholera plans for control or elimination (NCPs) are developed for each country's specific context, including appropriate targets for cholera control or elimination. This **framework focuses on providing guidance to countries and partners in developing and implementing their cholera control/elimination plans and activities and aligning them with the *Global Roadmap***. The GTFCC recognizes that each country will have different circumstances that will require adjustments to the guiding principles and suggested actions provided in this document. This framework is intended to assist national governments in all relevant sectors, as well as technical partners and any other stakeholders involved in the planning of cholera prevention and control activities.

Overview of key steps to develop an NCP

An NCP should be a multisectoral and comprehensive document that is operational and details all aspects of cholera prevention and control, and that is adapted to the local context and budgeted. The **NCP should be country-led and context-specific**. All relevant ministers, government agencies and institutions should be involved in the entire process, including development, implementation and monitoring. An NCP can be built on initiatives that already exist. As long as there is alignment to the objectives and axes stated in the *Global Roadmap*, the process shall not impede what has already been developed.

What should an NCP contain?

- Expression of commitment
- Comprehensive situational analysis
- Country-specific goals and milestones
- Implementation plans and budgets that can be updated on a regular basis

The NCP is a dynamic, multi-year document that states a country's goals regarding cholera control or elimination, as well as contains detailed implementation plans that coordinate all in-country actors towards those goals. The country will set interim checkpoints on the overall NCP progression and implement any corrective actions to improve results and efforts towards the goals. As activities progress, the implementation plan should be reviewed and revised on a regular basis – at a minimum annually –and updated based on cholera epidemiology. Annex A provides a checklist of activities to be undertaken when developing a NCP.

It is envisioned that NCP development will require five key steps, including:

1. **Expression of commitment:** Cholera should be recognized as a national priority by the affected countries and countries should demonstrate their political will and engagement in the *Global Roadmap*. Expression of commitment can be done through formal letters, statement of intent or policy directives from government officials.
2. **Situational analysis:** Following the expression of commitment, the county will conduct a comprehensive situational analysis that includes an overview of cholera epidemiology, identification of hotspots, key contextual factors (infrastructure, movement of population, social determinants, etc.) that can affect the spread of the disease, policy and regulatory frameworks, stakeholder analysis, and its capacity and existing resources to implement activities across the six pillars.
3. **Establish a national cholera coordination mechanism:** Countries will establish a multisectoral cholera coordination mechanism (e.g. task force or programme) with the goal of elimination/control that is inclusive of all relevant ministries (e.g. health, water, infrastructure, finance, etc.), stakeholders and partners and accountable to the highest level of government.
4. **Develop a multi-year and multisectoral NCP for control or elimination:** Using the situational analysis, countries will set their NCP goals related to the *Global Roadmap* and develop a costed plan for interventions targeted at hotspots to achieve their goals. Countries will define country-specific indicators to monitor implementation progress. Each NCP that is drafted will be reviewed and endorsed by the GTFCC's Independent Review Panel, which is composed of independent experts who will review the technical merit of the NCP and its alignment with the *Global Roadmap* objectives.
5. **Develop a monitoring and evaluation (M&E) logframe of the NCP at country level:** As part of the NCP, a standard M&E logframe should be developed. This logframe specifies inputs, activities, outputs, outcomes and impact for each of the indicators defined in the NCP. In addition, countries will be required to report on a small set of GTFCC standard indicators to monitor progress towards achievement of *Global Roadmap* goals on an annual basis.

Detailed information on the development of an NCP

Expression of commitment

Countries formally express their engagement in controlling or eliminating cholera through a multisectoral approach. By adopting this framework, countries pledge to engage on the principles of the *Global Roadmap* by agreeing to take evidence-based actions, which include enhancing epidemiological and laboratory surveillance, mapping cholera hotspots, improving access to timely treatment, promoting community engagement, integrating the use of oral cholera vaccine, and increasing investment and commitment to achieve Sustainable Development Goal 6 (SDG 6) for safely managed water and sanitation and improving hygienic conditions or behaviours in households, schools and health-care facilities in cholera hotspots. **Expressions of interest will vary by country and examples can include organizing multisectoral stakeholder meetings, establishing a national cholera programme or coordination mechanism, developing legislation on cholera control, or making public commitments to achieve the *Global Roadmap* goals**.

Situational analysis

As the second step, countries will conduct a comprehensive situational analysis, which will involve the following:
(1) cholera risk assessment, including a description of the country cholera epidemiological situation, and contextual and risk factors for spread; and **(2) capacity assessment**, including a description of current resources, capabilities, interventions, challenges and needs (by pillar) at the national level, in hotspots, and linkages to the community. The information gathered from the situational analysis will guide the formulation of the NCP while identifying gaps in technical/implementation capacity and funding. It should be noted that the situational analysis is a dynamic process and is to be updated as needed, depending on the stage of *Global Roadmap* implementation. It is recommended that the country consider conducting a multisectoral workshop to review the situational analysis to improve ownership before developing the NCP.

Key cholera definitions

Cholera endemic area: an area where confirmed cholera cases, resulting from local transmission, have been detected at least once in the past three years.

Cholera hotspot: a geographically limited area where environmental, cultural and/or socioeconomic conditions facilitate the transmission of the disease in that cholera persists or reappears regularly (e.g. episodic epidemics).

Source: *GTFCC's Interim Guidance Document on Cholera Surveillance*.

Cholera risk assessment for identification of hotspots

This section focuses on developing a strong understanding of cholera epidemiology, burden, risk and key contextual factors to identify hotspots. See Annex B for additional information and report templates of standardized information to be collected to identify hotspots as part of the situational analysis.

Review of historical cholera epidemiological indicators to identify areas with cholera burden

- Collect and compile all data on historical cholera burden, see the Excel file named NCP Tools and Templates and for more detailed guidance the GTFCC's technical note for countries to identify areas for intervention. **At a minimum, the past five years should be reviewed**. Note that this time frame depends on the specific country situation, and additional years will potentially need to be reviewed (e.g., 3-10 years).
  - **Mandatory information to be reviewed includes: mean annual incidence and proportion of weeks with reported cases.**
  - Additional information to refine rankings may include: case fatality rate, laboratory testing, confirmed cholera cases, and currently affected areas.
- The priority areas for intervention are delimited and well-defined administrative areas – level 2 or level 3 (e.g. districts or health catchment areas).
- Conduct a literature review of relevant studies on cholera epidemiology and gather information regarding any potential operational research projects.
- Develop as needed relevant graphs and maps to illustrate epidemiological information.
- Based on the analysis of data, identify the hotspots in the country.

Review contextual factors

For each identified area, evaluate the following contextual factors to further refine the ranking in terms of cholera risk and identify other at-risk areas prone for introduction ore re-emergence of cholera. The majority of these indicators will be binary and qualitative. The list below contains

suggestions for contextual factors to be reviewed and **countries should define what factors are relevant for their own situational analysis.**

- **Vulnerability**
  - Remote areas difficult to reach
  - Areas affected by humanitarian emergencies, including man-made or natural disasters
  - Areas with displaced population
  - Areas with high poverty index
  - Areas with vulnerable populations: Children with severe malnutrition, high HIV prevalence
  - Areas with special populations: prisoners, fishermen, military, etc
  - Areas with poor health systems
  - Areas with limited or poor preparedness or capacity for cholera response
- **Factors related to transmission or / and amplification**
  - Areas with high population density: Slums, refugees, IDP camps
  - Areas located on trade routes with high transit of people or influx of travellers, big urban centers, and transportation hubs
  - Areas with mass gatherings, market places, other major industries (e.g., mining or other major industrial activities)
  - Areas affected by extreme climate and weather conditions: heavy rains, flooding, droughts, periods of abnormally high temperatures
  - Areas bordering with choler affected countries with cross border movements
  - Areas adjacent to cholera hotspots
  - Areas with low immunity of the population based on earlier exposure to cholera from previous outbreaks, from endemic situations or by vaccination
- **Cultural or behavioural factors**
  - Areas with high proportion of open defecation
  - Areas with high proportion of population reluctant to use health services
  - Areas with low education level
- **Access to water, sanitation and hygiene (WASH) services and current WASH practices:**
  - An assessment of current levels of WASH coverage per SDG 6 (JMP – WHO / UNICEF Joint Monitoring Programme for Water, Sanitation, and Hygiene data may be used) and access to WASH services in hotspots.
  - An assessment of current WASH practices and risk behaviours that might cause disease transmission (e.g. does the population drink unsafe water, what is the knowledge of key handwashing times and actual behaviours, what is the prevalence of open defecation, levels of knowledge of prevention measures, food safety practices)
  - As part of this assessment and if available, countries could gather information pertaining to identified hotspots on water quality (e.g. proportion of households with access to improved water supply), including chlorination of piped supplies (proportion of households with access to basic sanitation), reliability of supplies, household water treatment and safe storage practices, and availability of household water treatment products, the proportion of people using unimproved sanitation, or additional details on sanitation services in high-risk areas such as internally displaced person/refugee camps/slums, itinerant/mobile populations and border areas. **This should also include WASH services in public institutions, particularly in health-care facilities, schools or educational facilities and markets.**

Please see GTFCC's technical note for countries to identify areas for intervention.

Capacity assessment by pillar

The NCP should include a capacity assessment of each pillar of the *Global Roadmap*, including **identification of existing services, funding and capabilities**. The capacity assessment should also provide a description of **main constraints, challenges and bottlenecks** (e.g. lack of funding or

technical resources, attitudes and behaviours, lack of political leadership or institutional coordination, etc.). In addition, any lessons learned from historical and ongoing work should be highlighted by pillar. For example, if previous OCV coverage achieved was high, there should be a description of what actions should be repeated to achieve high coverage in future campaigns. The sections below provide additional details on key items to be reviewed.

Further, the GTFCC Country Cholera Investment Case Tool can be used to develop high-level budgets and impact estimates for implementing the *Global Roadmap*. This tool provides strong country-specific advocacy messages. Also, refer to Annex B for a template and tools to be used for capacity assessments.

Coordination

This section should focus on identifying how cholera prevention, control and treatment activities are **coordinated at national and subnational levels, with key government actors, and national and international partners (e.g. GTFCC member institutions), as well as with other existing initiatives/programmes**.

(1) Common gaps identified

- Inefficient design of national cholera programme/coordination mechanism
  - Limited coordination across the different sectors working towards the same objective
  - Unclear roles and responsibilities
  - Duplicative departments working across various sectors in silos, resulting in a lack of centralized financial and administrative support focused on cholera
  - Insufficient funding budgeted for coordination activities
- Limited human and financial resources dedicated to cholera
  - No clear cholera focal point identified and unclear reporting lines (e.g. reporting only to the Ministry of Health, which consequently limits the effectiveness of the multisectoral approach, and results in poor reporting to the GTFCC and relevant partners)
- Poor monitoring of implementation activities
  - Monitoring activities are not planned or budgeted for as part of implementation
  - No clear reporting guidance is developed
- Imbalance of focusing solely on Axis 1 interventions (e.g. firefighting approach) without ensuring long-term development solutions as part of Axis 2

(2) Recommended activities

- **Provide a description of existing coordination bodies and mechanisms (national and international)** involved in cholera (e.g. National Cholera Task Force, Emergency Operation Center, clusters (Health, WASH), technical working groups such as Community Engagement, and regional platforms, and identify their ongoing activities and funding, including:
  - Identify any existing coordination mechanism between ministries managing WASH during outbreaks and for long-term interventions. Understand the existing goals and objectives of the national WASH programmes and how they apply to the hotspots.
  - Assess and identify potential areas of coordination with other programmes, such as the programme to combat polio or the Expanded Programme on Immunization
- **Review the existing policies, legislations and standard operating procedures (SOPs) related to cholera,** including preparedness, early warning, activation of the response and coordination, such as reviewing the integration policy of *Global Roadmap* pillars and data-sharing SOPs between all stakeholders at various administrative levels (e.g. WASH, health, etc.) for emergency situations; the availability of rapid response teams; and the country's experience in responding to cholera outbreaks

- **Conduct stakeholder analysis and mapping** to understand the roles and responsibilities of government departments, national and international partners, institutions and donors with regard to cholera prevention and control across all pillars, including identification of areas for collaboration and coordination
- **Assess the ability to conduct planned activities** for each pillar (e.g. is funding sufficient, is there sufficient manpower to conduct all activities, etc.). This may be done in the specific-pillar sections below and then reviewed at a multisectoral level after the assessment is completed in each pillar
- **Conduct a mapping of existing funding streams** available in cholera hotspots across *Global Roadmap* pillars, as well as assess the financial viability and the justification of the funding needs
- **Identify existing mechanisms for information sharing and high-quality information management** (for reporting and for operations support). Focus on interoperability of different information management systems for each pillar
- **Identify existing resources that can be allocated or leveraged to cholera**, identify gaps, and identify key resources needed to establish relevant mechanisms to ensure multisectoral coordination

Surveillance

The surveillance section will provide an overview of the country's **current capacity to conduct cholera surveillance**, including (i) capacity for early detection (community-based surveillance, use of rapid diagnostic tests (RDTs), specimen collection and transport); (ii) confirmation (laboratories with culture or polymerase chain reaction confirmation capabilities); and (iii) facilities to conduct data collection and reporting, analysis and interpretation of data, and production and dissemination of cholera reports.

(1) Common gaps identified

- Underperformance in early detection and confirmation of cholera and delayed response:
    - Absence of an effective reporting system recognized and used by all stakeholders to raise cholera alerts upon detection of a suspected cholera case
    - Limited knowledge and application of standard case definitions for data collection and timely reporting
    - Lack of appropriate supplies and equipment to collect and transport specimens to a laboratory for confirmation
    - Limited confirmation capacities of peripheral laboratories with hardware and regular supply of reagents to perform standard cholera diagnostics (e.g. culture-based, molecular)
    - Lack of integration of RDTs and consumables at peripheral levels to screen suspected cases as soon as they occur and organize for sample collection and referral
- Incomplete or inaccurate analysis of epidemiological data to estimate country cholera burden, identify hotspots, determine local risk factors and transmission patterns, monitor and evaluate the interventions and track progress:
    - Lack of access to data: Health-care workers (HCWs) and community health workers (CHWs) are not properly trained on case detection, data collection, management and reporting procedures
    - Lack of updated surveillance guidelines and standardized tools and procedures for data collection, reporting and analysis
- Absence of systematic and regular monitoring of water quality in all sources of drinking water (e.g. urban water supply networks, boreholes, deep wells) in cholera-affected areas, including lack of policy, guidance, implementation and enforcement of environmental surveillance or lack of training, supplies and tools for water testing. See linkages to WASH pillar.

(2) Recommended activities

- **Complete the questionnaire** "GTFCC cholera surveillance and laboratory capacity assessment".
- **Review existing assessments** of surveillance systems (e.g. polio transition plans) and **describe other surveillance programmes** (e.g. vaccine preventable disease, community-based programmes, other enteric diseases, polio, etc.) to identify opportunities for integration.
- **Review national SOPs or guidelines** for cholera surveillance (e.g. collection, transportation and storage of laboratory specimens, the national laboratory guidelines, the laboratory quality assurance system and its past evaluations, verification and investigation of outbreak alerts, ongoing reporting schedule and data sharing, mechanisms for community-based surveillance, and mechanisms for cross-border surveillance).
- **Conduct geographic mapping of laboratory sites and catchment populations** and compare against hotspots, including assessment of timing to transport samples.
- **Assess the sensitivity, specificity, completeness and timeliness** of surveillance systems and reporting protocols, defined as:
  - Sensitivity: Does the country have the capacity to detect cholera as soon as it occurs, across all at-risk areas?
  - Specificity: Is the surveillance system capable of confirming cholera (e.g. does the country only recognize acute watery diarrhoea)?
  - Timeliness: How long does it take for a suspected cholera case to be reported for investigation and laboratory confirmed?
  - Coverage: Does the cholera surveillance system cover all areas at risk in the country without any gaps?
- **Review the capacities and resources** for public health surveillance (e.g. existence of field epidemiology training programme, national public health research institutions, laboratory capacities, international agreements with reference laboratory, etc.)
- **Identify existing funding streams** for surveillance that may also be leveraged for cholera.
- **Assess the availability of laboratory supplies and consumables** in all sites covering cholera hotspots
- **Assess and review existing training plans:** frequency, materials and number of trainings conducted for surveillance and data officers

Case management

The situational analysis for case management will provide an overview of **the country's current capacity to treat cholera patients**.

(1) Common gaps identified

- High case-fatality rates are commonly reported at the onset of outbreaks due to inadequate access to treatment for geographic, social or financial reasons, and under-prepared health-care staff with inadequate materials.
- Network of health facilities, cholera treatment centres (CTCs) and oral rehydration points (ORPs) are not efficiently structured for rapid patient access
- Poor quality of care provided to patients:
  - Inadequate training of HCWs, CHWs and volunteers
  - Poor integration of cholera into the national curriculum, leading to inappropriate clinical diagnosis and treatment
  - Protocols, job descriptions and job aids not available at the onset of an outbreak or once cholera is suspected

- Lack of SOPs on screening, diagnosing and treating patients (e.g. inappropriate use of RDTs for clinical screening, overuse of intravenous solutions or antibiotics, incorrect adherence to the referral procedures)
- Insufficient supplies available at peripheral levels to appropriately treat patients (e.g. oral rehydration solution, intravenous solutions, etc.)

- Infection prevention and control (IPC) and WASH interventions are absent or insufficient in health-care facilities in hotspots resulting in cholera spreading from health facilities and other cholera-specific treatment facilities
- Communities in hotspot areas are unware of early identification of cholera symptoms, or do not trust available services to seek early treatment
- Insufficient financial and human resources to establish a cholera treatment network

(2) Recommended activities

- **Review national guidance, SOPS and protocols** (including job aids, care seeking and health promotion strategies and material, etc.) related to treatment and referral protocols, including co-morbidities and pregnant women, procurement/logistics, supply chain and stockpiling for materials and equipment; human resources training and deployment plan; guidelines on infection prevention and control (IPC), and tools for reporting and monitoring; setting up CTCs and ORP network, mobilization of additional staff, supplies and equipment, assessing capacity to rapidly establish this network
- **A geographic mapping of health-care facilities** (including CTCs and ORPs in every hotspot, detailing gaps in the availability of human resources, infrastructure (e.g. inpatient bed capacity) and access to WASH services by hardware (water, sanitation, handwashing infrastructure) and software (hygiene behaviours of HCWs) and IPC practices/protocols)
- **Assess availability of guidelines and protocols at the national level and in hotspots** and their use by personnel and with affected populations (in particular communication materials)
- **Assess availability of communication materials on accessing cholera care** at the community level
- Identify whether the country is using **CHW/volunteers** and assess their current capacity, highlighting any key challenges or successes
- Identify **community-based networks and partners** that would be engaged in promoting early care seeking and referrals to CTCs/ORPs and potential engagement of communities in building local treatment facilities
- **Assess the availability of medicines, medical equipment and medical supplies** at relevant treatment facilities, including rapid diagnostic tests
- Collect **any additional data by facility and identified hotspot** on the type of service provided, catchment population, and distance from nearest referral centre, if available
- **Assess and review existing training plans:** provide an overview of HCWs' capacity and training, whether cholera is part of the national curriculum for HCWs, nurses, CHWs and volunteers

Oral cholera vaccine

The OCV section will provide an overview of the **current capacity at country level and in hotspots to conduct cholera vaccination campaigns**.

(1) Common gaps identified

- Limited knowledge on OCV use to contribute to cholera control and prevention interventions
  - Poor understanding of OCV characteristics (e.g. efficacy/effectiveness, dosage, handling, storage, administration)

    - Targeting only active sub-sections of a larger hotspot area (e.g. vaccinating in areas after the epidemic has peaked rather than targeting areas that have a high risk of spread)
    - Limited knowledge of the recommended implementation strategies (e.g. when to use a fixed post or mobile sites, poor implementation of cold chain temperature processes, limited number of teams vaccinating, poor uptake of suggested strategies)
- Confusion regarding the processes and requirements to access OCV
    - When to access OCV, and through which mechanism (e.g. International Coordinating Group for emergency use or GTFCC for planned vaccination in hotspots)
    - Confusion regarding what documentation is needed to submit an OCV request
    - Varying level of quality of epidemiological analyses to justify OCV campaigns
- Insufficient planning conducted prior to the in-country arrival of vaccines that leads to delays in campaign implementation
- Poor or no post-vaccination evaluation and reporting
    - No budget planned to conduct post-vaccination evaluations such as coverage surveys
    - No standardization of the OCV evaluations
- Insufficient linkages to other cholera interventions, especially WASH and surveillance
- Population in hotspots do not have a complete understanding of who is eligible and should be vaccinated (e.g. adults aged 15 and over, pregnant and lactating women, etc.) or trust in the vaccination (efficacy and protocol)

(2) Recommended activities

- **Historical review** of previous OCV and other mass vaccination campaigns (e.g. measles, polio, yellow fever, etc.), **identifying key successes and challenges** experienced during vaccination (e.g. insufficient cold chain capacity, poor coverage achieved and why, reasons for non-vaccination, trust in vaccines, front-line workers and other potential demand-related factors)
- **Review any post-campaign evaluations**, reports or coverage surveys and analysis of community support, refusals and community feedback on the overall response
- A **summary table** of all relevant information on implemented OCV campaigns conducted in-country (date, areas targeted, number targeted and reached, partners involved, doses utilized, coverage reached, acceptability by populations, challenges with consent procedures)
- A **review of national guidance, SOPs and protocols** on procurement/logistics, supply chain/cold chain, social mobilization and community engagement, including identification of any historical stock issues during past OCV campaigns
- **Review of cold chain capacity available** at all levels
- **Identify any future plans** for introducing any routine vaccines or conducting campaigns (not limited to OCV)
- **Assess and review existing training plans** for the vaccination teams, supervisory staff, etc.

Water, sanitation and hygiene

The WASH situational analysis should provide an overview of the country's **current WASH policies, services and practices in hotspots**.

(1) Common gaps identified

- Limited knowledge on WASH interventions to contribute to cholera control and prevention
- Insufficient availability of WASH data at district/hotspot level
- Poor linkages with non-WASH interventions (e.g. health, epidemiology, OCV, community engagement), resulting in lack of prioritization of cholera hotspots for WASH interventions

- Insufficient funding, cost recovery or financial viability to implement interventions
- Lack of adherence to the regulatory framework by service providers leading to the lack of oversight and monitoring
- Absence of systematic and regular monitoring of water quality in all drinking-water sources (e.g. urban water supply networks, boreholes, deep wells) in cholera-affected areas. See potential linkages to surveillance pillar
    - Lack of policy, guidance, implementation and enforcement of environmental surveillance or lack of training and supplies/tools for water testing
    - Lack of coordination between ministries policies or targets (water, health, environment, etc.)
    - Lack of understanding on people's perception on water treatment and barriers/enablers to promote the use of treated water

A water and sanitation service is sustainable when:
It is functioning and being used
It is able to deliver an appropriate level of benefits (quality, quantity, convenience, continuity, health) to all, including the poorest women and men
It continues to function over a prolonged period of time, which goes beyond the lifespan of the original equipment
Its management is institutionalized
Its operation, maintenance, administrative and replacement costs are covered at the local level
It can be operated and maintained at the local level with limited but feasible external support;
It does not affect the environment negatively.

Source: Brikke (2002)

(2) Recommended activities

- **Mapping WASH vulnerabilities including preparing a table outlining WASH coverage** (as defined per SDG 6.1.1 and 6.1.2)[1] with inclusion of safely managed WASH practices by hotspots, including information on the data sources used and the reliability of estimates.
    - This should include a severity ranking of the specific WASH factors identified that can further aggravate transmission dynamics for the specific context. The information should be focused on the immediate public health risks due to WASH vulnerabilities.
- **Review the policy and regulatory framework for WASH, including national guidance, protocols and SOPs.** Identify the proportion and strength of local administrative units with established and operational policies and procedures for participation of local communities in water and sanitation management and hygiene in cholera hotspots (linked to SDG 6B).
- **Describe the existing WASH services, programmes at household, community and institutional levels (institutional should include at a minimum communities, schools and health-care facilities)**, assessing their vulnerabilities and strengths, future or ongoing projects (e.g. masterplans) stakeholders' analysis and their capacities to respond to cholera outbreaks; consider also the resilience to external shocks (e.g. climate change, water scarcity).
    - Potential factors to be evaluated include: level of staffing and types (e.g. environmental health officers, hygiene promoters, etc.), capacity for water quality monitoring, trainings conducted or training needs.
    - This should include factors contributing to community engagement, as existing community perceptions and beliefs and social norms impact WASH services and programmes.
- **Assess the capacity and feasibility of the WASH** sector for long-term cholera control and elimination, including review capacities of national and local government, technical and financial partners, civil society and the private sector (including capacities of staff (e.g. HCWs on hygiene promotion and providing supplies), human resources training, stockpiling, finance), financial viability and sustainability (e.g. cost recovery and operations and maintenance (O&M), perception surveys for willingness to pay and affordability as end users

[1] http://www.sdg6monitoring.org/indicators/target-61/indicators611/; http://www.sdg6monitoring.org/indicators/target-6-2/indicators621/

will play a key role in financing O&M) for longer-term cholera control and elimination. The box provides more information on the definition of sustainability of water and sanitation.

- **Assess and review existing training plans** related to WASH; this can include training of the community to conduct O&M of WASH infrastructure.

Community engagement

This section should provide an overview of the context that may impact the implementation of the NCP, the **current capacity to conduct community engagement activities (including social mobilization, health education, community empowerment, etc.).** The situational analysis in this section will also focus on all key cholera community engagement activities and interventions across all pillars (e.g. surveillance, OCV, management of care, hygiene, O&M or cost recovery of WASH infrastructure, etc.). The following actions should be undertaken:

(1) Common gaps identified

- Community has insufficient knowledge about the disease, its spread, and its prevention and potential treatment options
- No or limited multisectoral approach to community engagement (e.g. no shared priority behaviours for prevention and control, key messages and resources, activities are conducted in silos)
    - Limited coordination and sharing of information across stakeholders and partners
    - Cholera-related community engagement limited to outbreak response and not integrated into development programmes, as part of routine WASH
- Community engagement is conducted in isolation with the objective to delegate responsibility to the community
    - There is insufficient knowledge on the part of the cholera response to contextual factors, the political, social and cultural dynamics that shape people's relationship to the disease and the health response
- Failure to engage relevant community stakeholders (e.g. faith-based stakeholders), resulting in a community that is not well educated on the disease, its spread, or its prevention and potential treatment options
- Inability to align messages with the Ministry of Health and/or adapt messages to each audience and need
- Insufficient supplies or financing leads to inability of households to access and/or afford the resources to enable behavioural change (e.g. soap, clean water, household water chlorination, safe water containers, etc.), and little political willingness and funding to follow up on the suggestions from communities to stop transmission
- Focus on message dissemination and supply provision rather than active and strategic involvement of communities in preventing/reducing the risk of cholera transmission

(2) Recommended activities

- **Review any past assessments** of risk communication or community engagement interventions (e.g. Knowledge, Attitudes and Practices surveys, qualitative and anthropological analysis on the community's understanding of cholera as a disease, preventive practices, OCV uptake, current WASH behaviours related to hygiene, water treatment, food preparation and other local high risk behaviours and health-seeking behaviours, trust in formal health-care systems, O&M of infrastructure, etc.)
- **Review of national guidance and protocols** on health education, health promotion, social mobilization and behaviour change, including strategies, priority behaviours and related messages on cholera prevention, treatment and control, use of OCV, and WASH practices, including the availability of locally contextualized information, education, communication and other materials, workforce available for conducting community engagement activities, presence of CHWs and volunteers in hotspots
- **Identify key community stakeholders** (e.g. community influencers, local leaders, communities of interest, religious faith-based groups, civil society groups, adolescent groups, women's groups, marginalized groups, etc.) and community leaders, CHWs, traditional healers, trade unions and other relevant local stakeholders
- **Review the social, cultural, political and linguistic context** that could impact the implementation of the NCPs as well as community strengths and resources
- **Develop understanding** of community health literacy as well as linkages between community and health systems and community beliefs and behaviours towards cholera and the role of communities across surveillance, case management, WASH and OCV pillars
- **Identify existing initiatives** (e.g. risk communication and community engagement plans/programmes) and **activities at all levels (national, regional, district and hotspot)** (e.g. risk communication and community engagement plans), initiatives and financial resources to strengthen community participation across the surveillance, case management, OCV and WASH pillars or potential linkages to other diseases (e.g. polio, rotavirus, meningitis, typhoid, viral haemorrhagic fevers, etc.), frequency of training of community and volunteers
- **Assess and review existing training plans** to inform the community on the disease, identify symptoms, treatment seeking behaviour, etc.

See Annex B for additional information and report templates of standardized information to be collected by pillar for the situational analysis.

Establishment of national cholera coordination mechanism or programme

Based on the situational analysis, the country establishes a multisectoral coordination mechanism or national cholera programme aligned with the 2030 *Global Roadmap*, with the goal of control or elimination of cholera. It should be inclusive of all relevant and sector-related ministries (e.g. Ministry of Health, Ministry of Water, Ministry of Infrastructure, Ministry of Finance, Ministry of Education, local governments, municipalities, etc.) stakeholders and partners, and coordinated at the highest level. This programme should have accountability of NCP implementation to the highest government stakeholder (e.g. Prime Minister, President).

The national cholera coordinating mechanism or programme will develop SOPs that encourages the implementation of the multisectoral approach and outlines the roles and responsibilities of key actors, stakeholders and partners. The country should explore whether these supporting functions can be shared with other departments (e.g. diseases or initiatives). Countries currently experiencing protracted crises may wish to further adapt the coordination mechanism and its *Global Roadmap* goals.

Formulation of goals

Based on the information gathered in the situational analysis, the country should formulate the overarching goal for the national cholera programme. This goal must be aligned with the *Global Roadmap* goals of reducing cholera deaths by 90 per cent by 2030. It should also define whether the country chooses elimination or control, and by what year (e.g. "Achieve cholera elimination by 2025."). The goal should have a set of annual milestones to continuously monitor and report progress to GTFCC, donors and key stakeholders. An example of potential milestones of the overarching goal can be:

	Baseline	2020	2025	2030
Reduction of cholera deaths	N/A	50%	90%	90%
Case-fatality rate	5%	<3%	<1%	< 1%

NCP development, by pillar

This section focuses on providing guidance and considerations as part of the development of NCPs. It is organized by pillar, with the following sections: (a) an **introduction**; (b) potential **objectives**; and (c) potential **interventions** to enhance each pillar, which will have to be budgeted. Each of these sections presents examples that may be helpful when developing the NCP implementation plans and budgets for each pillar.

This section is not meant to replace existing technical notes or guidance, please see Annex D for relevant technical guidance. Instead, it is meant to bring all relevant actions together for the development of multisectoral NCP. For countries currently experiencing a national protracted crisis, it will be more important to focus on short- to medium-term interventions (in general pertaining to Axis 1 of the *Global Roadmap*), such as ensuring prompt case management, reinforced surveillance and conducting OCV campaigns that complement emergency WASH interventions, rather than on longer-term (e.g. capacity-building, infrastructure changes) interventions (in general pertaining to Axis 2). See Annex B for a template of implementation plans and budgets with completed samples.

Coordination

Introduction

The achievement of the *Global Roadmap* objectives will require strong country-level coordination and accountability across different sectors, which is highlighted as the *Global Roadmap's* Axis 3. Under the national cholera coordinating mechanism, the country should formalize the engagement and accountability of all relevant actors and sectors. At the local level, coordination should focus around the planning, implementation and monitoring of activities for Axis 1 and 2, which can be done through establishing a national cholera coordinating mechanism that is accountable to the highest levels of government. Given the multisectoral approach, **it is important to clearly assign roles and responsibilities among all actors, stakeholders and partners, to identify an in-country programme manager/coordinator focused on bringing all the pieces together, to ensure accountability to the country stakeholders, donors and the GTFCC**. The activities in this pillar should be focused on (i) establishing a national cholera coordination mechanism with clear roles and responsibilities; (ii) planning and implementing interventions related to Axis 1 and 2; and (iii) monitoring and reporting of progress.

Potential objectives

- Maintain strong multisectoral political commitment at all levels towards the *Global Roadmap* goals.
- Build and maintain systematic and effective coordination for all cholera prevention, control and treatment activities.
- Ensure that all stakeholders undergo readiness and preparedness activities to implement interventions related to the *Global Roadmap*.
- Monitor and report on implementation progress of cholera interventions and impact.

Potential interventions

(1) Establish a national cholera coordinating mechanism or programme

- After the country has expressed commitment in engaging in the *Global Roadmap*, and political will has been generated, the country will establish the national cholera coordinating mechanism (e.g. Prime Minister appoints a responsible individual to establish and coordinate this mechanism).
- Develop terms of reference for the identified positions. Positions should include National Cholera Programme Manager and relevant support (e.g. administrator, accounting officer, M&E officer, technical officer). The National Cholera Programme Manager will be responsible for facilitating coordination of in-country stakeholders, ensuring implementation of activities, serving as a national cholera champion, monitoring in-country financing, reporting to donors and coordinating with the GTFCC.
- Establish national reporting lines across different sectors to the highest level of accountability (e.g. Prime Minister).
- Establish other SOPs for the national cholera coordinating mechanism or programme, including:
    - Develop key objectives to achieve *Global Roadmap* goals;
    - Establish terms of reference for regular meetings and updates for all key stakeholders and partners, identifying key outcomes and actions to be undertaken after each meeting; and
    - Establish mechanisms or platforms to share alerts and epidemiological information to guide the actions of all key stakeholders and partners.

(2) Coordinate and develop necessary plans for early detection and rapid response (Axis 1)

- Develop protocols to establish early warning protocols and multisectoral rapid response teams, including training plans, and including at least WASH and health specialists at central and intermediate levels for alert verification and outbreak investigation and response.
    - Consider leveraging existing cluster coordination mechanism
- Objectives should include standardized daily reporting and confirmation of a cholera alert
- If there is a suspected case or alert, convene, equip and deploy a multisectoral outbreak investigation/rapid response team that includes, at a minimum, epidemiological, WASH, environmental health, clinician and lab specialists or technicians.
- If the alert is confirmed, the outbreak investigation team will begin organizing the response. Responsibilities can include: collection of data to develop situational reports, collection of data to develop necessary response, ensuring case management job aids and protocols are available, and positioning of ORPs/CTCs to improve access to care, in-home water treatment products, antibiotic prophylaxis to family members of index case(s), and conducting reactive vaccination campaigns.
- Routinely collect and analyse data to plan interventions (information for action); see linkages with the surveillance pillar.
- Develop training of staff to be deployed during an outbreak investigation/rapid response teams. Consider leveraging existing cluster coordination mechanisms

- Routinely collect, analyse and discuss data; see linkages with the surveillance pillar. If there is a suspected case or alert, convene, equip and deploy a multisectoral investigation/rapid response team that includes, at a minimum, epidemiological, WASH, environmental health, clinician and lab specialists or technicians. Objectives should include standardized daily reporting and confirmation of a cholera alert.
- If the alert is confirmed, investigation team will begin organizing the response. Responsibilities can include: collection of data to develop situational reports, collection of data to develop necessary response, ensuring that case management job aids and protocols are available, and positioning of ORPs/CTCs to improve access to care, in-home water treatment products, antibiotic prophylaxis to family members of index case(s), conducting reactive vaccination campaigns

(3) Coordinate plans for long term sustainable development solutions (Axis 2)

- Gather all implementation plans across sectors and incorporate them into the NCP, identifying any areas of duplication and potential gaps in proposed activities.
- Ensure that equity and inclusion approaches are included as part of budgeting and planning.
- Present and obtain approval of the consolidated NCP from all actors, stakeholders and partners.
- Submit the NCP on behalf of the country to the GTFCC and, as necessary, work with the GTFCC Independent Review Panel to address any comments.
- Strengthen health-care systems to ensure that cholera is well integrated with other disease control programmes.
- Continue to identify additional opportunities to encourage a multisectoral approach (e.g. include revised guidelines as part of the curriculum in medical and nursing schools).
- Ensure that the cholera coordination mechanism is integrated as part of the larger national development agenda.

(4) Monitor and reporting of progress

- Develop a national cholera programme logframe with Specific; Measurable; Achievable; Realistic; and Time-Related (SMART) indicators, including the mandatory GTFCC indicators; see Annex C.
- Develop a process for data reporting requirements (e.g. peripheral to district to regional to national to global) and conduct regular reporting upwards at national and global levels, ensure that data are also communicated to lower administrative levels.
- Conduct regular meetings with all stakeholders to update and evaluate progress on implementation activities and develop corrective actions as needed.
- Organize an annual multisectoral stakeholder review to assess progress on implementation of planned activities and propose corrective actions and/or ensure the inclusion of cholera information in other relevant annual sector reviews, such as WASH and health. Include conducting a review of budget and expenditures.
- Develop supervision and quality checks for each NCP pillar, in order to measure the performance of the coordination, the partnerships created and the capacity of the pillar for advocacy and resource mobilization; and evaluate the emergency response, with a focus on identifying gaps and developing solutions.
- As needed, regularly revise and disseminate technical guidelines and SOPs to reflect the lessons learned and best practices from past experiences, and to reinforce practices.

Surveillance

Introduction

Strengthening epidemiological and laboratory capacities to rapidly detect and confirm cholera is a key part of the *Global Roadmap*. Surveillance activities should be integrated within the existing

surveillance system and focus on improving the ability for timely detection and confirmation of cholera to quickly respond to outbreaks (Axis 1), identifying high-burden areas that require long-term interventions (Axis 2), monitoring implementation progress of the NCP at country level, and measuring and evaluating the impact of the interventions. **All proposed activities described should ensure the integration of cholera into the existing surveillance systems.**

Potential objectives

The objectives of a well-established integrated cholera surveillance system can include:

- Ensuring that all cholera alerts are investigated in a timely manner – e.g. within 48 hours via culture or polymerase chain reaction –to allow for timely implementation of full cholera control measures within five days of laboratory confirmation, including the following:
    - Develop a system that encourages or motivates the community to report potential cases to health authorities.
- An integrated cholera surveillance system ensures that data are routinely collected, updated and analysed, including the following:
    - Rapid investigation of alerts
    - Identification and mapping of cholera hotspots
    - Estimation and monitoring of cholera burden, country disease transmission patterns are defined and regularly updated, including across borders with neighbouring countries
    - Provides timely and complete reporting and analysis of data (e.g. patient registers, line lists, etc.)
    - Monitors and evaluates the effectiveness and impact of cholera interventions, tracking national progress to elimination or control
- Establishing a mutually beneficial partnership with an international reference laboratory for global epidemiology investigations and support for country priority capacity-building needs.

Potential interventions

(1) Ensure that cholera epidemiological and laboratory surveillance guidance, protocols, and processes are regularly updated and integrated into existing surveillance guidance, protocols and processes.

- Develop or update national cholera surveillance guidelines and SOPs, including standardized case definitions, use of RDTs and testing strategies (confirmation, antibiotic susceptibility, genetic sequencing, etc.), specimen collection, transport, and storage, data collection and reporting procedures and data analysis, provision of supplies and materials, handling stockpiling RDTs, environmental surveillance (see WASH section) and community-based surveillance.[2]
- Conduct an annual review of guidance, protocols and processes, identifying potential barriers and solutions to effective management of cholera surveillance. Implement, as necessary, changes to guidance, protocols and processes.
- Develop/update standard tools for data collection and reporting (e.g. patient registers, line lists etc.), incorporating cholera-related items.
- Establish a cross-border communication and collaboration mechanism with SOPs and mutual responsibilities.

[2] Community-based surveillance relies on the participation of the community in detecting, reporting, responding and monitoring health events in the community. This should be considered part of the surveillance system and is especially relevant in remote areas with difficult access to health facilities.

(2) Develop methods and plans for the regular evaluation of surveillance system quality, which includes cholera.

- Consider establishing a national reference laboratory (e.g. identify location, trained staff), or consider pooling resources for a supra-regional reference laboratory that integrates cholera and reinforces technical and diagnostic capacity (see linkages to section below on quality control and quality assurance).

(3) Ensure capacity for early detection and alert of cholera

- Deliver training in early warning procedures to health-care workers and CHWs focusing on improving knowledge of:
  - Cholera case definitions and alerting procedures when a cholera outbreak is suspected
  - Uses of RDTs, including testing strategies, procedures, interpretation of results, and limitations
  - Procedures for collecting, storing and transporting stool samples
- Brief the community on suspected cholera definitions and on the reporting mechanism to launch an investigation given their role in raising cholera alerts.
- Evaluate the performance and procedure of new RDT kits at the central level in the National Reference Laboratory prior to distribution and use.
- Develop job aids and SOPs on RDT use, specimen collection and transport and ensure they are distributed and available in all levels, including peripheral health-care facilities.
- Ensure that the supply of cholera RDTs and specimen collection and transport media supplies are in stock at all peripheral health-care facilities.

(4) Ensure capacity for laboratory confirmation of suspected cholera cases at lower levels

- Identify hotspots with poor laboratory confirmation capacity to conduct culture or polymerase chain reaction testing.
- Using collected information from the situational analysis, establish or reinforce laboratory capacity to ensure sufficient coverage of all hotspots. (e.g. may require decentralization of laboratories, adding additional human resources focused on cholera, upgrading equipment, or improving access to central laboratories).
- Develop multi-year training plans to laboratory technicians on culture and biochemical testing procedures. Deliver training and re-training to laboratory technicians.
- Ensure necessary hardware, reagents and supplies to identify toxigenic *Vibrio cholerae* O1/O139 are available in all laboratories systems/networks.
- Establish collaboration with regional or international reference laboratories to reinforce technical and diagnostic capacity at the national level (e.g. advanced molecular testing methods).

(5) Ensure capacity for data collection, reporting and analyses

- Develop a training plan for data clerks at peripheral levels that are responsible for reporting data to the national level.
- Adopt the GTFCC standardized tools and reports for data collection and analysis (e.g. report templates, situational analysis, etc.).
- Ensure that the GTFCC standardized tools for data collection are available at peripheral health-care facilities (e.g. equipment and reporting forms).

- Develop a training plan for surveillance officers at the central level.
- Conduct regular data analyses, particularly looking at the interventions implemented and tracking progress towards control or elimination, including:
    - Accurately revising national estimates of cholera burden;
    - Updating the cholera hotspots data by time, place and person; and
    - Reviewing cholera risk factors and transmission dynamics.
- Routinely disseminate surveillance data to all levels and multisectoral partners to ensure proper NCP planning and implementation.
- Routinely report surveillance data globally to contribute to the monitoring of regional and global cholera transmission patterns.

(6) Establish collaboration with national, regional or international reference laboratories

- Develop and implement quality assurance or quality control programmes at central and peripheral laboratories.
- Establish or reinforce cross-border communication and collaboration mechanisms for coordinated and joint multisectoral actions.

(7) Develop training plans

- Develop training and re-training schedules and materials for laboratory technicians and surveillance officers, including early warning procedures when a cholera outbreak is suspected, use of RDTs and their limitations, interpretation of results, culture and biochemical test procedures and data analyses.
- Train and equip environmental surveillance officers for testing and treatment of drinking-water sources (note linkages to WASH section).
- Train key stakeholders and partners on the interpretation of data and when to alert to a potential outbreak nearby.

Case management

Introduction

To decrease cholera mortality, one of the main challenges is to ensure that individuals with cholera have access to quality treatment as soon as symptoms appear, regardless of the disease progression. Case management interventions should be rapidly implemented as soon as there is an indication of cholera to reduce mortality and limit the spread of the disease. This entails the engagement of a cholera treatment network and strategies ranging from home-based or community care through overnight stay structures with highly trained medical staff as soon as cholera is suspected. Depending on the context, the treatment network may pre-exist or need to be established during a cholera event.

The activities in this pillar should be focused on ensuring that staff, CHWs and volunteers are appropriately trained at all times, ensuring sufficient supplies and materials are available at peripheral health facilities and in the community, improving access to treatment, and implementing WASH and IPC measures.

Potential objectives

- Ensure that the cholera case-fatality rate remains well below 1 per cent through effective case management;
- Reduce community deaths from suspected cholera by preventing infection and increasing early access to effective treatment;

- Stride towards achieving no facility-based cholera deaths; and
- Eliminate cholera transmission risk through the implementation of proper measures for IPC in health facilities.

Potential interventions

(1) Ensure the capacity of HCWs, CHWs and volunteers, and availability of supplies to diagnose and treat patients

- Develop or update all guidance, SOPs, job aids and protocols regarding triage, diagnosis, clinical management, referral guidelines, IPCs, data collection and reporting, supervision and the quality control of care, treatment of severe acute malnutrition, discharge protocols, etc.
- Ensure that all SOPs, protocols and job aids are distributed and displayed for easy access. Documentation should include information regarding case management – treatment (home, community and facility) and referral processes.
- Ensure that the identification and treatment of suspected cholera is integrated into the national curricula for HCWs. Include key signs, basic treatment, and when and how to refer patients in training programmes. Ensure that basic hygiene messages are also included (see WASH section below).
- Develop a training plan for HCWs, CHWs and volunteers at all levels, including diagnosis, assessment of dehydration, clinical management (e.g. treatment, antibiotic and adjunct therapies (e.g. zinc supplementation for children) adapted to the local context), community case management, early detection and referral system, how to fill out all forms (e.g. patient registers), basic precautions including regular hand hygiene and delivery of hygiene messages to family members and in treatment facilities, safe and dignified burial of individuals.
- Establish an annual plan to predict supply and infrastructure needs (e.g. number of beds, number of intravenous sets, chlorine, cleaning supplies, etc.) at all levels (peripheral, district, regional and national) and the ability to reorder supplies in a timely fashion.
- Ensure the availability of sufficient supplies and/or stockpiling of supplies (e.g. oral rehydration solution, intravenous kits, waste bins, handwashing stations with soap, chlorine solution preparation, cleaning supplies, protective gear, sprayers, body bags, etc.) at the peripheral health-care facilities.
- Ensure a regular monitoring of health worker activities at the community level and regular follow-up of their capacities through regular 'training refreshment' and feedback meetings.

(2) Improve access to cholera treatment

- Ensure existing care systems (e.g. CHWs/volunteers, community centres, hospitals) at peripheral levels in hotspots can identify and diagnose symptoms, adequately treat patients, know the referral pathways, and report patient information and data.
- Ensure that the identification and treatment of suspected cholera is included in the national curricula for CHWs and volunteers, and training opportunities for leaders and other relevant locally based government officials.
- Use surveillance data to identify areas to design/update the network of health-care facilities, ORPs and CTCs that are accessible to the most affected populations (e.g. may require decentralization)
- Estimate the supply and infrastructure needs at national, regional and district levels on an annual basis. Potential tools include a CTC calculator that incorporates historical, current and expected cholera epidemiology to calculate the needs and subsequently order new cholera kits and modules.

- Identify and determine the availability of additional surge staff.
- Establish a plan for management of treatment facilities, including rotation of staff to ensure that all facilities are functional 24/7 during outbreaks.

(3) Ensure that communities are engaged and seeking treatment early

- Use Knowledge, Attitudes and Practices surveys and qualitative data to inform risk communication and community engagement approaches that educate and motivate communities to identify symptoms of cholera and seek early care.
- Engage communities to provide suggestions as to how to improve cholera response and act on these solutions (e.g. support the organization of local-level activities to promote the use of ORPs and CTCs, hygiene and sanitation).
- Engage with communities to build trust among local health-care service providers and in the use of ORPs and CTCs and seeking early treatment.
- Develop interpersonal communication and counselling skills of front-line HCWs to promote early treatment-seeking.

(4) Ensure capacity for data reporting; see linkages to surveillance section

- Develop SOPs and protocols for data reporting, including identification of items to be reported, how often, and to whom and the quality of reporting expected.
- Ensure that HCWs, CHWs and volunteers understand and are trained on the standardized tools for data collection and interpretation of data; if necessary, conduct training.
- Develop checks and balances to ensure that the regular reporting of cholera is occurring.
- If qualitative approaches will be used during data collection efforts, partner with local social science institutes and learn from existing anthropological and other social science literature available on the intervention context.
- Ensure that relevant data will be shared across different pillars – in particular qualitative data which contains suggestions of affected communities – in a digestible and concurrent manner.

(5) Ensure that IPC and WASH measures are being implemented in health-care facilities, CTCs or ORPs

- Prioritize the implementation of WASH and IPC in programmes in health-care facilities held in cholera hotspots, ensuring that good practices are being utilized.
- Develop or update guidelines, SOPs and job aids on IPC, including safe management of health-care waste, safe disposal of faecal waste, safe disposal of grey waters, and safe management of dead bodies
- Organize appropriate patient flow and segregation in health-care facilities and CTCs
- Develop a plan to ensure the safe disposal of waste, excreta and vomit, as well as designated latrines for cholera patients who can walk
- Ensure the availability of sufficient safe water and food to cover the daily needs of patients, caregivers and staff
- Prepare and make available chlorine solutions for disinfection
- Train ancillary staff (cleaners, guards) on appropriate cleaning, IPC and WASH procedures

(6) Conduct assessments of health facilities, CTCs, and ORPs

- Integrate cholera into the existing supervisor plans for assessing quality of care given in hotspots (health facilities, CTCs, ORPs) in advance of a known cholera season, during cholera outbreaks, and during regular check-ins.

- Assess the quality of care given to patients – see the CTC checklist for a comprehensive list for an in-patient facility, which should include:
    - Assessing timely access to appropriate rehydration methods, management of treatment, and the "no one alive at admission should die due to cholera" principle
    - Identify and correct any delays of supplies arriving to health facilities, CTCs, ORPs or delays to receiving treatment (e.g. insufficient staff, inadequately trained staff)
    - Assess other main elements, including IPC measures, facility layout/organization, screening/admission processes, hospitalization areas, kitchen and meal preparation, treated drinking water, usable and accessible toilets, water and sanitation, latrines, laundry and showers, waste and dead body management, data management and reporting

Oral cholera vaccine

Introduction

OCVs should be used in areas with endemic cholera, in humanitarian crises with high risk of cholera, and during cholera outbreaks. The vaccines should always be used in conjunction with other cholera prevention and control strategies. Vaccination should not disrupt the provision of other high-priority health interventions (e.g. case management, emergency WASH) focused on controlling or preventing cholera outbreaks. In all settings, a series of criteria should be considered to guide the decision to vaccinate, including:

- The risk of cholera among the targeted populations and the risk of geographic spread for endemic, humanitarian and outbreak response;[3]
- The programmatic capacity to reach as many people as possible who are eligible to receive the vaccine and living in the targeted area (e.g. those aged ≥ 1 or 2 years, depending on the vaccine used); and
- Implementation of previous OCV campaigns. Cholera vaccination should not be carried out if a campaign has been conducted in the previous three years in the same population, unless justified by continuous transmission resulting from inadequate vaccine coverage during the previous campaign and/or substantial population movements.[4]

The implementation activities in this pillar should focus on improving the ability to conduct high-quality campaigns that cover a large proportion of the target population, and on ensuring sufficient M&E to improve future campaigns.

Potential objectives

The primary objectives of OCV campaigns will include:

- Obtaining high coverage of the targeted population (e.g. greater than 80 per cent) with low drop-out of the second dose of vaccination, resulting in population-level immunity.
- Ensuring a good understanding of the community, and facilitating the mobilization of the people who are eligible and should be vaccinated.
- Ensuring that campaign data are routinely collected and analysed to improve future vaccination campaigns, and that such data are reported to the national levels. Reported data

[3] Countries may also wish to assess the potential of pre-emptive vaccination for mass gatherings in high-risk locations.

[4] https://apps.who.int/iris/bitstream/handle/10665/258764/WER9234-477-498.pdf;jsessionid=68F60DB7A2B9C4CF5F49686B1EDCDC7A?sequence=1

should include vaccination registers, and numbers of doses received, administered and wasted.

- Ensuring that OCV is well integrated with the other *Global Roadmap* pillars, particularly using the opportunity of vaccination campaigns to conduct WASH activities and reinforce access to WASH in the longer term after vaccination campaigns (see the WASH section below for examples).

Potential interventions

(1) Develop medium term vaccination plans (up to 3 years)

- Prioritize hotspots based on public health needs (e.g. accessibility, unstable situations) using collected information from the situational analysis.
- Develop timelines of activities and identify key responsible parties, including identification of dates for each campaign, training of front-line workers, community networks to be mobilized, touchpoints to debrief on lessons learned, etc.
- Develop contingency plans for vaccination campaigns in unexpected locations (e.g. identify decision pathways for determining the use of OCV, preparation of readily available data for applications).

(2) Ensure availability of supplies and vaccines at all relevant levels

- Calculate the quantity of vaccines and supplies needed by site according to a calendar of implementation.
- Develop distribution plans for supplies and vaccines to reach peripheral health-care facilities five days prior to planned vaccination dates.
- Ensure sufficient and appropriate cold chain is available when campaigns are being conducted.
- Identify a process for reporting and requesting additional supplies and vaccines when stocks are running low (e.g. define 'low' by levels and ensure that relevant individuals are aware of process to request additional supplies and vaccines).

(3) Develop microplans and related budgets

- Utilize maps outlining distances and population spread to determine appropriate areas for fixed-post vaccination or areas that may require mobile vaccination.
    - Overlay the peripheral health facilities to ensure appropriate linkages with the case management pillar
    - Identify high-risk or hard-to-reach areas and population groups as well as adjusted vaccination strategies to reach target coverage
- Evaluate and plan for complementary implementation and linkages to other cholera interventions, with a focus on WASH interventions (see WASH section for additional information).
- Develop a budget and timeline of activities with identified responsible parties and deadlines. The budget should include activities from preparation to implementation, as well as M&E, such as training, preparation of supply chain and logistics, printing and distribution of vaccination cards and registers, social mobilization and community engagement, development of a supervision plan, and debrief of OCV campaigns for future campaigns. Please see Annex B for a sample Gavi budget OCV operational costs budget.

(4) Establish and ensure the capacity of vaccination teams

- Determine the composition and number of vaccination teams (e.g. coordinators, supervisors, vaccinators, health promoters, social mobilizers, etc.).
  - Calculate the expected number of people to be vaccinated per team per day
  - Calculate the number of teams needed to cover the population and the number of days
- Develop a training plan, including refresher training, for vaccination teams.
- Develop a plan for the supervision and monitoring of vaccination campaigns.
- Ensure that standardized tools for data collection are available at peripheral health-care facilities and that the vaccination team is trained on reporting requirements (e.g. equipment and reporting forms).
- Identify and engage implementing institutions to assist in OCV campaigns and assign roles and responsibilities.

(5) Ensure capacity for conducting M&E activities

- Ensure that vaccination teams are equipped and trained on vaccination data recording and reporting requirements during the campaign.
- Ensure that standardized tools for Adverse Event Following Immunization reporting are available at peripheral health-care facilities.
- Prepare, as necessary, forms and guidelines to report Adverse Event Following Immunization and conduct post-campaign evaluations.
- Prepare contingency communication plans and materials in case of Adverse Event Following Immunization or other negative reactions to the OCV campaign.
- Collect and report all campaign data to national surveillance officers for further compilation at the national level. Minimal data requirements include collecting information on the number of doses received and delivered, number of doses wasted, target population vaccine registers, and tally sheets for the second round.
- Plan and budget formal post-campaign evaluations (e.g. coverage surveys).
- Conduct any other relevant M&E activities – e.g. effectiveness of alternative delivery strategies, or cost-effectiveness studies – as needed.

Water, sanitation and hygiene

Introduction

WASH is the key intervention to long-term cholera elimination. The *Global Roadmap* aims to contribute to SDG 6 by focusing WASH efforts in historically marginalized areas that are characteristic of cholera hotspots. The section below focuses on providing examples of potential activities that should be undertaken as part of Axis 1. It provides a high-level overview of activities to be conducted as part of improving WASH in cholera hotspots (Axis 2), and activities that should be conducted as part of OCV campaigns or other health interventions. Countries experiencing national protracted crises should prioritize immediate or medium-term activities,[5] such as software activities focused on hygiene promotion and training.

[5] Countries experiencing national protracted crises are not expected to focus on large infrastructure changes.

Potential objectives

- Increase the proportion of the population with access to safely managed water and sanitation services and hygiene promotion in all cholera hotspots to reach 100 per cent (in line with SDG 6).
- Develop and sustain a governance and legal frameworks to support countries and show improved accountability.
- Ensure the engagement and involvement of communities and local government/providers to sustain WASH services management.
- Monitor WASH services in cholera hotspots.

Potential interventions

(1) Axis 1 – WASH preparedness and response to cholera outbreaks

- **Develop or update guidance, SOPs and strategies related to WASH in emergency settings** (in line with GTFCC guidelines) **and determine a dissemination plan**, including civil society and private sectors.
    - Documents may include a decision pathway for the identification of interventions to be used in emergency settings, and provision of emergency WASH supplies.
- Guidance documents should include WASH for IPC in cholera treatment facilities, water quality surveillance, and WASH in affected and at-risk populations, preparedness and logistical plans for distribution of commodities, and ensuring the pre-positioning of supplies for interventions in communities and health-care facilities.
- **Prepare training and capacity-building plans** for health workers, WASH staff, and community volunteers or workers based on a standardized set of modules focused on WASH preparedness and response to prevent disease transmission and control cholera, which may include training on disinfection of water supplies.
- **Conduct WASH interventions in affected and at-risk populations** (households, communities, and public institutions, schools or educational facilities, and markets) as part of an outbreak response. These interventions include the following examples:

Example components	Response to outbreak
Water supply	Water infrastructure quick fixes (e.g. rehabilitation of hand pumps, replacement of filtration systems and/or chlorination systems), provision of chlorinated drinking water (e.g. emergency tanks)
Household water treatment and storage	Safe water storage containers or water treatment kits
Water quality surveillance	Water safety plans
Environmental sanitation	Quick fixes of sanitation infrastructure (e.g. minor rehabilitation of waste water treatment plants, community cleaning campaigns)
Community engagement, Communication for Development (C4D), risk communication, hygiene promotion	Dialogue with community influencers and civil society groups, distribution of soap, oral rehydration solution, cleaning supplies, and promotion of hygiene behaviours for prevention of cholera (e.g. door-to-door promotion, community meetings, at health-care facilities, alongside vaccine campaigns) (see section below)

WASH and IPC in cholera treatment facilities	Distribution of guidelines, job aids and supplies (High Test Hypochlorite, containers) – links to management of care and community engagement; training and empowering workers to practice good IPC and hygiene behaviour change

(2) Axis 2 – Develop a WASH implementation plan in hotspots by aligning with the overall national objectives

- Using data from the situational analysis, **conduct a comparative analysis of existing activities and any identified gaps** to be addressed within the NCP in cholera hotspots as well as the fitness to conduct Axis 2 activities.
- **Conduct an analysis of existing water and sanitation infrastructure 'masterplans'** in hotspots to identify gaps and develop appropriate solution to address the gaps.
    - Ensure that the assessment considers **social, health and hygiene, technical, economic, financial, institutional and environmental**[6] factors when selecting the most appropriate solution. This ensures that the wide range of concerns associated with WASH infrastructures are addressed, as sustainable WASH development is not a direct result of solely technical or infrastructural aspects. This includes:
        - Social: population demographics and distribution (e.g. gender, people living with disabilities, elderly, pregnant women, household size, education levels, etc.); cultural customs and traditional habits (including anthropologic factors that influence use and uptake); cost, demand, willingness and ability to pay for different level of services; access and equity considerations
        - Health and hygiene: motivators and barriers to practices and behaviours by different groups; health statistics and services available
        - Technical: water availability, demand and use; water quality; potential for O&M of services based on availability of spare parts, materials and local capacity
        - Economic and financial: fitness and structure of the economy; cost, demand, willingness and ability to pay for different level of services; consideration for pro-poor tariff structures; available financing and funding methods
        - Institutional: policy and regulatory framework; organizational roles, responsibility and relationship between service providers, communities and end-users
        - Environmental: climate, rainfall and hydrology; soil conditions, geology and groundwater characteristics; water resource availability; sustainability and resource management
- Identify technical solutions to be implemented. Each **identified solutions should address household, community and public institutions and places** (e.g. health-care facilities, schools or educational facilities and markets) as deemed relevant.
- Each technical solution **should be costed and phased with planned timelines** for implementation and identified responsible parties. These plans should also be included as part of the development of costed and budgeted plans to reach the national objectives. Activities can include:
    - Create linkages to surveillance activities, particularly on environmental surveillance.
    - Improve or increase infrastructure and operation and maintenance needs in hotspots – e.g. boreholes, pit wells, etc.
    - Improve water safety and surveillance and household water treatment and safe storage, where appropriate and sustainable – e.g. subsidy scheme, distribution of safe water-storage containers

[6] WELL Resources (n.d.) *Choosing an appropriate technology – Brief 49*. Water Engineering Development Centre (WEDC) Publications: Loughborough University: Leicestershire, UK https://www.lboro.ac.uk/orgs/well/resources/technical-briefs/49-choosing-an-appropriate-technology.pdf

    - Conduct any planning activities related to environmental sanitation
- **Develop cost recovery and O&M plans** (recurrent and capital costs) for proposed technical solutions for the targeted hotspots as part of national plans. The O&M plans should be regularly monitored to check the condition and quality of the infrastructure.
- **Assess and design a financial strategy** based on the sound knowledge of financial flows, leveraging efficiency gains, and different sources of funding (e.g. financial viability); consider conducting a rate of return on investments.
- **Develop and conduct monitoring of key performance indicators** focused on the management of service provision.
- **Prepare training and capacity-building plans** for key stakeholders in hotspots (e.g. health workers, WASH staff, and community volunteers or workers) on household water treatment methods, handling and storage techniques, operations and maintenance activities, etc., based on a standardized set of modules focused on medium- to longer-term WASH actions aimed at cholera control and elimination. This should be linked to community engagement activities focused on behaviour change and participation to support the sustainability of safely managed WASH services.
- **Advocate for resources** at the national level for development and maintenance of WASH infrastructure to address vulnerable population (e.g. urban slums).
- **Engage community leaders and stakeholders** on how to maintain WASH infrastructure and target behaviour change (e.g. water safety plans, how to appropriately use latrines, how to keep toilets clean and accessible, processes to contain, treat and dispose excreta, proper garbage collection and disposal, appropriate and systematic hand washing at crucial times, appropriate water treatment and storage practices, safe food practices, safe preparation and safe burial practices).

(3) Activities that should be conducted during an OCV campaign or any other intervention

Example components	During OCV campaigns
Water supply	One-off water treatment/chlorination of water points
Household water treatment and storage	Same as above
Water quality surveillance	Punctual water-quality testing
Environmental sanitation	Emptying of pit latrines, community cleaning campaigns
Community engagement, C4D, risk communication, hygiene promotion	Dialogue with community influencers and civil society groups, distribution of soap, oral rehydration solution, cleaning supplies, and promotion of hygiene behaviours for the prevention of cholera; highlighting the importance of continuing these practices even after receiving OCV
WASH and IPC in cholera treatment facilities	Distribution of guidelines and job aids

Community engagement

Introduction

An epidemic of cholera can be more quickly controlled when the affected population knows how to protect themselves and their relatives and the community is engaged to limit the spread of the

disease, as well as when an enabling environment exists for those protective behaviours to emerge. Community engagement focuses on empowering communities and their social networks to reflect on and address a range of behaviours, cultural and contextual factors, and decisions that affect their lives and encourage proactive involvement in their development. This can be done through strategies that span across health promotion/education, social mobilization, risk communication, behaviour change communication and C4D. Further, by identifying barriers to uptake of interventions, teams can better tailor activities to suit the needs of each community. By identifying and addressing root causes, teams can best remove obstacles that may impede community uptake.

As the *Global Roadmap* promotes a multisectoral approach with different pillars of interventions that will all require community engagement for its success, these activities should be brought under one umbrella to leverage its strengths and available resources. The interventions in this pillar should focus on the identification of the communities and their goals, tailoring of harmonized messages and approaches to engage communities and identification of entry points.

Potential objectives

- Reduce community-level transmission and mortality through increasing awareness, knowledge and skills and promoting behaviours of cholera prevention and treatment tools, strengthening the community's role in cholera preparedness and response planning, including local-level coordination and providing culturally appropriate information and platforms to engage in discussions using trusted information sources (e.g. community networks and platforms for dialogue and engagement, local media).
- Develop a comprehensive community engagement plan that links all relevant pillars for both long-term behavioural change and in preparedness for outbreaks, and which works *with* communities.
- Work with community committees to empower communities to identify and address the root causes of barriers.

Potential interventions

(1) Identify the at-risk and vulnerable population and understand the community beliefs and behaviours in cholera hotspots

- Identify community stakeholders (e.g. local residents, communities of interest, religious/faith-based groups, racial, ethnic or cultural groups, adolescent and women's groups, etc).
- Identify key leaders (formal and informal) and/or CHWs to begin consulting and engaging as part of the development process.
- Engage with communities through participatory processes, including involving them in the design of preparedness and response activities.
- Develop an understanding of community beliefs and behaviours towards cholera and the *Global Roadmap* pillars.
    - Behaviours and beliefs should include prevention and care-seeking behaviours, acceptance of OCV, identification of any water and sanitation issues at the household and community levels, funerary practices, caring for sick persons, health-care referrals, hygiene practices perception, and fear of diarrhoeal diseases, specifically cholera, knowledge of prevention and treatment of diarrhoeal diseases, specifically cholera, etc.
- Ensure that community engagement strategies include the most marginalized and disabled people, as well as any equity and inclusion perspectives.
- Embed local social scientists in the response from the beginning and strengthen the link between local and global social science research networks.

(2) Identify and prioritize a comprehensive set of community engagement interventions

- Define an overall community engagement goal for the NCP and objectives for each pillar, and consider developing different objectives for Axis 1 or Axis 2, as well as cross-cutting objectives.
- Identify why and how community engagement can contribute to its results.
  - §
- Consult the community, discuss key roles community leaders and members can play, and potential entry points, solutions and strategies. Engage the community in the planning, implementation and evaluation stage of any cholera intervention.
- Develop key interventions to achieve goals and objectives, ensuring involvement of the community throughout the entire process.

(3) Develop pillar-specific community engagement activities

The section below provides additional considerations by pillar, with the focus that all materials and information should be regularly communicated to the community to ensure continuity of community engagement activities.

(a) Coordination

- Create a national task team or working group that brings together all partners working on community engagement to support the development and roll-out of the NCP; allow for the involvement of communities, using their input and information to drive wider coordination.
- Advocate for resources dedicated to cholera, including implementation of interventions and monitoring of progress towards *Global Roadmap* goals.
- Ensure that rapid response teams are using consistent messaging on health, cholera and hygiene, and that teams on the ground are able to provide technically correct answers to the affected population. Communities should also be given the opportunity to ask questions to the response teams.

(b) Surveillance

- Using the situational analysis, identify entry points to integrate cholera into existing community surveillance activities.
- Develop relevant materials for distribution to the community (e.g., information, education and communication on cholera symptoms, how to report cholera cases). Ensure that materials are provided in local languages and using local wording and categories that ensure comprehension.
- Conduct regular trainings (e.g. annual or bi-annually) of community and CHWs/volunteers and distribute relevant materials to communities and other key stakeholders to ensure the ability to identify cholera symptoms.
- Develop and communicate a clear process for the reporting of suspected cases to the health facility.
- Engage with non-biomedical health providers, supporting in the identification of cholera symptoms and encouraging (and creating systems) to referrals to ORPs and CTCs.

(c) Management of care

- Conduct community sessions and collaborate with local media to promote knowledge of and behaviours relating to identification of symptoms of cholera and the need to seek early treatment at local facilities, ORPs and CTCs.

- Develop relevant materials in collaboration with the community (e.g. discussion guides, locally relevant materials on cholera symptoms, how and when to seek care – where the treatment facilities are located and the differences between ORP and CTCs, different treatment options, safe burial practices — handling bodies at home, improve health-seeking behaviours, community case management of cholera).
- Distribute relevant materials and conduct regular training of affected communities and CHWs. As above, ensure that materials are provided in local languages and use local categories for ease of comprehension.
- Conduct communication sessions with caregivers in the community and at or near treatment facilities to build trust among health-care providers and to encourage use of treatment facilities or to be an "ambassador" for his/her community.
- Ensure the integration of traditional and private health-care providers into awareness-raising strategies and the set-up of surveillance and care systems.

(d) OCV

- Identify social, cultural and economic and other barriers to immunization (e.g. nomadic populations or religious groups). Adapt vaccination strategies accordingly.
- Develop risk communication and community engagement micro-plans and materials that cover OCV characteristics – eligibility, efficacy, number of doses, side effects, etc., and address vaccine hesitancy, and the timing and location of campaigns.
- Work with local media to ensure that mis- and dis-information is not disseminated to the local population.
- Develop and conduct communications around the timing of vaccination campaigns, and delivery strategies. Ensure that community engagement activities precede the roll-out of vaccinations, and these activities should continue during and after the vaccination period.
- Develop and distribute relevant materials and conduct regular training of community and CHWs.
- Ensure that linkages are made between HCWs and CHWs or community leaders.

(e) WASH

- Develop and pilot risk communication and community engagement plans and materials to communicate the proper processes (e.g. checklists, regular visits, protocols) to maintain any existing WASH infrastructure. Engage with communities through participatory processes to develop these strategies and plans.
- Develop and distribute relevant materials to the communities. Materials can include proper latrine use, how to maintain and safely clean latrines, hand washing during critical times, protection of water sources, food preparation and storage, practical water planning, awareness and consultation. Enroll trusted leaders in communities to show in person how to carry out these activities.
- Link (and time) the provision of WASH resources to hygiene promotion activities, so as to ensure there is an enabling environment for behaviour change.

(4) Develop and distribute materials communicating goals and objectives

- Identify key community engagement and communication entry points to set up and strengthen two-way communication to promote cholera prevention using a variety of communication channels – e.g. local and national media, incorporation of key messages in the school curriculum, capacity-building and mobilization of local cultural, traditional and religious leaders, community

events, other health or water events (e.g. Immunization week, World Water Day, Global Handwashing Day)

- Based on contextual understanding (including barriers and enablers towards cholera prevention/risk reduction), develop an understanding of priority behaviours and groups at risk, and foster harmonized approaches to communicate with and involve affected populations, including related key recommended actions, information and messages.
- Ensure that the identification and targeting of cholera-affected populations does not generate stigma or discrimination. Use information and dispel myths and rumours to protect more vulnerable populations from harm.
- Develop suggested media (e.g. radio, TV and social media materials) and print materials.
- Distribute suggested materials for local adoption by all stakeholders, including HCWs, CHWs and community leaders.

(5) Ensure that community engagement relationships are established and maintained

- Develop regular check-ins for community engagement focal points and key stakeholders across all pillars to avoid silos.
- Develop processes and checkpoints to ensure strong collaboration between HCWs and CHWs.
- Conduct assessments and revisions of community engagement messages and materials.

Monitoring and evaluation

The GTFCC collectively agreed on a minimum set of indicators, which were developed in coherence and to be aligned as much as possible with other global initiatives and strategies. Countries will be anticipated to report on these minimum set of indicators, which will be further rolled-up to the global level as part of the Annual Cholera Report. Countries will be expected to also develop their own M&E logframe to monitor their NCP implementation and their overall progress towards the achievement of their national objective. The standardized GTFCC indicators are detailed in Annex C.

Annex A. Checklist of Activities to Develop a NCP

Contains a high-level checklist that identifies the key steps to complete to develop a NCP.

Annex B. NCP Template and Tools

Contains a word document that provides an example of NCP structure, including standardized information that should be included in all NCPs.

Also contains an excel file that provides:

(i) Tools and templates to conduct a situational analysis, implementation planning and budgeting by pillar including the minimum data to be collected linked with automatic generation of graphs

(ii) Completed sample Gavi budget for OCV operational costs support

Annex C. GTFCC Country Profile

Contains an excel file to collect data on an annual basis to generate GTFCC country profiles on Roadmap implementation. Includes all standardized GTFCC indicators with definitions and potential data sources.

Annex D. Additional Technical Resources Available to the Country

Contains a list of technical resources that are available to the country for the situational analysis and the development of planning activities and budgets by pillar.

1. Situational analysis

- GTFCC Technical Note for countries to identify areas for intervention
- GTFCC Country Cholera Investment Case Tool

2. Surveillance

- GTFCC cholera surveillance and laboratory capacity assessment
- GTFCC Technical Note on the use of cholera rapid diagnostic tests
- GTFCC interim guidance on cholera surveillance
- GTFCC Technical Note on Laboratory support for Public Health surveillance
- TPP Cholera RDT
- GTFCC cholera outbreak response field manual

3. Case management

- GTFCC Technical Note on organization of case management during a cholera outbreak
- GTFCC Technical Note on WASH and IPC in Cholera Treatment Structures
- GTFCC Technical note on use of antibiotics on the treatment of cholera
- GTFCC Technical Note on the treatment of cholera in children with Severe Acute Malnutrition
- Revised Cholera Kit website, includes CTC calculator and checklist
  https://www.who.int/cholera/kit/en/
- GTFCC Cholera outbreak response field manual

4. Oral cholera vaccine

- WHO Guideline for the implementation of OCV campaigns
- GTFCC Technical note on OCV and travellers
- GTFCC Technical note on OCV and pregnant women
- WHO Position Paper
- IFRC Community-Based Health and First Aid (eCBHFA) Immunization module
- IFRC Epidemic Control for Volunteers (ECV)
- GTFCC Cholera outbreak response field manual
- Template for OCV Vaccination Plan

5. Water, sanitation and hygiene

- Axis 1: Household, Community and Public Institutions
  - WASH and IPC in CTCs Technical Guidance Note
  - Environmental Surveillance Note

- Outbreak Response Manual (Yellow Book)
- WASH for OCV campaigns (draft/under-development)
- Technical Factsheets/Checklists (draft/under-development)
- Training Framework (to be developed)

- Axis 2. Costed NCP WASH Guidance Package
  - Information Management System tool
  - Checklist for technical assessment (including social, economic/financial, environmental, community engagement, policy/governance aspects)
  - Technical costing tool
  - Monitoring tool
  - Training Framework
- Partner resources
  - ACF (2005) Water, sanitation and hygiene for populations at risk
  - ACF: Cholera Manual
  - GTFCC Cholera outbreak response field manual
  - IFRC: Community-Based Health and First Aid Communicable Disease Prevention module and WASH module
  - IFRC: Doer/Non-Doer Analysis
  - MSF (2004). Cholera guidelines
  - MSF (2010). Public health engineering in precarious situations
  - Oxfam: Cholera outbreak guidelines: preparedness, prevention and control
  - Oxfam: Community Engagement Guidelines
  - UNICEF: Community engagement/risk communications
  - UNICEF: Rapid Response Team Technical Note (under development)
  - WHO and UNICEF: Cholera Toolkit
  - WHO (2008). Essential environmental health standards in health care
  - WHO and UNICEF: Water and sanitation for health facility improvement tool (WASH FIT).
  - WHO: Guidelines on Drinking Water Quality
  - WHO: Household Water Treatment Technologies
  - WHO: Sanitation and Health - https://www.who.int/water_sanitation_health/publications/guidelines-on-sanitation-and-health/en/
  - WHO: Water Safety Planning – A roadmap to supporting resources
  - IFRC Hygiene promotion in Emergency guidelines https://ifrcwatsanmissionassistant.wordpress.com/hygiene-promotion/

6. Community engagement

- GTFCC Cholera outbreak response field manual
- IFRC Hygiene promotion in Emergency guidelines https://ifrcwatsanmissionassistant.wordpress.com/hygiene-promotion/
- IFRC community engagement and accountability guidelines
- https://ifrcwatsanmissionassistant.files.wordpress.com/2018/12/cea-guide-2401-high-resolution-1.pdf
- IFRC Community Based Health and First Aid (eCBHFA) Behaviour Change Module
- IFRC Doer/Non-Doer Analysis Tools
- WHO Risk Communications and Community Engagement guide
- Ground Truth Solutions "Perception and affected population surveys". http://groundtruthsolutions.org/wp-content/uploads/2017/12/OECD-Somalia_Affected-people-and-staff-survey-December-2017.pdf

GLOBAL TASK FORCE ON
CHOLERA CONTROL