

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

Joint WHO/UNICEF evaluation

Final Inception Report

23 July 2024



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ACRONYMS

Abbreviation	Definition
AWD	Acute Watery Diarrhoea
CSO	Civil Society Organisation
CSP	Country Support Platform
EQ	Evaluation Questions
ERG	Evaluation Reference Group
ESG	Evaluation Steering Group
GER	Gender, Equity, and Human Rights
GTFCC	Global Task Force for Cholera Control
IFRC	International Federation of Red Cross
IRP	Independent Review Panel
KII	Key Informant Interview
LMIC	Low- and Middle-Income Countries
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organisation
NCP	National Cholera Plan
OCV	Oral Cholera Vaccine
PAMIs	Priority Areas for Multisectoral Interventions
SC	Steering Committee
SDG	Sustainable Development Goals
ToC	Theory of Change
WASH	Water, Sanitation, and Hygiene
WG	Working Group
WHO	World Health Organization

1. INTRODUCTION

Cambridge Economic Policy Associates (CEPA) has been appointed following a competitive process to conduct a mid-term evaluation of the Global Task Force for Cholera Control (GTFCC). This evaluation has been commissioned by the World Health Organization (WHO) Evaluation Office on behalf of the GTFCC Secretariat and Steering Committee.

This Inception Report presents the evaluation framework, approach and methodology, alongside the evaluation work plan, timelines and deliverables. A draft version of the report was shared for feedback from the WHO Evaluation Office and the Evaluation Reference Group (ERG) and Evaluation Steering Group (ESG).

The introduction section provides information on the background, context and object of the evaluation (Section 1.1); evaluation purpose, objectives and scope (Section 1.2); a description of the work conducted in the inception phase and key emerging topics identified in this phase (Section 1.3), and the structure of this report (Section 1.4).

1.1. EVALUATION OBJECT, BACKGROUND AND CONTEXT

The **object of the evaluation** is the GTFCC and includes an assessment of the implementation of the Global Roadmap Strategy (Ending Cholera – A Global Roadmap to 2030). Both the GTFCC and the Roadmap are discussed in this section, alongside relevant background and context.

The **GTFCC** was established in 1991 by the Director-General of WHO and adopted by the World Health Assembly. It is a partnership of more than 50 institutions (non-governmental organisations [NGOs], academic and scientific institutions, UN agencies) to coordinate activities for cholera control at global, regional, and country levels. Between 1991 and 2007, the GTFCC went through phases of progress and less progress on account of a number of reasons including changes in the external and internal environment. After a period of inactivity, the GTFCC underwent revitalisation between 2011 and 2014, to further strengthen the WHO's impact on cholera through enhanced stakeholder coordination and collaboration.

In October 2017, the GTFCC convened a meeting with officials from cholera-affected countries, donors and technical partners to reaffirm their commitment to ending cholera as a threat to public health by 2030. This culminated in the launch of the **Global Roadmap Strategy (Ending Cholera – A Global Roadmap to 2030)**, which aims to reduce cholera deaths by 90%, eliminate cholera in 20 countries by 2030, and prevent uncontrolled outbreaks of the disease.¹ The **Roadmap has three strategic approaches**: (i) early detection and quick response to contain outbreaks; (ii) a targeted multi-sectoral approach to prevent cholera recurrence; and (iii) an effective mechanism of coordination for technical support, advocacy, resource mobilisation, and partnership at local and global levels.²

The GTFCC operates in bringing organisations together and serves as a coordination platform to support countries in the implementation of the Global Roadmap. The **objectives of the Task Force** are to:³

- Support the design and implementation of global strategies to contribute to cholera prevention and control globally;
- Provide a forum for technical exchange, coordination, and cooperation on cholera-related activities to strengthen countries' capacity to prevent and control cholera, especially those related to implementation of proven effective strategies and monitoring of progress, dissemination and implementation of technical guidelines, operational manuals, etc.;

¹ Global Task Force on Cholera Control (GTFCC). (2020). Ending Cholera: A Global Roadmap to 2030

² Ibid

³ Mid-term independent evaluation of the Global Task Force on Cholera Control (GTFCC) 2017-2030, Terms of Reference –25 January 2024

- Support the development of a research agenda with special emphasis on evaluating innovative approaches to cholera prevention and control in affected countries; and
- Increase the visibility of cholera as an important global public health problem through integration and dissemination of information about cholera prevention and control and conducting advocacy and resource mobilization activities to support cholera prevention and control at national, regional, and global levels.

The **governance structure of the GTFCC**, coupled with descriptions of the roles of each entity are as follows:

- **Steering Committee (SC):**⁴ The SC is responsible for oversight, strategic direction, and accountability for the GTFCC as whole. The SC features representatives from endemic countries and members of GTFCC partner organisations.
- **Independent Review Panel (IRP):**⁵ An independent technical review mechanism responsible for transparent and in-depth review of national cholera plans (NCPs).
- **GTFCC Secretariat:**⁶ The GTFCC Secretariat (herein after referred to as the “Secretariat”) is hosted at the WHO. The Secretariat works under the supervision of, and reports to, the SC and ensures coordination between the WHO cholera program and the country support platform (CSP).
- **WHO and GTFCC Technical Working Groups (WGs):**⁷ WGs provide cholera-specific normative and programmatic guidance on the oral cholera vaccine (OCVs), water, sanitation and hygiene (WASH), epidemiology, laboratory and case management.
- **Country Support Platform (CSP):**⁸ The CSP was established in 2020 and is housed at the International Federation of Red Cross (IFRC) and Red Crescent Societies. The CSP leads the multi-sectoral support that the GTFCC provides to countries for the implementation of their NCPs. It coordinates technical assistance, advocacy and fundraising for NCPs, monitoring and evaluation of national plans, and the implementation of research projects. The CSP supports the short, medium and long-term deployment of GTFCC multi-sectoral expertise in countries.

In addition, the GTFCC General Assembly is held annually and it provides all relevant stakeholders with the opportunity to review progress and highlight challenges faced and enables country representatives to express their needs. Figure 1.1 presents the governance structure.⁹

⁴ Global Task Force on Cholera Control, Global Task Force on Cholera Control Steering Committee - Terms of Reference

⁵ Global Task Force on Cholera Control, Global Task Force on Cholera Control Independent Review Panel - Terms of Reference

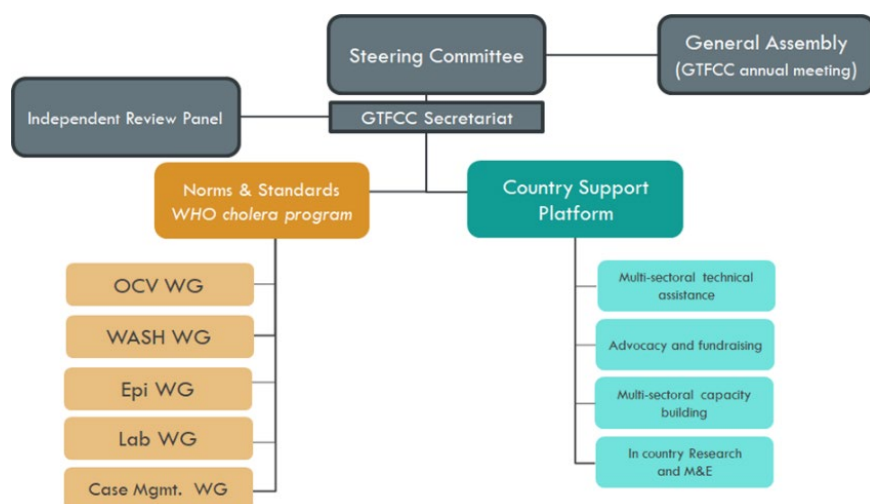
⁶ Global Task Force on Cholera Control, Global Task Force on Cholera Control Operational Model

⁷ Global Task Force on Cholera Control, Global Task Force on Cholera Control Working Groups - Terms of Reference

⁸ Global Task Force on Cholera Control, Global Task Force on Cholera Control Country Support Platform - Terms of Reference

⁹ Mid-term independent evaluation of the Global Task Force on Cholera Control (GTFCC) 2017-2030, Terms of Reference –25 January 2024

Figure 1.1: GTFCC governance structure



Our experience has been that stakeholders use terminology related to the GTFCC in a few ways and it requires more precision for understanding. For the purposes of this evaluation, we distinguish between “the GTFCC partnership” that refers to GTFCC as a collaborative mechanism between all partners and members, and “the GTFCC” which refers to the GTFCC internal organisational structures including the SC, the CSP, WGs, IRP and Secretariat.

Since the launch of the Global Roadmap Strategy in 2017 several critical events, within the cholera space and more broadly across global health, have significantly changed the global and local cholera landscape. These developments, and the changes they have triggered, inform the rationale for this review. As the midpoint between the 2017-2030 period, 2024 is an opportune time to assess the progress made under the Global Roadmap and evaluate the GTFCC’s strategies within the evolving landscape. Key developments include:

- **Cholera outbreaks:** There has been a resurgence of cholera in previously cholera-free areas, with over 51 countries now managing outbreaks compared to 47 in 2017.¹⁰
- **Cholera vaccines landscape:** A global upsurge in cases has led to the unprecedented demand for cholera vaccines from affected countries and a consequent strain on the global stockpile. The use of the stockpile is managed by the International Coordination Group for Vaccine Provision (ICG) and led by the WHO, with support from Gavi. In 2018, the Gavi Vaccine Investment Strategy (VIS) called for the inclusion of the OCV as a preventive vaccination in hotspot areas, which in the short term further increased demand and exposed the limit of supply.¹¹ In April 2024, the WHO announced that a new OCV, Evuichol-S, has received WHO prequalification and can now be made available to impacted countries. This approval is expected to increase the global OCV supply from 38 million in 2023 to 50 million in 2024 alongside other capacity and manufacturing expansions and investment.¹²
- **COVID-19 pandemic impact:** The pandemic significantly altered the global health landscape and has highlighted the need for improved pandemic prevention, preparedness, and response (PPPR). Multi-lateral agencies and international organisations embraced the need to strengthen surveillance systems, local manufacturing of health products, health systems, and community management of cases. COVID-19 has had crucial implications on the management of diseases with epidemic and pandemic potential.

¹⁰ GTFCC (2024). Mid-term Evaluation ToR

¹¹ In the longer term it is expect that preventive program launched in January 2023 within Gavi will increase support the increase in global supply availability, as it is expected to help provide predictable demand that allows manufacturers to have a longer term forecasted demand to plan for and produce for.

¹² UNICEF (2024). Gavi and UNICEF welcome approval of new oral cholera vaccine

- **Climate change, conflicts, and displacements:** These factors have increased the frequency and re-emergence of cholera outbreaks, and there is a growing recognition of the climate change-health nexus through forums such as the 28th meeting of the Conference of the Parties (COP28).¹³

Overall, progress on reducing cholera related deaths has been slower than expected, also due to increase in the number of outbreaks over time, amongst other factors. This is one factor in preventing successful and sustainable achievement of the SDGs 3 and 6.

Beyond the changing context described above, several other factors have necessitated this review including the need to review the GTFCC's operational focus and organisational structure and the extent to which this aids the GTFCC to fulfil its commitments under the Global Roadmap Strategy 2030. One key aspect is the GTFCC's coalition approach which involves stakeholders across various sectors, emphasising the integration of Water, Sanitation, and Hygiene (WASH) with health programs, and balancing emergency and development needs. However, coordination across sectors and investment in WASH and health systems remains challenging. Another aspect is the GTFCC's vital role in promoting and supporting the Global Roadmap at country level and how well it delivers against this role. This includes providing advocacy, coordination, policy guidance, and technical assistance for developing and implementing NCPs.

1.2. EVALUATION PURPOSE, OBJECTIVES AND SCOPE

As outlined in the Terms of Reference (ToR), the **purpose** of this evaluation is to assess progress of the delivery of the GTFCC Global Roadmap and to draw the way forward to ensure successful adaptation to a global landscape marked by significant epidemiological, political and climatic changes, incorporating risk analysis and reprioritising accordingly. The evaluation will be used to generate evidence that will inform decisions about the strategic and operational future of the GTFCC and include recommendations that will help identify ways to better adapt and effectively deliver the 2030 Roadmap. It is expected that the findings from this evaluation will inform the direction of travel of the GTFCC and implementation of the Roadmap going forward until 2030. It will primarily be a formative and forward-looking evaluation, with a good balance between ensuring accountability and learning lessons for the future. As noted previously, the evaluation is being undertaken now as a mid-point between when the Roadmap was launched (2017) and its end year (2030).

The **core evaluation objectives** are:¹⁴

- document the extent to which results have been reached at the country level¹⁵, and assess progress and gaps as documented in the GTFCC monitoring and evaluation frameworks, its indicators and targets and overall strategy milestones;
- identify key achievements, best practices, challenges, gaps, and areas for improvement in the design and implementation of the GTFCC;
- identify the key contextual factors and changes that are affecting cholera spread and transmission risk profile and influencing programme implementation;
- establish the adequacy of the governance structures, mechanisms and processes of the GTFCC, including its Secretariat, to achieve agreed goals; and
- make recommendations as appropriate on the way forward to improve performance and adaptation to a changed global landscape, and to ensure sustainability beyond 2030.

¹³ Mid-term independent evaluation of the Global Task Force on Cholera Control (GTFCC) 2017-2030, Terms of Reference –25 January 2024

¹⁴ Mid-term independent evaluation of the Global Task Force on Cholera Control (GTFCC) 2017-2030, Terms of Reference –25 January 2024

¹⁵ As stated in the ToR, this assessment is at a relatively high level based on GTFCC documents. Where possible, more detail will be provided in country case studies.

With regard to **project scope**, the evaluation will assess the progress of the GTFCC Global Roadmap implementation from 2017 to May 2024, spanning across global, regional and country organizational levels and partners. It will particularly focus on the coordination and programmatic delivery by relevant GTFCC entities, including the Secretariat, at the global, regional, and country levels. Additionally, the evaluation will take into account the evolving global landscape and changing risk profiles of cholera-affected countries. The evaluation will not evaluate events pre 2017 given the several changes to the GTFCC over time.

The primary **audience** for this evaluation are those closely involved with the internal structures of the GTFCC (e.g. Secretariat, SC, CSP, IRP, WGs), as well as partners and donors of the GTFCC. Additional relevant stakeholders include all GTFCC partners and stakeholders working in cholera including and cholera affected countries.

The primary **modifications to the original ToR** of the evaluation relate to timings, given the delay in starting the evaluation. In terms of evaluation questions, these have been streamlined in the evaluation framework (further details are provided in Appendix G).

1.3. INCEPTION WORK AND EMERGING TOPICS

To date, the inception phase has entailed:

- An initial review of key documents and data including available resources from the GTFCC website, documents shared by the WHO Evaluation Office as well as wider academic papers and grey literature.¹⁶ Appendix A provides a list of references.
- Kick-off meetings with the ESG, and the ERG as well as inception phase consultations with members of both of these groups (See Appendix H for a full list of ESG and ERG members and Appendix C for a full list of members that were interviewed);¹⁷
- Evaluation team attendance at the GTFCC annual General Assembly including a session with the ERG and ESG discussing the draft evaluation theory of change (ToC), evaluation framework and approach and country case studies;
- Review of the existing Roadmap ToC and development of a revised ToC for this evaluation (Section 2.3);
- Further development of the evaluation framework, technical approach and evaluation methods for the assignment, building on CEPA's Technical Proposal (Section 2 and Appendices B-H); and
- Update of the evaluation work plan, timelines and deliverables (Section 4).

Based on the work undertaken to date, and particularly key points of feedback during the inception interviews, some of the key emerging topics identified include those noted below. Some of these have also been discussed as part of the evaluation approach in Section 2 and will be explored in detail through the evaluation. For avoidance of doubt, these are not a comprehensive set of issues and only an early indication of some relevant issues.

- The **Roadmap** is considered broadly fit for purpose (although with a lack of clarity regarding the degree of emphasis across its three axes especially between prevention and outbreak) but a significant challenge has been in terms of implementation of the Roadmap.
- The GTFCC have had a **number of areas of success** including, (i) bringing stakeholders together and having a regular roundtable of partners working on cholera and working towards a common goal; (ii) improving the number of countries with programmes and multisectoral plans for cholera; (iii) developing GTFCC guidance (although it

¹⁶ We highlight that at the time of writing this report, we were still waiting for key additional documents from WHO (e.g., Advocacy Strategy, M&E framework, Cholera progress reports etc.) which have not been included in the initial document review and will be part of the core phase desk-based review.

¹⁷ All ERG and ESG members were contacted for interviews based on the suggestion of the WHO Evaluation Office.

is less clear to what extent countries are using guidance) and (iv) supporting the identification of priority areas for multisectoral interventions (PAMIs) for cholera control across countries.

- There have been **some aspects that have been more challenging**: (i) cholera resurgence has impacted focus and resources away from prevention, alongside challenges in timeliness to respond to outbreaks; (ii) there has been insufficient engagement of WASH and broader development partners; (iii) available financial and human resources has been a significant limiting factor for activities of the GTFCC and for implementation of the Roadmap, alongside an imbalance of funds towards certain areas (OCV, surveillance) with more progress in these areas and less in other areas (e.g. WASH, case management).
- Some areas have had **mixed results** such as OCV which has experienced progress in terms of uptake and efforts to solve vaccine supply issues, but vaccine supplies remain a significant challenge.
- In terms of the **internal structures of the GTFCC**, early feedback has indicated: (i) the SC has a number of benefits to its structure but a weakness has been in terms of making and actioning decisions; (ii) the CSP has been a useful addition bringing in an 'operational arm' of GTFCC and the associated focus on countries but it is unclear if the current structure is fit for purpose; (iii) progress in the WGs has been mixed with some doing much better than others, linked to funding as noted above; and (iv) the IRP has not worked as well as expected, partly due to challenges with coordination.

1.4. STRUCTURE OF THIS REPORT

This report is structured as follows:

- Section 2 provides the evaluation framework and approach, including methods as well as GER, ethical and data management considerations;
- Section 3 outlines the evaluation governance, validation and finalisation
- Section 4 sets out the workplan, including timelines and key deliverables.

The main report is supported by the following appendices:

- Appendix A lists references of documents reviewed during this inception phase;
- Appendix B provides an overview of the stakeholder mapping exercise conducted in the inception phase;
- Appendix C includes the list of consultees interviewed at inception phase;
- Appendix D contains the list of interview guides including the inception phase interview guide as well as draft interview guides (country and global) for the core phase of the evaluation;
- Appendix E covers further details on the country case study including the main areas of exploration for the case studies, the country selection methodology and the proposed list of countries for case studies;
- Appendix F includes the evaluation matrix which provides an overview of all evaluation questions, key areas of exploration, and methods that will be employed;
- Appendix G summarises the modifications made to the evaluation questions from the original TOR;
- Appendix H outlines the composition of the ESG and ERG;
- Appendix I presents the evaluation workplan visually represented in the form of a Gantt chart; and
- Appendix J details CEPA's quality assurance policy and outlines the roles of the project manager and project partner in ensuring quality.

2. EVALUATION FRAMEWORK AND METHODOLOGY

This section presents the evaluation framework and methodology. Section 2.1 presents the overall evaluation approach, Section 2.2 presents the evaluation framework and questions, Section 2.3 describes the theory-based approach to the evaluation, Section 2.4 outlines the detailed approach by evaluation question, Section 2.5 includes an overview of the evaluation methods and analysis methods and tools, and Section 2.6 highlights gender, equity and human rights (GER), ethical and data management considerations.

2.1. OVERALL EVALUATION APPROACH

The overall approach will be theory-based which means that it will be grounded in a Theory of Change (ToC) for the GTFCC and the Global Roadmap (discussed in Section 2.3 below). The evaluation will use a non-experimental approach as the nature of the GTFCC and its Roadmap are not amenable to other approaches such as randomization or case control designs. It will be delivered utilising a mixed-methods (e.g. interviews, document review and data analysis, survey) and case study approach. It will be utilisation focused, meaning that we will seek to maximize the usefulness of this evaluation and enhance the utilisation of its findings through engaging regularly with the primary audience throughout the evaluation process. In particular this will be through key informant interviews, engagement with the ERG and ESG members and a workshop to discuss findings and recommendations.

2.2. EVALUATION FRAMEWORK AND QUESTIONS

Figure 2.1 sets out the evaluation framework, structured around the OECD DAC evaluation criteria. The criteria include:¹⁸

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

The evaluation will not cover the evaluation criteria of impact.

In addition, there is a cross-cutting criteria on GER.

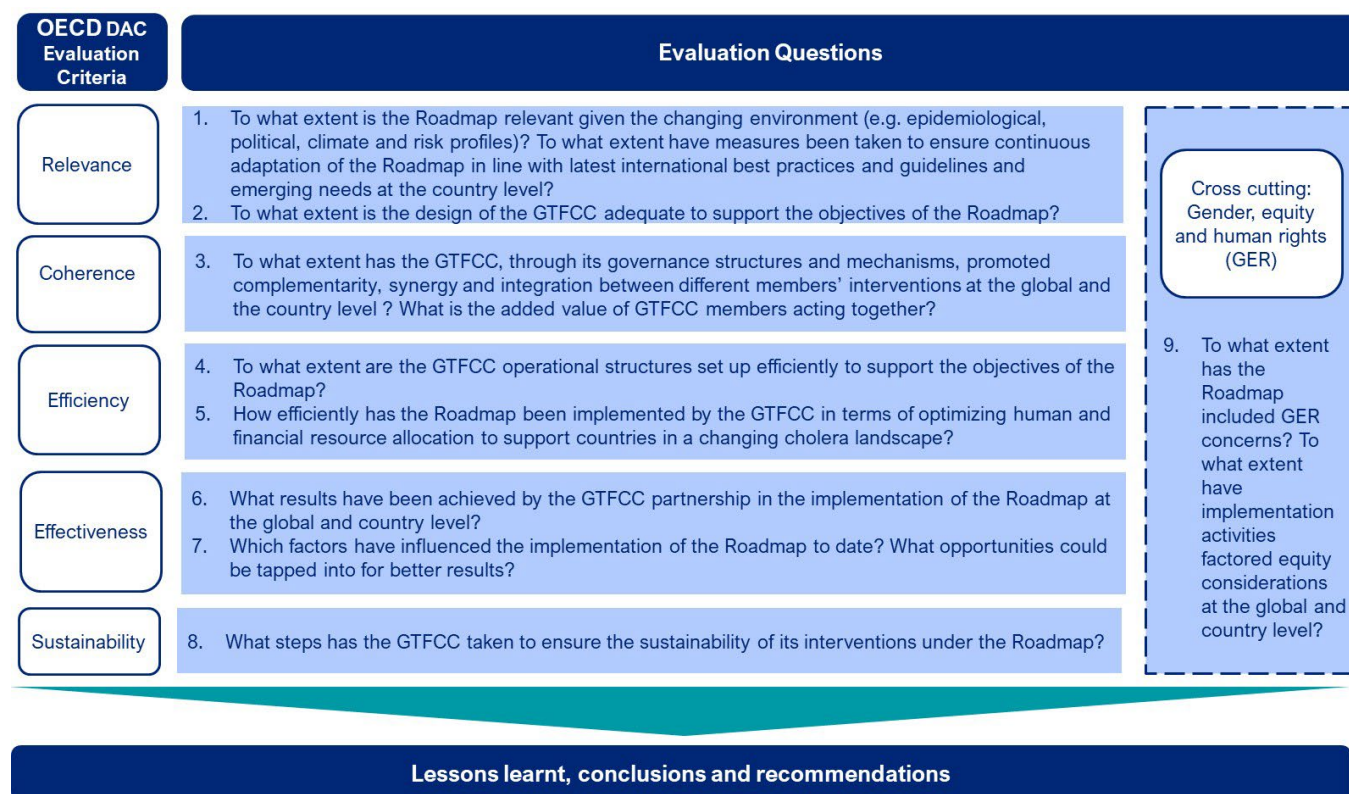
As can be seen in the figure, evaluation questions have been revised under these criteria, which reflect the scope of the evaluation as per the ToRs and the context of the GTFCC.

Appendix G includes a mapping of the original ToR questions against the questions presented in the evaluation framework in Figure 2.1.

Section 2.4 below provides the detailed approach by evaluation question.

¹⁸ <https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm>

Figure 2.1. Evaluation framework and questions



2.3. THEORY-BASED APPROACH

The evaluation will adopt a theory-based approach, which means that it will be grounded in a ToC for the GTFCC and the Global Roadmap. A review of the existing GTFCC Roadmap ToC (included on page 13 of the Roadmap) was conducted during this inception phase and was found to be too high-level to meaningfully serve as a reference ToC for this evaluation. We have therefore built on the existing Roadmap ToC to develop a more comprehensive ToC that both articulates the pathway to impact from country-level cholera prevention and control activities as well as the specific added value of the GTFCC partnership. The updated ToC is presented in Figure 2.2.

The process for developing the revised ToC entailed:

- Comprehensive review of the GTFCC Roadmap and key documents: inputs to develop this draft ToC have been mainly drawn from the GTFCC Roadmap content as well as insights gathered across the document review.
- Inception phase consultations: where consultees highlighted the different areas of good and slow progress that contributed to our thinking on pathways to results.
- Establishing assumptions and risk factors: an essential step of this analysis also involved outlining the key assumptions for success underlying the pathway to impact of the Roadmap as well as key risk factors. The difference between the two is that the former are aspects that have to be in place to ensure achievement of results whilst the latter are aspects that may or may not arise and impact progress.
- Presentation to the ESG and ERG: An earlier draft of the ToC was presented for feedback from the ERG and ESG at the General Assembly and the Draft Inception Report with feedback being incorporated into this revised version.

We understand that the GTFCC (as a partnership) aims to implement the Roadmap through its three axes focused on (i) Axis 1 - outbreaks; (ii) Axis 2 - prevention and (iii) Axis 3 - multi-sectoral partnership. The two main outcomes of work undertaken through the Roadmap relate to the outbreaks and prevention activities as depicted in the ToC figure. Whilst the Roadmap outlines partner coordination as a third axis, we see this work as leading into the outcomes of Axis 1 and Axis 2. Therefore, we present the three axes, with associated inputs and activities, outputs and outcomes as follows:

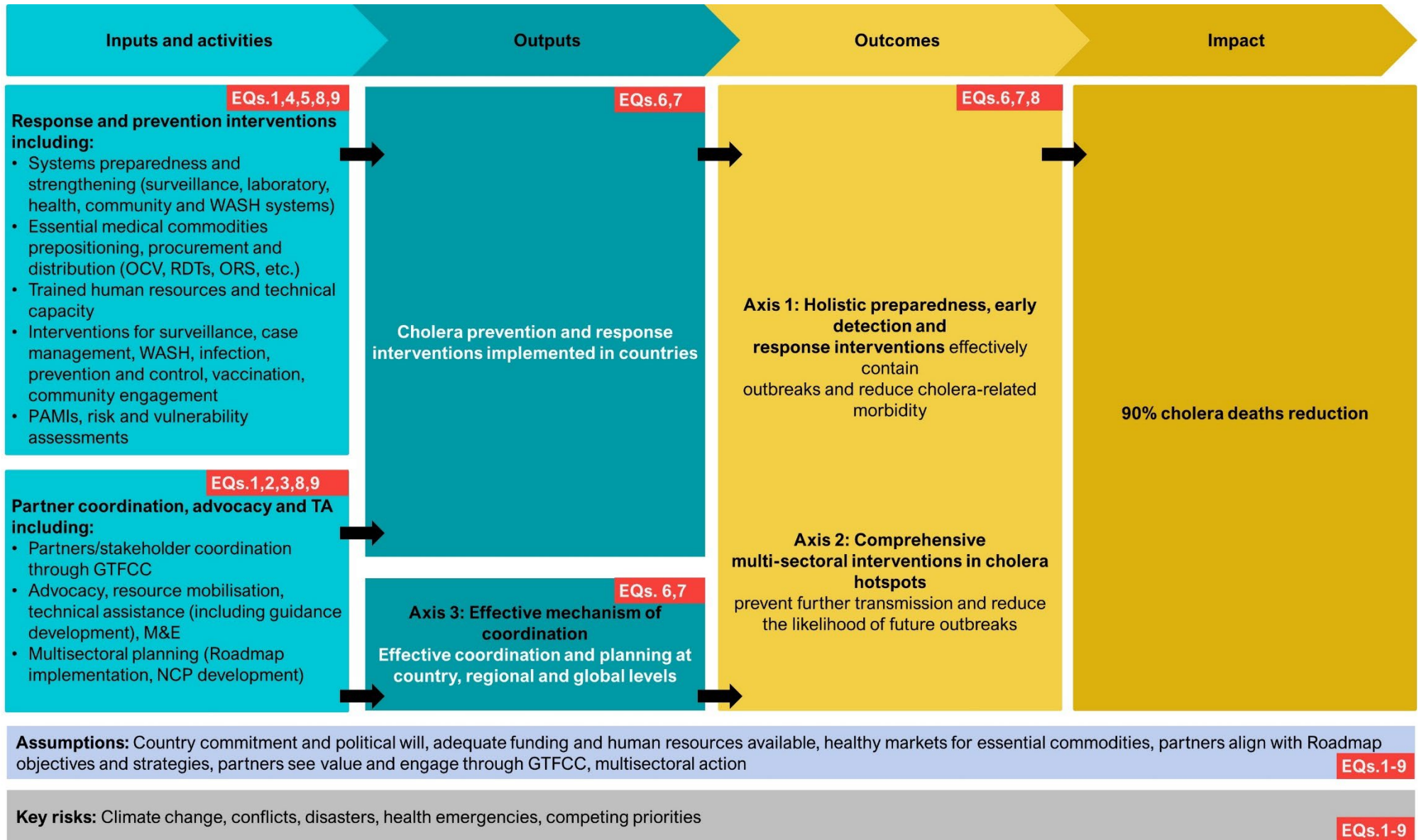
- **Delivering support to countries for cholera prevention and response interventions, which entails:**
 - **Axis 1: early detection and quick response to contain outbreaks** to strengthen countries' and partners' capacity to anticipate and effectively contain outbreaks. This is undertaken through systems preparedness (e.g., strengthening early warning surveillance and laboratory capacities, emergency stocks pre-positioning, health and WASH preparedness) and detection and rapid response interventions (e.g., case management, emergency WASH, OCV campaign, community engagement etc.)
 - **Axis 2: multisectoral action to prevent cholera** to drive efforts on cholera prevention and stop further transmission of cholera, especially in areas most heavily affected by the disease (PAMIs or hotspots) in endemic countries. This is done through long term measures implementation including long-term WASH, preventative vaccination, health systems strengthening, risk communication and social mobilisation, cross-border collaboration etc.
- **Ensuring effective partnership, coordination, advocacy and technical assistance (TA), through:**
 - **Axis 3: effective mechanism of coordination** for technical assistance (including research/implementation research), resource mobilisation, and partnership to increase and strengthen technical support, maximise the use of available resources across partners through aligned and complementary multisectoral actions. This includes facilitating robust collaboration between global and national stakeholders through the GTFCC and supporting country level coordination across priority countries (as defined in the Roadmap) as well as in any countries facing acute outbreaks.

Ultimately the intended **impact of the Roadmap** is to enable progressive cholera elimination across priority countries¹⁹ and stopping catastrophic cholera outbreaks from happening in fragile settings, in view of **reducing cholera deaths by 90% by 2030**.

The evaluation will use the ToC as a base and consider how actions from the GTFCC partnership have worked in practice to deliver results, assess any deviations from the theory and explore reasons for deviation. The analysis will support an assessment of what works well and less well with the GTFCC, its efforts to reach the aims of the roadmap, and aid in the framing of recommendations for the future of the GTFCC work. Evaluation questions (EQs) are mapped onto the ToC in red boxes to reflect this.

¹⁹ Roadmap target include eliminating cholera in 20 countries by 2030

Figure 2.2: Updated GTFCC Roadmap ToC



2.4. DETAILED APPROACH BY EVALUATION QUESTION

This section provides the detailed evaluation approach in terms of key aspects for assessment and methodological approaches to assessing the evaluation questions. Questions are covered under sections by evaluation criteria of relevance (Section 2.4.1), coherence (Section 2.4.2), efficiency (Section 2.4.3), effectiveness (Section 2.4.4), sustainability (Section 2.4.5) and GER (Section 2.4.6) as well as a final section on lessons learnt, conclusions and recommendations (Section 2.4.7).

2.4.1. Relevance

Under this first evaluation dimension, we will consider, **To what extent are the GTFCC design and strategy adequate to support the achievement of the Roadmap's 2030 goals?** We see this as a key dimension for this evaluation given how the cholera context has shifted since the Roadmap was designed and with aim of achieving the 2030 Roadmap goals.

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

As described in Section 1.1 above, there have been a number of changes in the environment since the Roadmap was developed. This question will assess whether the Roadmap, and its three strategic axes are still relevant given how much the cholera context has shifted over time (e.g. epidemiological, political, climate and risk profiles). Key areas to explore include:

- **The ambitions of the Roadmap and whether these are still appropriate** (e.g. 90% reduction in cholera deaths) given current levels of resurgence, changing external context as well as political will and availability of resources globally.
- **The comprehensiveness of and balance between the three strategic axes of the Roadmap** i.e. (i) early detection and quick response to contain outbreaks; (ii) targeted approach to improve prevention (focusing on PAMIs) and (iii) coordination of human, technical and financial resources. This is particularly with regards to focus on prevention and control activities versus outbreak activities given the increase in the number of outbreaks in recent years.
- **Considerations regarding the relevance of the package of interventions to prevent and control cholera**, i.e. WASH, leadership and coordination, case management, surveillance and reporting, OCV and community engagement.
- **The alignment of the Roadmap with relevant global and regional frameworks.** This would include 2-3 frameworks focusing on aspects such as PPPR and emergencies more broadly.

In addition, under this question we, will consider to what extent **measures have been taken to ensure adaptation of the Roadmap** in line with latest international best practices and guidelines and emerging needs at the country level. This will include a review of the extent to which the Roadmap includes considerations for (i) adapting interventions to emerging threats and (ii) leveraging opportunities in cholera control.

This assessment will be undertaken through an examination of the Roadmap as well as a review of documentation and stakeholder interviews at the global and country levels.

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

The design of the GTFCC is critical for it to fulfil its commitments under the Roadmap by 2030. This design encompasses both the GTFCC's focus and organisational structure. This assessment is distinct from Question 4 within the Efficiency dimension (see below), where we will consider the functioning of the GTFCC. Under this question, key aspects and questions to consider include:

- **Relevance and appropriateness of the objectives and activities of the GTFCC²⁰:** As a starting point, we would seek to assess whether the objectives of the GTFCC in terms of (i) supporting the design and implementation of global strategies; (ii) providing a forum for technical exchange, coordination, and cooperation on cholera-related activities to strengthen countries' capacity, (iii) supporting the development of a research agenda and (iv) increasing the visibility of cholera as an important global public health problem are still the most relevant objectives in relation to the current priorities and country needs with regards to cholera. This would include an assessment regarding the extent to which the GTFCC was designed to support multi-country outbreaks as well as prevention activities. At a high level, we would seek to assess the GTFCC activities (as outlined in the ToC) performed through the various structures of the GTFCC (e.g. CSP, WGs, Secretariat etc.) to consider whether they adequately support the achievement of the Roadmap objectives. Key aspects include whether the activities are comprehensive and/ or appropriate and the extent of partner buy-in and awareness of these activities.
- **Appropriateness of the GTFCC's governance and operational structures,** including roles and responsibilities to ensure they are fit for purpose in the evolving landscape. Key aspects to consider include (i) the GTFCC Secretariat and whether the roles and responsibilities allocated to the Secretariat as set out in GTFCC Operational Model²¹ and ToRs are appropriate; (ii) the SC,²² its mandate and objectives as well as its composition and membership, (iii) the IRP,²³ its principles and purpose and composition; and (iv) the WGs,²⁴ their areas of responsibility, composition and leadership (see for CSP below). We will also assess the nature of the hosting relationship with WHO focusing on the value-added by both entities to each other's work and ensuring clear separation of roles and responsibilities.
- **Adequacy of partner engagement with the GTFCC,** including whether all the relevant partners are involved to enable the GTFCC to attain its objectives (e.g., humanitarian, health, infrastructures and broader development partners as well as country stakeholders).
- **Adequacy of engagement of countries** including:
 - The role of the CSP²⁵ – its purpose, overall objectives and function, requirements of the hosting institution and the structure (at the global and country level, and very recently shifting to more of a regional focus).
 - The degree to which the GTFCC structures are centralised and whether there should be more of a shift to regional and country levels. If so, what resources would be required for this? What are countries' roles and responsibilities?

2.4.2. Coherence

Under this coherence dimension, we will assess **how coherently is the GTFCC working to optimize the implementation of the Roadmap?**

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

This evaluation provides an opportunity to assess how the Task Force's approach to stakeholder collaboration has evolved since 2017, and what learnings the organisation can incorporate moving forward. We will seek to explore whether the GTFCC has been able to foster and promote complementarity and synergy between cholera stakeholders at the global and country levels. Specifically:

²⁰ Global Task Force on Cholera Control, Global Task Force on Cholera Control (GTFCC) - Terms of Reference

²¹ Global Task Force on Cholera Control, Global Task Force on Cholera Control Operational Model

²² Global Task Force on Cholera Control, Global Task Force on Cholera Control Steering Committee - Terms of Reference

²³ Global Task Force on Cholera Control, Global Task Force on Cholera Control Independent Review Panel - Terms of Reference

²⁴ Global Task Force on Cholera Control, Global Task Force on Cholera Control Working Groups - Terms of Reference

²⁵ Global Task Force on Cholera Control, Global Task Force on Cholera Control Country Support Platform - Terms of Reference

At the global and country levels: an assessment of the added value of GTFCC members acting together.

At the global level: the extent to which the GTFCC internal structures (including the SC, Secretariat, CSP, the IRP, and the WGs) have been able to foster alignment between partners in terms of approach and interventions delivered within and between different pillars of the strategy to promote a coherent and balanced approach to cholera control. We will also look at how partners have been mobilised to support the GTFCC objectives and what aspects work well and less well. A key aspect of this assessment will be a review of the challenges faced in progressing the work of the GTFCC given the voluntary nature of partner contributions and whether there are sufficient incentives for action.

In addition, we will seek to understand the extent to which the work of the GTFCC internal structures is coherent with programs/ departments within WHO.

At the country level:

- How well the GTFCC has promoted alignment of partners' efforts with country priorities (e.g., alignment with NCPs), evidence of integration of GTFCC and partners' responses in country systems;
- The extent to which the CSP²⁶ has strengthened coherence of interventions with country needs and the ability of the CSP to act as a feedback mechanism to better align GTFCC work at global level with changing contexts in country;
- The extent to which GTFCC (including through the CSP) has supported communication, knowledge sharing and capacity building among countries and partners to promote a more coherent approach to cholera control at country level.

2.4.3. Efficiency

Under this dimension, we will assess **how efficiently the GTFCC operational structures have been set up** to support the objectives of the Roadmap as well as **how efficiently the Roadmap has been implemented by the GTFCC**.

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

Under this question we will examine the **functioning of the GTFCC** in terms of its internal structures and what works well and less well with the ways it has been operating to support the objectives of the Roadmap. We see this question as highly complementary with the assessment made under relevance however, whilst the first will explore the GTFCC adequacy in terms of its composition and structuring, this current question will investigate successes or gaps in terms of the GTFCC functioning and the ability of each of its internal structures to deliver what they are set out to do. Similarly, aspects relating to collaboration/ coordination between structures will be assessed under the dimension of coherence. Some specific areas to explore here will include:

- **SC** including how it is currently working, what works well and less well with regards to its ability to be a strategic and agile decision-making body on behalf of the whole partnership;
- **Secretariat**, its capacity to deliver as well as clarity regarding their role (e.g., supporting country outbreak responses currently when this was not expected in the GTFCC governance ToRs);
- **WGs** membership and representation, leadership, understanding of roles and responsibilities, communications and management, operating processes and meetings;

²⁶ The GTFCC Operating Model 8th July 2019 notes that “CSP leads the multi sectoral support that the GTFCC provides to countries for the implementation of their NCPs. Under the guidance of the GTFCC Secretariat, it coordinates technical assistance to countries, the delivery of commodities, advocacy and fundraising for the NCPs, monitoring & evaluation of national plans, and the implementation of research projects. The CSP manages the short, medium and long-term deployment of GTFCC multi-sectoral expertise in countries, including for advocacy, coordination and policy guidance. The CSP is hosted by a partner agency and operates under GTFCC Secretariat leadership and coordination.

- **General Assembly** and its usefulness as a forum for all members to meet and take strategic decisions;
- the **IRP** and its functioning in terms of reviewing NCPs, its capacity and operating model to meet the needs of countries;
- the **CSP** including its capacity and functioning to support countries.
- Across the GTFCC governance structures, how well these are set up to facilitate timely decision-making and implementation of the roadmap strategies and whether they have been adequately resourced to fulfil their roles.

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

Under this question, we will assess the extent to which the Roadmap has been efficiently implemented by the GTFCC.

To date we have not received systematic or consolidated data on funding and resources allocated to the GTFCC or countries. Therefore, we expect this analysis to be relatively high level and based on qualitative feedback.

Specifically, we will consider:

- Use of **resources allocated to the GTFCC** and the balance of funding across its activities and its internal structures (Secretariat, CSP, Working Groups etc.). One aspect already highlighted from stakeholder consultations is the imbalance of funding for certain activities within the GTFCC (e.g. OCV which is well funded while WASH is not).
- With regards to **implementation at country level**, we will firstly explore the extent to which countries have an understanding of and are aware of the GTFCC and the support it can provide through its various structures (e.g. CSP, WGs, etc). Secondly, we will also explore the extent to which the GTFCC is able to channel resources (e.g., human, commodities) to meet country needs and how flexible is this support when countries ask for it. This includes the CSP capacity to coordinate technical assistance efficiently (short, medium and long term). We will also examine efficiency in relation to the implementation of responses and cholera programs in country and assess whether the GTFCC was able to promote optimisation across partners and in country (e.g., through integration in national systems, complementarity between partners) to maximise the use of limited available resources. Considerations regarding support to countries to mobilise resources (domestically and from partners is discussed under effectiveness).

2.4.4. Effectiveness

This dimension is key to this evaluation as it assesses progress of the GTFCC through the overarching question, **to what extent has the GTFCC achieved the Roadmap's expected results?**

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

The first question under this dimension seeks to assess progress made through the efforts of the GTFCC as a collaborative partnership to deliver the results expected of the Roadmap. We will assess progress across the three strategic axes of the Roadmap considering the following questions and approaches:

- **Axis 1 – improving outbreak containment and reducing the global burden of cholera through early detection and rapid response:** To what extent has the GTFCC partnership (through the work of its different entities) contributed to strengthening preparedness, surveillance and outbreak response? What have been the results of these efforts? How well has the GTFCC been able to support priority countries as well as respond to the needs of non-priority countries that have recently faced a recurrence of cholera cases?
- **Axis 2 – increasing prevention of disease occurrence through targeted multi-sectoral interventions in cholera hotspots.** Here, we will aim to assess the extent to which the GTFCC partnership has been able to drive multisectoral action and contribute to implementing comprehensive preventative interventions in country. We will also seek to identify what has worked well or less well in the implementation of the GTFCC strategic approach under this axis (i.e., hotspot targeting) and issues affecting the implementation of key preventative interventions more specifically (e.g., community engagement, challenges in implementing long-term WASH, preventative OCV campaigns). We will review what the results have been from these efforts.

- To assess progress made against axis 1 and 2, we would closely examine the Roadmap and its monitoring and evaluation (M&E) framework including measurement indicators, as well as any other measurement/ reporting of the GTFCC (e.g. progress reports) to understand how it seeks to track, measure and evaluate progress. We understand that a review of the M&E framework for the Roadmap is currently in progress and so this input will be incorporated in our assessment.
- **Axis 3 – ensuring effective mechanism of coordination for technical support, resource mobilisation, and partnership at local and global levels.** We will look to analyse what the GTFCC is achieving through its various functions namely:
 - Providing a **forum for technical exchange, coordination, and cooperation on cholera-related activities** to strengthen countries’ capacity to prevent and control cholera, especially those related to implementation of proven effective strategies and monitoring of progress, dissemination and implementation of technical guidelines, operational manuals, etc.;
 - Supporting the development of a **research agenda** to aid cholera prevention and control in affected countries and supporting research uptake to inform decision-making;
 - Increasing the visibility of cholera as an important global public health problem through integration and dissemination of information about cholera prevention and control and conducting **advocacy** to support cholera prevention and control at national, regional, and global levels;
 - **Technical working groups** and their products and knowledge sharing;
 - **Supporting implementation of country level activities** including in CSP and non-CSP supported countries (described further below).
 - **Ensuring adequate resource mobilization and/or exploring the use of economic incentives or innovative financing mechanisms.** There is currently a lack of diversity of donors and therefore we would consider the extent to which additional resources have been able to be raised – e.g. by the Secretariat or the CSP, or whether countries have been able to mobilise funds. A limitation we foresee in in this regard is not having visibility of instances where partners have been able to mobilise resources and allocated their own resources to cholera efforts.
- For the areas mentioned above on axis 3, we will consider the outputs of these activities (e.g. the extent to which the GTFCC provided quality guidance, how much the guidance has been used and whether it has contributed to achieving results at the national level, the contribution of the GTFCC using new research to inform cholera response etc). We will also consider the results as summarised in M&E reporting and progress reports.²⁷ Information from M&E reporting and progress reports will be complemented by evidence collected through the stakeholder interviews (and survey feedback where possible).

Across all these axes, through our country level assessment, we would seek to analyse: (i) what are the various forms of support provided to countries; (ii) what are the country and partner views on the value of this support; (iii) how has the support been delivered in practice and have there been any challenges (e.g. to what extent has the GTFCC provide adequate support and guidance to countries in developing and implementing their NCPs); (iv) what progress are countries exhibiting with regards to improved cholera control or management of cholera outbreaks and (v) how have specific examples of success stories or best practices resulting from GTFCC interventions in different countries contributed to achieving global and national goals.

Further, again through the country level assessment but this time focusing on the countries not as engaged with the GTFCC, we would seek to assess what potential and demand there is for the GTFCC support and whether less engaged countries aware of guidance and tools.

The above assessments would be supported by wider stakeholder consultations, the e-survey and document review. Value-add or counterfactual analysis entails considering the “what if” scenario if the intervention was absent or

²⁷ Subject to data availability

different, and we will seek to analyse these aspects through pressure-testing the issue in stakeholder consultations. Within this analysis, we will also review the “value add” of specific achievements.

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

Within this question we will seek to understand the factors that have influenced implementation of the Roadmap and associated progress and results through the country case studies. This assessment would include:

- **Factors that have aided implementation of the Roadmap** (e.g. financial resources for activities such as OCV, WASH infrastructure and strengthening surveillance systems, leadership and political will, outputs from WGs (including guidance); improved partner coordination, adoption of NCPs);
- **Factors that have hindered the implementation of the Roadmap** to date and challenges that have emerged (e.g. limited financial and human resources, cholera outbreaks affecting the focus on prevention, unbalanced focus across the Roadmap package of interventions, lack of political will and national recognition of cholera cases, countries and partners lack of ability to anticipate outbreaks and respond early etc.);
- **Country level factors affecting progress**, e.g. degree of investment in infrastructure, cholera programme management and whether it is managed with multi-sectoral partners or the Ministry of Health, ability to track implementation, changes in government, availability on supplies (including lab and diagnostic supplies), human resources to implement cholera plans, degree of community engagement etc.

2.4.5. Sustainability

This dimension of the evaluation focuses on the **sustainability of the GTFCC activities**.

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

In the first part of this question, we will assess the **extent to which activities set out in the Roadmap aim to facilitate the sustainability of cholera interventions** (e.g. inclusion of a framework or exit strategy or support for capacity building). This would include a detailed review of the Roadmap. Given the importance of capacity building and WASH interventions in terms of sustainability of cholera activities, these would be key areas to review. In addition, an assessment of stakeholders’ understanding of these interventions in the Roadmap would be ascertained through stakeholder consultations.

Secondly, we will consider to what extent steps have been taken by the GTFCC to ensure sustainability of achievements post 2030 and sustainability of interventions in terms of **financial, programmatic and environmental considerations**. Questions and areas to review include:

- **Financial:** This is a key consideration given the small number of donors for cholera and the risk that poses. Questions to explore include: (i) How sustainable are the GTFCC activities from a financial resources perspective (including CSP supported activities)? (ii) To what extent has the GTFCC been able to tap into existing resources where feasible (e.g., focusing SDG WASH projects on cholera PAMIs, repurposing Global Polio Eradication Initiative (GPEI) resources (including surveillance) for cholera control)²⁸? (iii) To what extent has the GTFCC advocated to new donors or engaged existing donors to increase financial contributions for cholera at global and country level? At a high level, and drawing from the country case studies, we will consider sustainability of NCPs. Some of these aspects have also been highlighted under the effectiveness question above.
- **Programmatic:** How has the GTFCC, through its entities, in particular the Secretariat and the CSP, supported countries’ efforts to ensure longer term sustainability of interventions? At a high level, and drawing from the country case studies, we will consider the extent to which countries are (i) integrating cholera programmes and with other disease areas and approaches, (ii) adapting to changing risk profiles and emerging cholera situations; (iii) capacity building within communities and institutions to implement sustainable interventions; (iv) a focus on

²⁸ As suggested in the Roadmap

long term WASH activities and (v) considerations regarding an 'exit strategy' for work of the CSP which is multi-sectoral in nature and housed outside of the government.

- **Environmental:** At a high level, and drawing from the country case studies, we will consider to what extent are environmental aspects being considered for the future of global cholera prevention and control efforts? This relates in particular to considerations regarding urbanisation, climate change and other key environmental factors (rain, humidity and temperature) on cholera.

2.4.6. Gender, equity and human rights (GER)

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

This question is a cross-cutting question and will cover:

Firstly, in terms of the **design** of the Roadmap, the extent to which the Roadmap considers and addresses GER concerns.

Secondly, how consistently and how meaningfully GER considerations have been taken into account in the **implementation** of the Roadmap, drawing mainly on the country case studies. This includes a review of to what extent: (i) do data collection and analytical methods include disaggregated epidemiological and management data for vulnerability and social criteria (e.g. gender, equity, and geographic location); and (ii) are such data and analysis used to inform decision-making and implementation?

2.4.7. Lessons learnt, conclusions, and recommendations

Following our assessment of the range of evaluation questions described above, we will summarise our findings and provide the GTFCC with an assessment of the overall success of the Roadmap, lessons learned, aspects that are working well and less well of the GTFCC itself and actionable recommendations to inform future efforts.

2.5. DATA COLLECTION METHODS AND ANALYSIS METHODS AND TOOLS

This section provides details on the data collection methods²⁹ (Section 2.5.1) that will be used for this evaluation as well as analysis methods and tools (Section 2.5.2). The final sub-section in Section 2.5.2 below discusses the approach to evidence synthesis and analysis, triangulation and robustness assessment of findings. Appendix F includes an evaluation matrix which presents an overview of the evaluation methods applied for each of the evaluation framework questions.

2.5.1. Data collection methods

Desk-based review of documents and data

The desk-based review will entail a comprehensive review of relevant documents³⁰ from GTFCC, countries and partners and will be a first method to collate evidence across the various evaluation questions. The evaluation team will pull out relevant material and evidence by evaluation questions and key areas using a standardised template.

Key documents to review will include:

- GTFCC documentation such as GTFCC Roadmap and monitoring framework,³¹ GTFCC governance documents including SC, WGs, IRP and CSP TORs and other governance documents, GTFCC General Assembly annual meetings documents, commissioned reports, SC meeting minutes and reports, monitoring and progress reports,

²⁹ Additional methods considered included comparator analysis. However this has not been included in order to prioritise existing methods in the available time and budget for this evaluation

³⁰ The evaluators have not yet received all available documentation regarding the GTFCC

³¹ We understand this is currently being developed.

GTFCC guidance documents (e.g. NCP Interim Guiding Document Monitoring and Reporting Section), operational guidelines or manuals for cholera prevention and control (updated since 2017). etc.

- Documents from partners and donors such as WHO, UNICEF, Gavi, CDC, etc. including overarching strategies and frameworks (e.g., Gavi Market Shaping Roadmap for Oral Cholera Vaccines), previous reviews and other evaluative reports (e.g., Evaluation Synthesis of United Nations System and Development Bank Work Towards SDG 6), monitoring reports, etc.
- Selected review of relevant academic and grey literature on cholera reduction, responses, activities, successes and challenges.

Note that country-specific documents will be reviewed for the country case studies, as detailed below.

Subject to data availability, we propose to undertake high level quantitative analysis to support triangulation of data from the desk review and stakeholder interviews. This may include analysis of results data, drawn from annual reports and other sources of data (e.g., disease burden data from the WHO global cholera and Acute Watery Diarrhoea (AWD) dashboard, OCV vaccination rates and distribution, coverage of WASH services) to conduct a trend analysis across countries where possible and provide an overview of progress made against the Roadmap. Depending on available data, we could also undertake a review of financial data and mapping of funding allocated towards key areas of the Roadmap (e.g., WASH) through the GTFCC.

Stakeholder consultations

Semi-structured key informant interviews (KIIs) and focus group discussions (FGDs) will be an important methodological tool for the evaluation, to gather a range of perspectives and insights across key informants. These interviews will help contextualise and validate findings from the document review. Where relevant and possible, we will combine certain stakeholders in FGDs to stimulate joint discussions and assessments. This will also help to increase the number of respondents efficiently.

We have selected consultees across the stakeholder groups based on the stakeholder mapping presented in Appendix B. We will aim to ensure different stakeholder groups are included based on their level of influence and level of engagement with the GTFCC.

A participatory approach has been used to identify stakeholders, enlisting support from ERG and ESG members in particular. As such, a core phase list of consultees has been collated drawing on the stakeholder list included in the evaluation ToR and based on inputs gathered during the inception phase especially from members of the ERG and ESG.

The draft core phase list of consultees is included in an attached excel document (together with more details regarding the stakeholder mapping). We will conduct interviews at the global, regional and country level during the core evaluation phase, with the following key stakeholder groups:

- GTFCC “internal” stakeholders, including GTFCC Secretariat, GTFCC SC, IRP, WGs and the CSP;
- GTFCC partners and community representatives directly involved in delivering the Roadmap, such as UN agencies (e.g., WHO, UNICEF), delivery and implementing partners (e.g., Gavi, MSF, WaterAid, IFRC) etc. at the global and regional levels;
- Donors/ financing partners such as foundations (BMGF, the Wellcome Trust), Veolia Foundation,³² bilateral (AfD, FCDO, USAID), multilateral (World Bank) etc.;
- Research institutions, such as the icddr,b, Institut Pasteur, CERMES, ICMR, LSHTM, Johns Hopkins Bloomberg School of Public Health etc. (in addition, we will seek to interview in-country academic institutions as part of the country case studies); and

³² The Veolia Foundation funded large scale water network in cholera endemic DRC. Therefore, this consultation could be included in a case study for the DRC, should that country be selected as a country case study.

- Select country-level stakeholders from non-case study countries to gather key lessons and feedback and consolidate insights collated through the country case studies and through the online survey. In particular, we propose to include stakeholders from countries which have recently had a cholera outbreak and are new to engaging with the GTFCC.

We will hold the majority of the KII interviews virtually over Microsoft Teams.

Interviews will be conducted using best interview practices (e.g., respecting anonymity, avoiding the use of leading questions, having two member teams for interviews to limit biases/ differences in interpretation, using the same interview guide across groups of stakeholders).

Interview guides will be provided to consultees ahead of the interview to aid with their preparation. Draft interview guides are included in Appendix D. An initial interview guide will be tested with a few consultees, and if required, updates will be made for subsequent interviews.

Considerations regarding stakeholders' participation, special needs and vulnerabilities are provided in Section 2.5.3. In addition, further details regarding ethical considerations and storage of consultation notes are provided in Section 2.8.

Country case studies

We have planned for six country case studies, with a mix of in-person (four) and desk-based (two) case studies, that will permit gathering of country perspectives and a deeper assessment of successes, challenges and lessons pertaining to the work of the GTFCC and implementation of the Roadmap. The country case studies will be used in the evaluation as one of the key sources of evidence across relevant evaluation questions as well as provide learnings for specific countries. Further details on the main areas of exploration through the country case studies are outlined in Appendix E. The country case studies findings will be documented in specific reports to be annexed to the main evaluation report.³³

The country selection has been carefully compiled to allow for diverse representation across key criteria for this evaluation (Appendix E includes further details). A long list of 60 initial countries was developed. This was then reduced applying the following criteria:

- **Exclusion criteria:** Countries were excluded based on the following criteria: (i) countries where GTFCC is not engaged;³⁴ (ii) countries that are not reporting cholera and do not acknowledge or recognise cholera; and (iii) countries with no reported outbreak. In addition (iv) countries from the EURO region were excluded to give priority to countries located in cholera endemic geographical regions and which account for the biggest burden of cholera.
- **Primary inclusion criteria:** Countries were then shortlisted based on seven primary inclusion criteria including: (i) country regional/ geographical location to ensure a mix across regions; (ii) countries which were part of the original Roadmap priority list, (iii) countries where the CSP formally operates (CSP countries); (iv) countries where the CSP does not formally operate (non-CSP countries)³⁵; (v) countries that have had a PAMI exercise conducted; (vi) countries that have an NCP; (iv) countries in fragile/conflict context.
- **Secondary criteria:** A second selection was conducted to (i) ensure that primary selection criteria were met in at least one country (and with a preference for countries which included a larger number of selection criteria) and (ii) ensure feasibility to conduct the case studies.

³³ A protocol for the development of the country case study reports will be developed in the core phase.

³⁴ We will seek to capture inputs from countries not currently actively engaged with the GTCC through the survey and select consultations.

³⁵ Noting that non-CSP countries may still receive some support from CSP and other structures from the GTFCC

ESG and ERG members recommendations compiled during this inception phase were considered to inform the selection of countries and backup list. Table 2.1 presents the proposed country selection and Table 2.2 presents the proposed back-up country selection.

The final selection of countries will be based on confirmation of availability of WHO and UNICEF country offices to support the case studies and availability of country stakeholders.³⁶ Considerations in terms of evaluation budget and availability of quality associates at the country level to support some case studies will also inform the final selection of countries.

Table 2.1: Proposed country case study selection (green depicts criteria met)

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

Table 2.2: Proposed back-up country case study selection (green depicts criteria met)

Back up selection									
	Cameroon	Benin	Niger	Zimbabwe	Zambia	Ethiopia	Sudan	Pakistan	Nepal
Region	AFRO-WCA	AFRO-WCA	AFRO-ESA	AFRO-ESA	AFRO-ESA	AFRO-ESA	EMRO	EMRO	SEARO
Roadmap priority list									
CSP									
Non-CSP									
PAMI									
NCP									
Fragile context									
Working language	French	French	French	English	English	English	English	English	English

In terms of methods, each country case study will entail:

³⁶ Ethiopia and the Philippines have recently been included as country case studies in the current Evaluation of WHO's contribution to WASH and Health through its Water, Sanitation and Hygiene Strategy 2018-2025. Although these two evaluations only have some overlap, where possible, evidence will be utilised from the case studies in that evaluation.

- A **desk-based component**, including a review of key cholera responses documentation e.g., NCPs, outbreak response documentation, country progress reports (e.g., from GTFCC or partners), responses after action reviews, long term WASH plans³⁷ etc.
- **National stakeholder interviews** (approximately 15-20 for in-person and 6-8 for desk-based country case studies), including key decision makers at national and local level (e.g., Ministries of Health (MoH) officials from infectious disease/epidemic control departments, Ministry of infrastructure /urban development, Ministry of water and sanitation), country representative in the GTFCC, CSP focal point/liason, technical and implementing partners (e.g., WHO, UNICEF, MSF), civil society organisations (CSOs), community-based organisations (CBOs), research institutions and other relevant in-country partners.

In terms of process, the WHO evaluation office and UNICEF will check availability with their respective country offices to support the case studies. The evaluation team will also rely on the support from key partners (e.g. WHO, UNICEF, CSP, GTFCC Secretariat and others) to provide support in identifying and introducing us to potential consultees at the country level.

Survey

The online survey will form an integral part of the methodology for this evaluation and allow quantification of responses to the evaluation questions. It will be shared with all relevant global, regional and country level stakeholders and therefore serve as a critical tool to gather feedback from a wider range of stakeholders than would have otherwise been possible with the country case studies and consultations only. It will also provide an option for anonymous feedback if preferred by stakeholders.

Survey questions: The survey will serve to answer a number of questions in the evaluation framework. It will help collate comprehensive global and country level insights to better understand the relevance of the GTFCC work, progress against the Global Roadmap, including barriers and enablers, as well as the influence of the GTFCC work level in terms of policies, guidelines, regulations, investments, multisectoral working, technical guidance, and the broader value add of GTFCC in strengthening health system responses cholera prevention, detection and control. A draft survey questionnaire will be shared for comments in the core phase.

Survey respondents: The survey will be sent out to relevant stakeholders including key country stakeholders involved in country level coordination and responses (e.g. Ministry of Health, Ministry of Local Government, local experts (in health/environment) NGOs/CSOs) as well as global and regional level stakeholders (the same stakeholder groups listed in the consultations above and more if relevant). This list will be compiled based on attendees and stakeholders contacted to attend the most recent General Assembly as well as consultee suggestions. In addition, to cater for additional stakeholders not included in these original lists, respondents will be asked to share the survey to other relevant respondents within their organisations. We will require the support of WHO (and potentially other GTFCC partners) to help with dissemination and follow up to promote a higher response rate from the selected participants.

Survey process: The survey would be issued as an online questionnaire, on the e-survey platform, SurveyMonkey and will be tested first internally by CEPA to ensure its functionality and access by stakeholders. We have planned for reminders to be shared by WHO to encourage maximum participation of stakeholders in the survey.

Participation and engagement at the annual General Assembly

The evaluation team attended the GTFCC General Assembly in the week of 17th June 2024 which provide inputs for the evaluation through engagement with key stakeholders and participation in the technical sessions. In particular, the team met with the ERG and ESG and obtained feedback on the draft evaluation framework, ToC and methods.

³⁷ Subject to data availability

2.5.2. Analysis methods and tools

Counterfactual and contribution analysis

This evaluation will include a counterfactual analysis assessing what might have happened in the absence of a GTFCC partnership, to provide an assessment of the perceived value add of the GTFCC partnership and the extent of its contribution to progress made in the fight against cholera. This approach considers the complex issues of linkages between different stages of results, the challenge of attribution versus contribution and the development and measurement of counterfactuals and value-add. Evidence informing the counterfactual analysis will be sourced primarily from the country case studies and consultations with global partners.

Evidence synthesis, triangulation and robustness assessment

All the data collected through the various methods will be organised and triangulated internally through the use of an evidence matrix. For each evaluation question/ sub-question, we will extract the raw information from the document and data review, the qualitative data has been collected from the stakeholder interviews, e-survey and country case studies. This will ensure a comprehensive and consistent approach to analysing, synthesising and triangulating the information and data to support the evaluation findings. This process will also ensure that the findings are based on an accurate triangulation of all the body of evidence collected, thereby minimising the risk of bias and improving the robustness of the findings.

The evidence matrix will also include the strength of the evidence/ robustness rating for each of the findings. All of the sources of evidence will be considered when determining an evaluation finding and the strength of that finding. In line with good evaluation practice, we will assess the strength of the evidence by evaluating both the:

- *Quality of the evidence:* quality of the documentation and feedback by considering aspects such as the source and reliability of the quantitative data and qualitative information (where possible/ relevant), and involvement of the consultee providing feedback on a specific issue (e.g. implementers may be conflicted to provide positive rather than critical feedback, etc.).
- *Quantity of the evidence:* the extent to which findings are consistent after being triangulated across sources of information. In terms of consultations, we will consider how many consultee responses will support the same view, or instances in which views might have been contradictory.

Table 2.3 below summarises the robustness assessment framework that we will use to assess the strength of the collected evidence across a four-point scale.

Table 2.3: Robustness rating for emerging themes/main findings

Rating	Assessment of the findings by strength of evidence
Strong (1)	<ul style="list-style-type: none"> • The finding is supported by data and/or documentation which is categorised as being of good quality by the evaluators; and • The finding is supported by a majority of consultations and country case studies, with relevant consultee base for specific issues at hand; and • The finding is well supported through the e-survey responses.
Moderate (2)	<ul style="list-style-type: none"> • The finding is supported by a majority of the data and /or documentation with a mix of good and poor quality; and/or • The finding is supported by a majority of the consultation responses including from the country case studies and/ or • The finding is reasonably well supported through the e-survey responses.
Limited (3)	<ul style="list-style-type: none"> • The finding is supported by some data and/or documentation which is categorised as being of poor quality; or • The finding is supported by some consultations (global/ country) as well as a few sources being used for comparison (i.e. documentation) or • The finding is partially supported through the e-survey responses.
Poor (4) – will not be included in the evaluation report	<ul style="list-style-type: none"> • The finding is supported by various data and/or documents of poor quality; or • The finding is supported by some/few reports only and not by any of the data and/or documents being used for comparison; or

- The finding is supported only by a few consultations (global/ country) or contradictory consultations and e-survey responses

2.5.3. Considerations regarding stakeholder participation, special needs and vulnerabilities

To **maximise stakeholders participation** in the evaluation, we have planned for sufficient time in the core phase for methods requiring stakeholders inputs (e.g., consultations, country case studies, survey), and will ensure early planning with stakeholders to provide adequate notice ahead of our engagement. Should a stakeholder no longer be available, we will liaise with them and/or WHO, the ESG and ERG as appropriate, to identify an alternative. Timely feedback from the ESG and ERG (on the consultee list, country case studies and survey) will be necessary to ensure adequate planning time for the core phase activities.

We will also pay particular attention to the lists of participants (for consultations, survey and case studies) to **promote balanced representation of stakeholders** across different geographical location (global, regional and country level), gender groups, and from groups whose voices may be traditionally less prominent in decision-making (e.g., communities).³⁸ The final lists of participants will be based on WHO, ESG and ERG final recommendations. The use of online consultations and an online survey will also aid with stakeholders participation across different locations. Consultees will be selected based on their role within the country cholera landscape, and where possible, efforts will be made to ensure equity in consultee distribution.

We plan to use **disability-sensitive approaches** across all consultations, including the use of clear, concise and simple language, avoiding jargon and acronyms, repeating key points and confirming stakeholders understanding as needed, as well as using accessible tools and formats that are compatible with assistive technologies (e.g., using Microsoft Teams for online consultations which offers caption options). As needed, stakeholders may be offered different options of communication methods to share their feedback in a format that work best for them (e.g., written feedback by email or oral feedback via audio). The use of the online survey also provides an option for written feedback to country stakeholders who might prefer this option.

Moreover, our **team includes multilingual people** (e.g., French and English speaking) in addition to our in-country associates who speak the local language.³⁹ This provides further options to engage with stakeholders in their preferred language in a more inclusive and participatory manner.

³⁸ Based on suggestion from other stakeholders, especially in country case studies.

³⁹ Depending on the final country selection for case studies

2.5.4. Limitations and evaluability of the evaluation

Table 2.4. below highlights the main risks identified and measures in place to mitigate them. We particularly highlight that at the moment of writing this inception report, we have not yet received all documents available from the GTFCC which limits our ability to fully assess the evaluability of this evaluation across evaluation questions.

Table 2.4: Evaluability and risk management overview

Main risks/ evaluability limitations	Likelihood/ Severity	Mitigation measures
<p>Limited availability of data including challenges with completeness and comprehensiveness of GTFCC, partners and country documentation to cover all topics in the evaluation. This includes:</p> <ul style="list-style-type: none"> Limited management and financial documentation from GTFCC to provide evidence regarding the efficiency evaluation question EQ.5. Limited epidemiological data across countries, progress reports and indicators, especially affecting the ability to assess effectiveness under EQ.6. In addition, some of this data can also be inaccurate, especially publicly available data (e.g. reporting of cholera cases). Limited M&E data compiled systematically across countries and years to assess progress of implementation of the Roadmap. This will especially affect the ability to assess effectiveness under EQ.6. Limited availability of sustainability frameworks, related indicators and data to provide evidence for the sustainability dimension under EQ.9. Limited epidemiological and management data for vulnerability and social criteria (e.g. gender, equity, and geographic location) to answer EQ.10 on GER. 	High/ High	<p>(a) Comprehensive compilation of documentation across GTFCC stakeholders and available dashboards. Documentation will be reviewed throughout the core phase as they become available. Additional data sources will be sought where possible (e.g. from the Secretariat regarding epidemiological data that is not publicly available/ is not accurate)</p> <p>(b) Use of mixed-methods approach including consultations, country case studies, survey and quantitative analysis to complement and triangulate information and findings across a number of evidence sources.</p> <p>(c) Ensure multi-stakeholder representation in our consultation list to provide feedback across all relevant topics and triangulate feedback across stakeholder interviews.</p>
<p>Technical Challenges inherent to the large scope of work, stakeholders and evidence to triangulate across numerous data sources. This includes:</p> <ul style="list-style-type: none"> Challenges in stakeholders not being fully aware of GTFCC work and unable to identify results attributable to GTFCC given the role of multiple organisations in cholera response and interventions delivery. 	Medium/ High	<p>(a) Use of evaluation matrix to support triangulation of evidence from multiple and numerous sources;</p> <p>(b) Select the most relevant stakeholders for consultation based on feedback from ESG and ERG to mitigate any consultation bias (e.g., stakeholders with vested interests in the outcome of the evaluation) and quality of stakeholder feedback (e.g., stakeholders with limited understanding of GTFCC).</p> <p>(c) Include a brief introductory in consultation and survey questions to ascertain the degree of GTFCC knowledge from stakeholders. Include a preamble regarding the nature of the GTFCC and the objectives of the evaluation in survey and interview questionnaire.</p>

Main risks/ evaluability limitations	Likelihood/ Severity	Mitigation measures
<ul style="list-style-type: none"> Generalisation of country findings especially from country case studies to draw overall conclusions may present challenges. 		<p>Ask follow up/ probing questions as required to clarify stakeholders' responses regarding GTFCC contribution to results.</p> <p>(d) Employ robust selection criteria on countries for case studies to ensure adequate representation of different country context, drawing lessons learned from case studies whilst recognising not all findings from a country may be generalizable, highlight where the evidence base is based on select countries only and where there is divergence in experiences;</p> <p>(e) Complement insights from country case studies with consultations (with select non-case study country stakeholders) as well as feedback from the survey to increase the likelihood of generating comprehensive findings/ lessons on the performance of the GTFCC as a whole.</p>
<p>Operational challenges given extensive scope of evaluation. This includes:</p> <ul style="list-style-type: none"> Limited stakeholder availability for consultations and survey participation Limited country availability for case study visits Potential delays in data sharing and review and feedback given multiple priorities for the GTFCC and its stakeholders 	Medium/ High	<p>(a) Use of inception period to identify countries and key stakeholders with guidance from the WHO, ESG and ERG and engage key stakeholders early on to maximise participation in the core phase.</p> <p>(b) Active support and guidance from WHO, ESG and ERG to contact stakeholders, especially those less engaged with the GTFCC, and to disseminate the survey.</p> <p>(b) Robust management approach in place, with internal communication within evaluation team and use of management tools to identify issues early on (e.g., stakeholder unavailability) and support effective troubleshooting and quality control;</p> <p>(c) Effective ongoing communication with the WHO to raise any operational challenges and identify mitigation measures.</p>
<p>Managerial including key risks to project management and delivery, timeliness and budget management</p>	Medium/ Medium	<p>(a) Develop a clear work plan at the start of the assignment with deadlines agreed with WHO Evaluation Office and flexibility in timeline where feasible. The workplan will also be shared with stakeholders, as relevant (e.g., ESG/ERG through the Inception Report), so everyone is aware of the timelines and their role (e.g. in terms of supplying documentation, reviewing report drafts, etc.)</p> <p>(b) Budget related risks e.g., with regard to scope creep during the inception and core phases of the evaluation, which we will seek to manage tightly with WHO. We can be flexible to evolve the work based on what is deemed most relevant and useful for this evaluation, however trade-offs in terms of level of effort and time would the need to be considered.</p>

2.6. GER, ETHICAL AND DATA MANAGEMENT CONSIDERATIONS

In this section we discuss (i) GER, (ii) ethical and (iii) data management considerations for the evaluation.

Gender, equity and human rights considerations (GER)

Gender, equity and human rights (GER) considerations will be included in the evaluation design and implementation, as follows:

- **Equitable team composition:** The core evaluation team is gender-balanced (four women and one man) and has diverse nationalities. Four team members are currently based in the UK and one member based in India. Country-based associates are still to be confirmed.
- **Design of evaluation questions and tools:** The evaluation questions, as found in the ToR integrate GER considerations, specifically EQ9 (Cross cutting: GER). The tools also have been developed to reflect GER considerations where possible (see Section 2.5.3).
- **Recruitment of participants for KIIs and FGDs:** The evaluation team will monitor the profiles of participants of the KIIs and FGDs to ensure a balanced and representative participation. Attention will be paid to the range and diversity of partners involved with the campaigns, and their representation of marginalised groups.
- **Analysis of data:** Where possible, the data collected, such as the KII and FGDs data, will be disaggregated based on GER considerations, such as gender and location.

The evaluation team will comply with the relevant UNEG and WHO guidance of GEHR, including: [Guidelines on Integrating Human Rights and Gender Equality in Evaluations \(2011\)](#), and [2014. WHO Guidance Note on Integrating Health Equity, Gender Equality, Disability Inclusion and Human Rights in WHO Evaluations](#), and [WHO Policy on Disability](#).

Ethical considerations

The evaluation will be conducted in accordance with international best practices and standards in evaluation and the evaluators will respect the key principles of evaluation including:

- clarity
- integrity
- independence
- honesty
- transparency
- accountability
- accuracy
- non-discrimination and impartiality
- do no harm and Leave no one behind
- confidentiality
- protection of the data collected

Participating WHO staff and the external stakeholders will be assured anonymity and confidentiality at the beginning of the interviews/FGDs and will be able to provide their informed consent in a set space for questions and answers prior to the interviews/discussions. Staff and stakeholders responding to the survey will be assured that their responses will be treated confidentially and anonymously.

The evaluators will maintain professional integrity by ensuring that information, knowledge, and data gathered during the evaluation process will be used for the evaluation process exclusively. The evaluators commit to avoiding conflicts of interest in all aspects of their work.

The evaluation team will comply with the UNEG [Ethical Guidelines for Evaluations](#) and [WHO Evaluation Policy](#).

Data management

The evaluation team will use the utmost discretion in managing any data generated by the evaluation and shared by the WHO. The evaluation team will use two online repositories for stocking data: the WHO SharePoint extranet and an external secured drive only accessible to the evaluation team. In the analysis of the data, any identifiable information will be anonymised. All raw data will be archived securely after completion of the project.

3. EVALUATION TEAM, GOVERNANCE, VALIDATION AND FINALISATION

This section includes Section 3.1. which provides details of the evaluation team, roles and responsibilities, Section 3.2. which describes the mechanisms for governance of this evaluation and Section 3.2. that describes the process of validation and finalisation for this evaluation.

3.1. EVALUATION TEAM, ROLES AND RESPONSIBILITIES

Table 3.1. provides an overview of the evaluation team, including the roles and responsibilities across team members.

Table 3.1: Overview of evaluation team roles and responsibilities

Team member, position	Expertise	Roles and responsibilities
Core team		
Kaveri Kumar, Team Leader CEPA Partner	Kaveri brings around 20 years' experience in designing and implementing a wide range of evaluations and strategic reviews for global health organisations. She led CEPA's past evaluation of the GTFCC, has been actively engaged in our work with Gavi across its vaccine support, and has a special focus on health systems strengthening and pandemic preparedness.	<ul style="list-style-type: none"> Team Lead, providing strategic guidance and steering project delivery across the full methodology. Leads client engagement and stakeholder consultation, with participation in all key meetings.
Laura Grobicki, Evaluation Specialist and Project Manager CEPA Managing Consultant	Laura has significant experience managing evaluations for a range of global health initiatives, and was also the lead consultant for the 2017 GTFCC review. She has worked on a range of evaluations since with similar mandates, including case studies, for Gavi, Global Fund, Unitaid and the WHO Evaluation Office.	<ul style="list-style-type: none"> Leads desk review, stakeholder consultations, and online survey. Conduct country case studies Project manage the evaluation through providing day-to-day engagement and management with client.
Lauren D'Mello-Guyett, Cholera Control and WASH Expert Independent Consultant with part-time role as an LSHTM Assistant Professor	Lauren has extensive experience and expertise in Cholera prevention, control and epidemiology, culminating over 15 years of experience in Cholera response both at the global and in country level. She brings wide-ranging skills and strong technical expertise including in areas of cholera epidemiology and evaluation of WASH interventions in humanitarian crises.	<ul style="list-style-type: none"> Provide technical cholera and WASH-focused advisory input throughout the evaluation. Participate in stakeholder consultations. Analyse findings from country case studies.

Team member, position	Expertise	Roles and responsibilities
Milca Agbenou, Evaluator CEPA Consultant	Milca is a global health specialist with solid experience supporting humanitarian programs, including cholera responses in Southern Africa, and health programs integrating WASH and Infection, Prevention and Control interventions in cholera endemic countries across Africa, Asia and LAC. Milca brings strong mix-methods analytical and research skills having worked on a range of evaluations and analytical assignments.	<ul style="list-style-type: none"> • Conduct analysis across evaluation methods including desk review, consultations, survey and case studies. • Support overall project delivery.
Abdallah Abba-Aji, Analyst CEPA Economist	Abdallah has clinical experience as well as mixed-methods analytical and research skills. He has medical doctor training and has experience working in West Africa.	<ul style="list-style-type: none"> • Conduct analysis including data analysis, survey analysis and case studies. • Support overall project delivery.
Country consultants		
Country associates (TBC depending on country selection)	Country associates bring a wide range of country level expertise across the priorities of the GTFCC Cholera Roadmap 2030 (e.g. epidemiology, WASH, vaccines, health system strengthening, health surveillance, case management and community engagement).	<ul style="list-style-type: none"> • Provide country inputs into the evaluation and lead/ support on country case studies.

3.2. EVALUATION GOVERNANCE

The WHO Evaluation Office is responsible for the overall management of this evaluation with support from UNICEF Evaluation Office and guidance of the ESG and ERG. ESG and ERG members include representatives from the various structures of the GTFCC (e.g. Secretariat, SC, CSP, IRP, WGs) as well as key partners, donors and countries. They represent the primary users for this evaluation and as such, have a direct, identifiable stake in this review, and the capacity to implement the recommendations from the evaluation. A full list of ESG and ERG members is presented in Appendix H.

The ESG and ERG constitute the main governance mechanism for this evaluation. **The ESG** comprises members from the GTFCC SC which have been nominated by the Chair. The role of the ESG includes ensuring factual accuracy of the final inception and evaluation reports. **The ERG** comprises focal points from key stakeholders of the GTFCC and technical experts on cholera control matters. The ERG acts as a technical advisory group and is responsible for reviewing all deliverables from this evaluation and providing technical insights throughout its implementation.

We have planned for **multiple engagement points with the ESG and ERG** throughout this evaluation to ensure their effective participation and full engagement during the course of the assignment including with regards to the evaluation design, implementation and validation of activities, deliverables and recommendations. Key points of engagement include: (i) inception phase kick meetings and consultations, (ii) engagement at the 2024 GTFCC General Assembly, (iii) presentation of initial findings; and (iv) stakeholder workshop to present final evaluation findings and recommendations. Further details our proposed engagement points with the ESG and ERG are outline under the 'Proposed workplan and timeline' in Section 4. These engagement points will be carefully planned and facilitated to provide opportunities for rich exchanges with the ESG and ERG, and gather feedback to maximise the utility of the evaluation findings and recommendations.

The Evaluation Manager from the WHO evaluation office is responsible for facilitating the evaluation process, ensuring access to relevant documentation/ data and key interlocutors within and outside WHO, coordinating dissemination of evaluation deliverables for comments and feedback from the ESG and ERG, and supporting the delivery of select activities (e.g., survey) etc. The Evaluation Manager will be the main point of contact with the

evaluators and will provide guidance regarding budget and timing considerations to ensure effective delivery of the evaluation (as described further in Section 4.2 on project management and quality assurance).

3.3. VALIDATION AND FINALISATION

In addition to the points noted above in terms of engagement with the ERG and ESG and WHO which will be part of the process to validate and finalise the evaluation, the evaluation findings will be shared with GTFCC stakeholders through a stakeholder workshop. In this workshop evaluation findings and recommendations will be presented in order to facilitate co-creation of recommendations following the submission of the Draft Report and before the submission of the Final Report.

4. PROPOSED WORKPLAN, TIMELINES AND PROJECT MANAGEMENT

This section includes Section 4.1. with details of the evaluation timelines and deliverables, and Section 4.2. on the project management and quality assurance processes for this evaluation.

4.1. TIMELINES AND DELIVERABLES

Table 4.1 provides a summary of the workplan and key deliverables. These are target timeframes which may need to be adapted depending on progress of the evaluation and availability of key stakeholders. Figure I.1. in Appendix I includes the project workplan presented in a Gantt chart format.

Table 4.1: Summary of project workplan and timelines for Phase 2

Phase	Description of main tasks	Key deliverables and review timelines
Inception	<ul style="list-style-type: none"> Project inception phase featured virtual kick-off meetings with ERG and ESG and inception consultations with select GTFCC stakeholders. Desk-based research and document review to support development and submission of Draft Inception Report. Draft Inception Report presented and discussed in GTFCC General Assembly meetings and feedback obtained from the WHO Evaluation Office, ESG and ERG. 	<p>Draft Inception Report: 12 June 2024</p> <p>Second Draft Inception Report 27 June 2024</p> <p>GTFCC feedback: 16 July 2024</p> <p>Final Inception Report: 23 July 2024</p>
Core	<ul style="list-style-type: none"> Further desk-based research will be supplemented with data collected from interviews and the e-survey. Undertaking of six country case studies. Development of initial findings in PowerPoint document and Draft Report. 	<p>Initial Findings Deck: Week of 23 September 2024</p> <p>Draft Report: Week of 23 September 2024</p> <p>GTFCC feedback: Week of 14 October 2024</p>
Finalisation	<ul style="list-style-type: none"> Evaluation findings and recommendations to be presented at stakeholder workshop. Finalisation of report and brief. 	<p>Final Report: Week of 25 November 2024</p>
Project management	<ul style="list-style-type: none"> We have planned for regular progress updates on a weekly or fortnightly basis throughout this evaluation which will be carried out via remote calls/ email. The project manager will attend the calls with other team members attending some of the calls when necessary (e.g., to discuss feedback on draft deliverables). 	Weekly or fortnightly meetings

4.2. PROJECT MANAGEMENT AND QUALITY ASSURANCE

Effective execution of this evaluation will require tight planning and management, as well as efficient coordination and communication between the evaluation team and the WHO Evaluation Office throughout the evaluation. In addition, engagement and receiving inputs from the ERG and ESG will be very important as noted in Section 3.1 above on evaluation governance.

To this end, the Project Manager (Laura Grobicki) will be responsible for overseeing effective planning, day-to-day running and overall management of this evaluation with the WHO Evaluation Office. The Project Manager is also responsible for enabling effective teamwork and information flow across workstreams and members of the evaluation team, through regular internal catch ups, efficient information sharing using selected communication channels and effective collaboration on shared deliverables and activities.

To facilitate a strong coordination and adequate oversight on project progress with the WHO Evaluation Office, fortnightly or weekly catch ups have been planned. The Project Manager will be responsible for providing the updates during the calls, with the Team Leader and other team members attending as required, in addition to attending additional calls when necessary (e.g., to discuss feedback on draft deliverables).

Meeting the timelines for this review will require: (i) timely sharing of key documents and data by the WHO Evaluation Office/ GTFCC Secretariat, (ii) timely review of deliverables by the WHO Evaluation Office and ERG and ESG, and (iii) timely availability of stakeholders for consultations. The Project Manager will work closely with the WHO Evaluation Office to ensure these are well done.

Effective execution of this project will also require solid quality assurance. Relating to deliverables in particular, external quality assurance will be provided by the WHO Evaluation Office who will also obtain feedback from the ESG and ERG. Feedback will then be incorporated into deliverables by CEPA who will follow internal quality assurance process under the responsibility of the Project Manager and the Project Partner as described in Appendix J. Deliverables will be quality assured through the Team Leader (Kaveri Kumar), Senior Evaluation Specialist (Laura Grobicki). The process of quality assurance will primarily involve a review of completeness in relation to the agreements made with the client on a deliverable, general flow and validity/ robustness of the presentation, editorial review, and cross checking for appropriate handling of any confidential information.

Appendix A REFERENCES

In this appendix we outline the key documents reviewed for this final Inception Report.

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Appendix B **DRAFT STAKEHOLDER MAPPING AND PROPOSED LIST OF CORE PHASE CONSULTEES**

This Appendix presents a summary of the stakeholder mapping conducted during the inception phase. A detailed version of the stakeholder mapping has been provided in the excel file named 'CEPA_Stakeholder mapping and proposed core phase consultee list' shared as an attachment with this report. This excel also includes the list of proposed core phase consultees.

The stakeholder mapping represents our current understanding of key stakeholder groups that are relevant to the GTFCC and implementation of cholera responses and prevention activities in general. Specifically, this exercise aimed to outline the extent to which the GTFCC is engaged, or ideally should be engaged with these groups of stakeholders – either directly (e.g. through the Secretariat) or indirectly (e.g. through the GTFCC partners). This exercise was informed by insights from the document review as well as feedback from stakeholders interviewed during the inception phase of the evaluation. This stakeholder mapping provided the basis for informing the list of stakeholders that will be engaged during this evaluation and for compiling the draft core phase consultee list. The evaluation will aim to engage stakeholders across all four quadrants of this stakeholder map (as shown in Figure B.1).

Figure B.1 presents the results of the stakeholder mapping as follows:

- Degree of engagement with GTFCC (e.g., stakeholders with dedicated capacity to engage with GTFCC such as the Secretariat who have high availability versus non-priority countries⁴⁰ at low risk of outbreaks who are less engaged) represented across the x axis.
- Degree of influence over the GTFCC and Roadmap success (i.e., stakeholders power to take key decisions that may facilitate or hinder the implementation of GTFCC and Roadmap activities) as shown on the y axis;
- In four quadrants as follows:
 - Top right quadrant: stakeholders with a high influence (over the GTFCC and Roadmap success) as well as high engagement with the GTFCC. This currently includes (i) GTFCC dedicated staff (e.g., Secretariat, CSP staff), (ii) individual representatives of key partners, countries and donors that have committed some of their time/ capacity to participate in the GTFCC internal structures (e.g., members of the working groups and task team,⁴¹ steering committee, IRP etc.), and (iii) priority countries from the Roadmap that are engaged through the CSP.
 - Top left quadrant: stakeholders with a high influence over the GTFCC and Roadmap success but low engagement with the GTFCC. This currently includes (ii) organisations of key partners (technical, implementing and research partners), donors and industry actors that may have dedicated representatives in the GTFCC but would also have other staff with a high degree of influence who are not engaged with the GTFCC;⁴² (ii) key donors that have a high degree of influence but are currently less engaged with the GTFCC (e.g., World Bank, African Development Bank (AfDB) etc.); regional agencies less engaged with the GTFCC (e.g., Africa CDC, African Union) and (iii) priority countries from the Roadmap that are non-CSP thus currently receiving some support but less than CSP countries.
 - Bottom right quadrant: stakeholders with a low influence over the GTFCC and Roadmap success but high engagement with the GTFCC. This currently includes non-priority countries that may be at risk or

⁴⁰ Non-priority countries refer to countries that are not included in the Roadmap list of priority countries

⁴¹ GTFCC advocacy task team

⁴² For these organisations, representatives in the GTFCC would need to be selected strategically to enable meaningful participation in the GTCC and effective knowledge sharing in their organisation.

Appendix C **INCEPTION PHASE LIST OF CONSULTEES**

Appendix C provides the list stakeholders interviewed during the inception phase of this evaluation in Table C.1.

Table C.1: Consultee list for inception phase

Organisation/Department	Name	Position/ Area of focus
South Africa Delegate	Frew G Benson	Chief Director, National Department of Health of South Africa/ Clinical Executive, Rahima Moosa Hospital
CDC	Vikas Kapil	Global Immunization and Vaccines Division Lead
CDC	Chris Braden	Deputy Director, National Center for Emerging and Zoonotic Infectious
BMGF	Duncan Steele	Deputy director and Strategic Lead for Enteric Vaccines
BMGF	Tanya Shewchuk	Senior Program Officer, Immunization Team
UNICEF (also ERG)	Elke Johanna De Buhr	Evaluation specialist, WASH and climate change
UNICEF	Jerome Pfaffmann	Senior Advisor, Public Health Emergencies
US CDC	Thomas Handzel	Wash expertise
BMGF	Helen Matzger	Deputy Director, Vaccine Programs
Gavi	Allyson Russell	Senior Programme Manager, Outbreaks and Global Health Security, Vaccine Programmes Team
IFRC	Christopher Brewer	Africa Cholera Coordinator
MSF	Iza CIGLENECKI	Operational Research Coordinator
WHO	BARON, Emmanuel	WHE/HEI/EHI, Epidemiologist
GTFCC Secretariat	Marion Martinez Valiente	Technical officer WHO, Focal point GTFCC Secretariat
Country delegate - Pakistan	Rabail Javed	Deputy director, Pakistan Health Research Council, Ministry of Health, National Cholera Control Strategy Focal Person
GTFCC Secretariat	Philippe Barboza	Head of GTFCC Secretariat, GTFCC
CSP (IFRC)	Annika Wendland	CSP Coordinator

Appendix D **INTERVIEW GUIDES**

Appendix D provides select interview guides for the inception phase (Section D.1) as well as draft interview guides for global level stakeholders (Section D.2) and country level stakeholders (Section D.3). These guides will be further developed in the core phase after experience of a few interviews and will also be tailored to different stakeholders.

D.1. INCEPTION PHASE INTERVIEW GUIDE

This guide sets out the questions as part of the inception phase of our evaluation, and these can be further tailored during the consultation. As part of the inception phase of work for the assignment, the interviews will be used to gather views on priorities and key issues for the evaluation. This will support the development of a relevant and focused evaluation design.

Inception phase interview questions:

1. What do you view as the priority questions for this mid-term independent evaluation of the GTFCC?
2. What do you view as the key achievements and value add of the GTFCC between 2017 to mid-2024? What do you view as being the key challenges, gaps, and areas for improvement?
3. What aspects do you think work well and less well in term of governance structures, mechanisms and processes of the GTFCC?
4. What do you consider to be key contextual factors and changes that are affecting cholera spread and transmission risk profile and influencing programme implementation?
5. What is your advice on key methods for the evaluation – e.g. key documents or data for review, key stakeholders for consultations, and country case studies (currently planned for six country case studies)?

D.2. CORE PHASE INTERVIEW GUIDES

Here we have included interview guides for the core phase consultations at global and country level. These interview guides currently include crosscutting questions as well as examples of specific questions for key stakeholders. These guides will be further developed and tailored for different stakeholders.

D.2.1. Global interview guide

1. To what extent is the Roadmap still fit for purpose given the change in context since its design, in terms of (i) how appropriate are its ambitions and targets? (ii) the degree of focus/ emphasis on each of the three strategic axes of the Roadmap (outbreak response, prevention, coordination of human, technical and financial resources)? (iii) the proposed interventions to prevent and control cholera (e.g., WASH, leadership and coordination, case management, surveillance and reporting, OCV and community engagement) and (iv) the alignment of the Roadmap with relevant global and regional frameworks (e.g. focusing on pandemic prevention, preparedness, and response and emergencies)?
2. To what extent is the design of the GTFCC still fit for purpose to support the achievement of the Roadmap in terms of its focus and organisational structure? Specifically:
 - i. Are the objectives of the GTFCC still the most relevant objectives in relation to the current priorities and country needs with regards to cholera? Does the GTFCC pursue the most relevant activities in support of these objectives? *The objectives include (i) supporting the design and implementation of global strategies; (ii) providing a forum for technical exchange, coordination, and cooperation on cholera-related activities to strengthen countries' capacity, (iii) supporting the development of a research agenda and (iv) increasing the visibility of cholera as an important global public health problem).*
 - ii. How appropriate are the GTFCC governance and operational structures, specifically: (i) the GTFCC Secretariat and whether the roles and responsibilities allocated to the Secretariat are appropriate; (ii) the

- SC, its mandate and objectives as well as its composition and membership, (iii) the IRP, its principles and purpose and composition; and (iv) the WGs, their areas of responsibility, composition and leadership.
- iii. In terms of the nature of the hosting relationship with WHO, is there a value-add by both WHO and GTFCC to each other's work, and are there clear separation of roles and responsibilities?
 - iv. Is there adequate engagement of countries? Do you consider the role of the CSP (e.g. purpose, overall objective, structure) to be appropriate? Should there be more of a shift to work at the regional and country level and if so, what resources do you think would be required for this?
 - v. Are all relevant partners engaged with the GTFCC? If not, which partners are not engaged?
3. To what extent have the GTFCC internal structures (including the SC, Secretariat, CSP, the IRP, and the WGs) been able to foster alignment between partners in terms of approach and interventions delivered within and between different pillars of the strategy to promote a coherent and balanced approach to cholera control?
 - i. To what extent is the work of the GTFCC internal structures coherent with programs/ departments within WHO?
 - ii. Given the GTFCC relies predominantly on voluntary partner contributions, what is working well and less well because of this, and are there sufficient incentives for action? What improvements could be made to strengthen: (i) stakeholders engagement and participation in the GTFCC (ii) Alignment and synergy between partners at global level and country level? (iii) wider stakeholders' engagement with GTFCC (e.g., partners, donors and countries not represented in the GTFCC or not currently engaged)?
 4. What is working well/ less well it terms of the functioning of the GTFCC and what can be improved? Specifically, Regarding specific internal structures:
 - i. Steering committee: What works well and less well with regards to its ability to be a strategic and agile decision-making body on behalf of the whole partnership?
 - ii. Secretariat: What's working well or less well including its capacity to deliver as well as clarity regarding their role (e.g., supporting country outbreak responses currently when this was not expected in the GTFCC governance ToRs)?
 - iii. Working groups: What's working well and less well including aspects such as membership and representation, leadership, understanding of roles and responsibilities, communications and management, operating processes and meetings? What factors have facilitated of hindered the work of the WGs?
 - iv. General Assembly: How useful is it as a forum for all members to meet and take strategic decisions?
 - v. IRP: What's working well or less well including in terms of reviewing NCPs, its capacity and operating model to meet the needs of countries?
 - vi. CSP: What is working well or less well in in terms its ability to support countries (e.g. country knowledge and clarity on CSP role, technical support, resource mobilisation, coordination of partners in-country)?
 5. How efficiently has the Roadmap been implemented by the GTFCC in terms of optimizing human and financial resource allocation to support countries in a changing cholera landscape? Specifically, use of resources allocated to the GTFCC (e.g. Secretariat, CSP, Working Groups) and the balance of funding across its activities and internal structures? To what extent is the GTFCC is able to channel resources (e.g., human, commodities) to meet country needs and how flexible is this support when countries ask for it?
 6. What progress has been achieved in the implementation of the Roadmap with regards to (i) Axis 1: Improving outbreak containment and reducing the global burden of cholera through early detection and rapid response? (ii) Axis 2: Increasing prevention of disease occurrence through targeted multi-sectoral interventions in cholera hotspots? (iii) Axis 3: Ensuring effective mechanism of coordination for technical support, resource mobilisation, and partnership at local and global levels? Specifically:

- i. For Axis 1 and 2, what have been the results of these efforts? How balanced have cholera interventions been at country level across the key strategic interventions of the Roadmap under each axis (e.g., WASH, leadership and coordination, case management, surveillance and reporting, OCV and community engagement)?
 - ii. What has worked well or less well in the implementation of the GTFCC strategic approach under axis 2 (i.e., hotspot targeting)?
 - iii. What has the GTFCC achieved through its various functions, and what has worked well and less well? specifically: (a) being a forum for technical exchange, coordination, and cooperation on cholera-related activities to strengthen countries' capacity; (b) supporting the development of a research agenda; (c) conducting advocacy; (iv) technical working groups and their products and knowledge sharing (including how much this guidance has been used); (v) supporting implementation of country level activities including in CSP and non-CSP supported countries and (vi) ensuring adequate resource mobilization?
 - iv. To what extent has the GTFCC contributed to this progress? (Please give specific examples of areas where the GTFCC has made a clear contribution against each axis).
 - v. What would have happened in the absence of the work of the GTFCC?
7. What factors have facilitated or hindered progress of implementation of the Roadmap under each of these axes (e.g., resources, financing, GTFCC functioning, environmental and contextual factors, country level factors)?
 8. To what extent is the Roadmap designed to enable sustainability of cholera interventions post 2030 in terms of financial, programmatic and environmental considerations?
 9. How have gender, equity and human rights considerations been integrated in the implementation of the Roadmap?
 10. What would be 2-3 recommendations you would like to share with regards to strengthening the GTFCC and accelerating progress of implementation of the Roadmap?

D.2.2. Country interview guide

1. What is your awareness of the GTFCC and its role? What has been your engagement with the GTFCC or the work it has produced (e.g. guidance documents)? What support have you received through the GTFCC?
2. What is your awareness of the End Cholera Roadmap? How relevant is this Roadmap to country needs and country contexts? To what extent has the Roadmap encouraged or galvanised action on cholera in country?
3. How well have country stakeholders been able to engage with the GTFCC through its internal structures (e.g., representation or engagement with the SC, Secretariat, WGs, IRP, CSP)? To what extent is the current design of the GTFCC structures (e.g., CSP, IRP, WGs) enabling adequate participation, engagement and support of countries? What's missing or could be improved?
4. How well has the GTFCC promoted better alignment of partners' interventions with national priorities at the country level? To what extent has the GTFCC supported communication, knowledge sharing and capacity building among countries and partners to promote a more coherent approach to cholera control at country level?
5. What progress have been achieved in the implementation of the Roadmap at country level with regards to (i) Axis 1: Improving outbreak containment and reducing the global burden of cholera through early detection and rapid response? (ii) Axis 2: Increasing prevention of disease occurrence through targeted multi-sectoral interventions in cholera hotspots? (iii) Axis 3: Ensuring effective mechanism of coordination for technical support, resource mobilisation, and partnership at local and global levels?
 - a. What activities have been most helpful to enable progress against each of these axes?
 - b. What have been the results and impact of these efforts?
 - c. What has worked well and less well in terms of the support provided?

- d. To what extent has the GTFCC (through its internal structures and as a partnership) contributed to this progress? (Please give specific examples of areas where the GTFCC has made a clear contribution against each axis). What would have happened in the absence of the GTFCC?
6. What factors have facilitated or hindered progress under each of these axes? (e.g., resources, financing, capacity, political will, GTFCC functioning, environmental and contextual factors, political will)
7. What measures have been implemented in country to ensure sustainable progress on cholera in terms of financial, programmatic and environmental considerations? How has the GTFCC contributed to promoting sustainable cholera interventions? What could be improved?
8. How have gender, equity and human rights considerations been integrated in implementation of cholera control interventions? Please provide examples.
9. What would be 2-3 recommendations you would like to share with regards to strengthening the support from GTFCC and accelerating progress against the Roadmap in country?

CSP supported countries (additional question to questions 1-8 above)

1. To what extent has the CSP been able to facilitate effective country support in terms of:
 - a. ensuring that cholera interventions are coherent, evidence based, aligned with the government and Global Roadmap objectives.
 - b. facilitating and optimising coordination of technical assistance at national level from GTFCC members and other stakeholders?
 - c. coordinating technical assistance for developing and reviewing the NCPs. What has worked well or less well with regards to this support?
 - d. supporting advocacy and resource mobilization efforts for the implementation of countries' NCPs?
 - e. providing support for the monitoring and evaluation of NCPs after its launched (in countries that have developed one with the support of the CSP)?
 - f. facilitating coordination of GTFCC partners' activities to ensure coherent, optimized, and synergized interventions and adherence to GTFCC approved guidance?
2. What support and activities have been most helpful? How easy was it to engage and request support from the CSP? What is missing or could be improved to strengthen CSP support to countries?

Non-CSP countries (additional questions to questions 1-8 above)

1. What support has the country been able to receive from the GTFCC (through its internal structures, e.g., Secretariat, WGs)? What activities have been most helpful?
2. How easy is it to access information on the GTFCC including who to contact and information on the support they can provide?
3. What is missing or could be improved to strengthen GTFCC engagement and support to non-CSP countries?

Non engaged countries (separate questions from those presented above)

1. What is your awareness of the GTFCC and its role?
2. Are you aware of the GTFCC guidance and tools?
3. If you have engaged with the GTFCC before:
 - a. In what ways had your country engaged with the GTFCC, its partners or the work it has produced (e.g. guidance documents)?
 - b. What worked well or less well in that engagement? What could have been improved?
 - c. Why is your country no longer engaged with the GTFCC?
4. If you have not engaged with the GTFCC before:

- a. What type of engagement and support from the GTFCC would be most beneficial to support effective cholera control in your country?

Appendix E **COUNTRY CASE STUDIES**

This Appendix presents the details for the country case studies to be conducted. Section E.1 outlines the main areas of exploration in the country case studies, Section E.2 presents the country selection methodology and Section E.3 includes the proposed list of countries for case studies.

E.1. MAIN AREAS OF EXPLORATION THROUGH COUNTRY CASE STUDIES

The country case studies will provide evidence for the evaluation across the evaluation questions from a country perspective. Key areas of exploration will include:

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

E.2. COUNTRY SELECTION METHODOLOGY

This section outlines the methodology applied to select countries for case studies to conduct as part of this evaluation. The methodology was developed with the objective to ensure:

- (i) countries are selected to offer diversity across key country characteristics and key factors (e.g. relevant insights and key learnings) as represented by the selection criteria; and
- (ii) planning for country case studies takes into account the feasibility based on country contexts given ongoing events in countries as well as evaluation feasibility considerations (e.g. budget, availability of countries to be included as a case study).

The criteria used for this process have been selected based on document review, inputs from stakeholders in the inception phase (through consultations as well as feedback compiled during the GTFCC General Assembly). The methodology entailed a five-step approach that has been applied as follows:

Step 1: List compilation

We compiled a long list of countries for potential selection as a case study. 60 countries were compiled in total (as presented in Table E.1.) including:

- 47 priority countries from the original list of priority countries from the Roadmap;

- Countries from the list of priority countries presented in the WHO 2023-2024 Global Strategic Preparedness Readiness and Response Plan for Cholera⁴⁴ as proxy for most current countries prioritised for Cholera responses (this included ten additional countries not overlapping with Roadmap priority countries);
- Three additional countries suggested by the GTFCC Secretariat: countries that have recently had a cholera outbreak (Comoros and the French overseas department of Mayotte) or were undergoing the PAMIs process (Madagascar).

Table E.1: Long list of 60 countries compiled for case studies selection (green depicts inclusion)

Long list of countries compiled	Part of Roadmap 47 priority countries	Part of WHO 2023-2024 Global Strategic Preparedness Readiness and Response Plan for Cholera	Additional countries suggested
Afghanistan			
Angola			
Bangladesh			
Benin			
Burkina Faso			
Burundi			
Cameroon			
Central African Republic			
Chad			
Comoros			
Congo			
Côte d'Ivoire			
Democratic Republic of the Congo			
Djibouti			
Dominican Republic			
Eritrea			
Eswatini			
Ethiopia			
Ghana			
Guinea			
Guinea-Bissau			
Haiti			
India			
Iran (Islamic Republic of)			
Iraq			
Jordan			
Kenya			
Lebanon			
Liberia			
Malawi			
Madagascar			

⁴⁴ The [WHO 2023-2024 Global Strategic Preparedness Readiness and Response Plan for Cholera](#) outlined 46 priority countries including 36 that were overlapping with the original Roadmap priority list and 10 new countries.

Long list of countries compiled	Part of Roadmap 47 priority countries	Part of WHO 2023-2024 Global Strategic Preparedness Readiness and Response Plan for Cholera	Additional countries suggested
Mali			
Mayotte (French overseas department of)			
Malaysia			
Mozambique			
Myanmar			
Namibia			
Nepal			
Niger			
Nigeria			
occupied Palestinian territory, including East Jerusalem			
Pakistan			
Philippines			
Papua New Guinea			
Rwanda			
Sierra Leone			
Somalia			
South Africa			
South Sudan			
Sudan			
Syrian Arab Republic			
Thailand			
Togo			
Türkiye			
Uganda			
Ukraine			
United Republic of Tanzania			
Yemen			
Zambia			
Zimbabwe			

Step 2: Development of a shorter list based on exclusion criteria

The following exclusion criteria factors were considered:

1. Countries where the GTFCC is not engaged, therefore likely offering less in-depth insights and making it harder to coordinate a case study. Insights from some of these countries would be captured through the survey and global interviews.
2. Countries that are not reporting cholera, that do not acknowledge or recognise cholera, or have no reported outbreak, and that may therefore be less inclined to be included as case studies.
3. Countries from the EURO region - given the limited number of country case studies, we have given priority to countries in cholera endemic geographical regions that account for the biggest burden of cholera globally. Whilst we acknowledge the recent recrudescence of cholera cases in countries from non-endemic regions too (e.g., in the French overseas department of Mayotte), we anticipate that relevant insights on this new development can be captured through the survey and stakeholder consultations.

Information regarding criteria 1 and 2 were compiled based on feedback from the GTFCC Secretariat.

A total of 26 countries were excluded based on these factors (Afghanistan, Central African Republic, Chad, Congo, Cote d'Ivoire, Djibouti, Dominican Republic, Eritrea, Ghana, Guinea, Guinea-Bissau, India, Iran, Iraq, Jordan, Liberia, Mayotte, Malaysia, Myanmar, Philippines, Papua New Guinea, Rwanda, Sierra Leone, Thailand, Türkiye, Ukraine) which left 34 remaining countries.

Step 3: Purposeful selection based on primary inclusion criteria

From this list of 34 countries, a purposeful selection was conducted to ensure balanced representation across key country characteristics and enable learning-oriented case studies. These criteria included:

- (i) country regional/ geographical location;
- (ii) countries which were part of the original Roadmap priority list;
- (iii) countries where the CSP formally operates (CSP countries);
- (iv) countries where the CSP does not formally operate (non-CSP countries);⁴⁵
- (v) countries that have had a PAMI exercise conducted;
- (vi) countries that have a NCP;
- (vii) countries in fragile/conflict contexts;

Table E.2. below outlines an overview of the 34 countries presented across all primary inclusion criteria.

⁴⁵ Noting that non-CSP countries may still receive some support from CSP and other structures from the GTFCC

Table E.2.: Overview of 34 countries presented across all primary inclusion criteria

Country	Roadmap priority list	PAMI	NCP	CSP	non CSP	Fragile/ Conflict context	Region	Official working language
Angola							AFRO-ESA	Portuguese
Bangladesh							SEARO	English
Benin							AFRO-WCA	French
Burkina Faso							AFRO-WCA	French
Burundi							AFRO-ESA	French
Cameroon							AFRO-WCA	French
Comoros							AFRO-ESA	French
DRC							AFRO-WCA	French
Eswatini							AFRO-ESA	English
Ethiopia							AFRO-ESA	English
Haiti							AMRO	French
Kenya							AFRO-ESA	English
Lebanon							EMRO	French
Malawi							AFRO-ESA	English
Madagascar							AFRO-ESA	French
Mali							AFRO-WCA	French
Mozambique							AFRO-ESA	Portuguese
Namibia							AFRO-ESA	English

Country	Roadmap priority list	PAMI	NCP	CSP	non CSP	Fragile/ Conflict context	Region	Official working language
Nepal							SEARO	English
Niger							AFRO-WCA	French
Nigeria							AFRO-WCA	English
occupied Palestinian territory							EMRO	English
Pakistan							EMRO	English
Somalia							EMRO	English
South Africa							AFRO-ESA	English
South Sudan							AFRO-ESA	English
Sudan							EMRO	English
Syrian Arab Republic							EMRO	English
Togo							AFRO-WCA	French
Uganda							AFRO-ESA	English
Tanzania							AFRO-ESA	English
Yemen							EMRO	English
Zambia							AFRO-ESA	English
Zimbabwe							AFRO-ESA	English

Step 4: Shortlisted selection

Countries which offered fewer learning opportunities based on selection criteria were excluded after ensuring that enough other countries included the various criteria. A second selection was conducted to (i) ensure that primary selection criteria were met in at least one country and (ii) considerations toward feasibility⁴⁶ to conduct the case study. ESG and ERG members recommendations compiled during this inception phase were also considered to inform the selection of countries and backup list. 15 countries were then shortlisted as presented in table E.3.

Table E.3.: Selection of countries by region (numbers indicate number of selection criteria met)

Region	Option 1	Option 2	Option 3	Option 4
AFRO (WCA)	DRC (5), Nigeria (4)	Cameroon (3)	Benin (3)	Niger (4)
AFRO (ESA)	Kenya (3)	Zimbabwe (4)	Zambia (4)	Ethiopia (4)
EMRO	Somalia (4)	Sudan (4)	Pakistan (2)	
SEARO	Bangladesh (5)	Nepal (2)		
AMRO (LAC)	Haiti (3)			

We also sought to consider additional factors that could provide beneficial learnings from countries such as (i) reported reemergence of cholera in the country after eradication, (ii) reported progress on long term WASH, (iii) report of recent large outbreak, (iv) transborder transmission. However, due to the limited availability/ quality of publicly reported data on these indicators, these were not included in the selection criteria but have been factored as additional considerations.

The tables below provide an overview of criteria met across the proposed selection (Table E.4.) and back-up selection (Table E.5.).

Table E.4.: Proposed selection of countries (green depicts criteria met)

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

Table E.5.: Proposed back up selection of countries (green depicts criteria met)

Back up selection									
	Cameroon	Benin	Niger	Zimbabwe	Zambia	Ethiopia	Sudan	Pakistan	Nepal
Region	AFRO-WCA	AFRO-WCA	AFRO-ESA	AFRO-ESA	AFRO-ESA	AFRO-ESA	EMRO	EMRO	SEARO

⁴⁶ Feasibility was assessed in terms of security, logistics (e.g., evaluation team capability to conduct face to face or remote case study for this country), language (i.e., available team member speaking the country language), etc.

Back up selection									
Roadmap priority list									
CSP									
Non-CSP									
PAMI									
NCP									
Fragile context									
Working language	French	French	French	English	English	English	English	English	English

Step 5: Confirmation by the ESG/ERG and based on feasibility assessment

The first draft country list was reviewed by the ESG and ERG for feedback and informed the list proposed in this report. Another aspect that will determine confirmation of the country case studies is availability of WHO and UNICEF country offices to support the case studies and availability of country stakeholders.⁴⁷ In case a proposed country is not available, a replacement country can be selected from the backup list which has similar characteristics to the previously selected country. Considerations in terms of evaluation budget and availability of quality associates at the country level to support some case studies will also inform the final selection of countries.

⁴⁷ Ethiopia and the Philippines have recently been included as country case studies in the current Evaluation of WHO's contribution to WASH and Health through its Water, Sanitation and Hygiene Strategy 2018-2025. Although these two evaluations only have some overlap, where possible, evidence will be utilised from the case studies in that evaluation.

Appendix F **EVALUATION MATRIX**

The evaluation matrix is presented in Table F.1. This provides an overview of all evaluation questions, key areas of exploration, and methods that will be employed. Methods are colour shaded to reflect the degree to which they will be used to inform the assessment of each evaluation question (green=critical use, orange= significant/ moderate use, red=limited/no use).

Table F.1: Evaluation matrix

Evaluation criteria	Evaluation question	Key areas	Methods			
			Document review	KIIs	Quantitative data analysis	Country case studies
Relevance	EQ1. To what extent is the Roadmap relevant given the changing environment (e.g. epidemiological, political, climate and risk profiles)? To what extent have measures been taken to ensure continuous adaptation of the Roadmap in line with latest international best practices and guidelines and emerging needs at the country level?	<ul style="list-style-type: none"> • Ambitions of the Roadmap and whether these are still appropriate • Comprehensiveness of, and balance between, the three strategic axes of the Roadmap • Considerations regarding the relevance of the package of interventions to prevent and control cholera • Alignment of the Roadmap GTFCC work with relevant global and regional frameworks • Measures have been taken to ensure adaptation of the Roadmap 	Comprehensive review of GTFCC documents including the Roadmap, progress reports, General Assembly meeting reports, Steering Committee meeting minutes, country guidance documents	Interviews with a range of stakeholders, particularly the GTFCC Secretariat, ESG / ERG members representing partners and donors, country stakeholders etc.	n/a	Analysis of country documents including NCPs and existing country progress reports, stakeholders consultations at country level, survey responses
	EQ2. To what extent is the design of the GTFCC adequate to support the objectives of the Roadmap?	<ul style="list-style-type: none"> • Relevance and appropriateness of the objectives and activities of the GTFCC 	Comprehensive review of GTFCC documents including Roadmap, GTFCC TORs (GTFCC, SC, WGs, CSP, IRP),	Interviews with a range of stakeholders, particularly the GTFCC Secretariat, ESG / ERG members representing	n/a	Stakeholders consultations at country level in particular feedback on CSP and country

Evaluation criteria	Evaluation question	Key areas	Methods			
			Document review	KIIs	Quantitative data analysis	Country case studies
		<ul style="list-style-type: none"> • Appropriateness of the GTFCC's governance and operational structures • Adequacy of partner engagement with the GTFCC • Adequacy of engagement of countries 	GTFCC operational model	partners and donors, members of working groups, country stakeholders etc		participation in GTFCC, survey responses
Coherence	EQ3. To what extent has the GTFCC, through its governance structures and mechanisms, promoted complementarity, synergy and integration between different members' interventions at the global and the country level? What is the added value of GTFCC members acting together?	<p>At global and/or country levels</p> <ul style="list-style-type: none"> • added value of GTFCC members acting together • contribution of GTFCC to promote alignment between partners • alignment to country priorities, coherence of interventions with country needs 	Comprehensive review of GTFCC documents including, particularly the Roadmap, national country plans, GTFCC partners strategy documents	Interviews with a range of stakeholders, particularly the GTFCC Secretariat, ESG / ERG members representing partners and donors, members of GTFCC, SC, WGs, CSP, IRP, country stakeholders etc.	n/a	Analysis of country documents including NCPs and existing country progress reports, stakeholders consultations at country level, survey responses
Efficiency	EQ4. To what extent are the GTFCC operational structures set up efficiently to support the objectives of the Roadmap?	<ul style="list-style-type: none"> • Functioning of the GTFCC internal structures (SC, Secretariat, WGS, General Assembly, IRP, CSP) 	Review of multiple GTFCC documents including the Roadmap, GTFCC TORs (GTFCC, SC, WGs, CSP, IRP), GTFCC operational model, progress reports, General Assembly meeting reports, Steering Committee meeting minutes	Interviews with a range of stakeholders, particularly the GTFCC Secretariat, ESG / ERG members representing partners and donors, members of GTFCC, SC, WGs, CSP, IRP, country stakeholders etc.	Evidence of GTFCC funding, resource allocation across structures. Subject to data availability	Country stakeholders feedback (consultations, survey) in particular regarding CSP, coordination and functioning for outbreak responses and prevention interventions

Evaluation criteria	Evaluation question	Key areas	Methods			
			Document review	KIIs	Quantitative data analysis	Country case studies
	EQ5. How efficiently has the Roadmap been implemented by the GTFCC in terms of optimizing human and financial resource allocation to support countries in a changing cholera landscape?	<ul style="list-style-type: none"> • Use of resources allocated to the GTFCC • Implementation at country level (e.g., channelling of resources at country level, optimisation across partners etc.) 	Review of GTFCC management and financial documentation. Subject to data availability	Interviews with a range of stakeholders, particularly the GTFCC Secretariat, ESG / ERG members representing partners and donors, members of GTFCC, SC, WGs, CSP, IRP, country stakeholders etc	Evidence of GTFCC funding, resource allocation across GTFCC structures and to countries. Subject to data availability	Analysis of country documents, stakeholders consultations at country level, NCPs and existing country progress reports, survey responses, cholera programmes and partners responses documents.
Effectiveness	EQ6. What results have been achieved by the GTFCC partnership in the implementation of the Roadmap at the global and country level?	Progress across Roadmap axes: <ul style="list-style-type: none"> • Axis 1 – improving outbreak containment and reducing the global burden of cholera through early detection and rapid response • Axis 2 – increasing prevention of disease occurrence through targeted multi-sectoral interventions in cholera hotspots • Axis 3 – ensuring effective mechanism of coordination for technical support, resource mobilisation, and partnership at local and global levels 	Review of key GTFCC documents including Roadmap, progress reports, General Assembly meeting reports, Steering Committee meeting minutes, country progress reports	Interviews with a range of stakeholders, particularly countries, GTFCC Secretariat, ESG / ERG members, wider partners and donors, members of GTFCC, SC, WGs, CSP, IRP etc	Trend analysis on epidemiological data, funding and resources allocation to countries. Subject to data availability	Analysis of country documents, stakeholders consultations at country level, NCPs and existing country progress reports, survey responses, cholera programmes and partners responses documents.

Evaluation criteria	Evaluation question	Key areas	Methods			
			Document review	KIIs	Quantitative data analysis	Country case studies
	EQ7. Which factors have influenced the implementation of the Roadmap to date? What opportunities could be tapped into for better results?	<ul style="list-style-type: none"> Factors that have aided implementation of the Roadmap Factors that have hindered the implementation of the Roadmap Country level factors affecting progress 	Review of key GTFCC documents including progress reports, General Assembly meeting reports, Steering Committee meeting minutes, country progress reports	Interviews with a range of stakeholders, particularly the GTFCC Secretariat, ESG / ERG members representing partners and donors, members of GTFCC, SC, WGs, CSP, IRP, country stakeholders etc	n/a	Analysis of country documents, stakeholders consultations at country level, NCPs and existing country progress reports, survey responses
Sustainability	EQ8. What steps has the GTFCC taken to ensure the sustainability of its interventions under the Roadmap?	<ul style="list-style-type: none"> Extent to which activities set out in the Roadmap aim to facilitate the sustainability of cholera interventions Financial, programmatic and environmental considerations for sustainability 	Review of key GTFCC documents including progress reports, Roadmap, General Assembly meeting reports, Steering Committee meeting minutes, country progress reports	Interviews with the range of stakeholders, particularly the GTFCC Secretariat, ESG / ERG members, SC, WGs, CSP, IRP, wider partners and donors, country stakeholders etc	Funding analysis. Subject to data availability	Analysis of country documents including NCPs and existing country progress reports, stakeholder consultations at country level, survey responses
Cross cutting: Gender, equity and human rights (GER)	EQ9. To what extent has the Roadmap included GER concerns? To what extent have implementation activities factored equity considerations at the global and country level?	<ul style="list-style-type: none"> GER considerations in the design of the Roadmap GER considerations in the implementation of the Roadmap 	Review of GTFCC documents including RoadMap, progress reports, General Assembly meeting reports, Steering Committee meeting minutes, country progress reports	Interviews with the range of stakeholders, including partners and community representatives, country stakeholders etc	n/a	Analysis of country documents including NCPs, stakeholder consultations at country level, survey responses.

Appendix G MODIFICATIONS TO TOR EVALUATION QUESTIONS

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

Tale G.1 maps out the original evaluation questions and sub-questions as per the TOR against the updated evaluation questions.

Table G.1: Overview of modifications to ToR

OECD Criteria and related overarching question as per TOR	Evaluation sub-questions	Relevant Evaluation Question (EQ)	Updated evaluation question under each criteria
Relevance: To what extent are the GTFCC design and strategy adequate to support the achievement of the Roadmap's 2030 goals?	<ul style="list-style-type: none"> How adequate are the GTFCC design, governance structures and mechanisms supporting the GTFCC (including the Secretariat) for the delivery of the objectives of the End Cholera Global Roadmap in terms of: i) engaging the right partners at global, regional and country level, and ii) providing an appropriate framework to steer and coordinate implementation of activities for maximum impact? 	Covered under EQ2	Relevance <ul style="list-style-type: none"> EQ1. To what extent is the Roadmap relevant given the changing environment (e.g. epidemiological, political, climate and risk profiles)? To what extent have measures been taken to ensure continuous adaptation of the Roadmap in line with latest international best practices and guidelines and emerging needs at the country level? EQ2. To what extent is the design of the GTFCC adequate to support the objectives of the Roadmap?
	<ul style="list-style-type: none"> Considering the parameters of the original context in which it was launched, and accounting for the changed global landscape, to what extent does the GTFCC Roadmap (and related guidance) support adaptation to, i.e. i) global epidemiological, political, and climatic changes since 2017, and ii) changing risk profiles and emerging issues/contexts? 	Covered under EQ1	
	<ul style="list-style-type: none"> To what extent are measures being taken to ensure continuous adaptation of the Roadmap in line with: i) international best practices in providing coordination and support to countries and partners and ii) with national cholera strategies and tools? 	Covered under EQ1	
Effectiveness: To what extent has the GTFCC achieved the Roadmap's expected results?	<ul style="list-style-type: none"> What results have been achieved by the GTFCC, through its different entities in the implementation of the Roadmap, and how do they align with expected results in terms of: i) global progress towards achieving strategic objectives/outcomes, and ii) measurable country-level outcomes. 	Covered under EQ6	Effectiveness <ul style="list-style-type: none"> EQ6. What results have been achieved by the GTFCC partnership in the implementation of the Roadmap at the global and country level? EQ7. Which factors have influenced the implementation of the Roadmap to date?
	<ul style="list-style-type: none"> How have specific examples of success stories or best practices resulting from GTFCC interventions in different countries contributed to achieving global and national goals? 	Covered under EQ6	

OECD Criteria and related overarching question as per TOR	Evaluation sub-questions	Relevant Evaluation Question (EQ)	Updated evaluation question under each criteria
	<ul style="list-style-type: none"> Which factors have influenced the implementation of the Roadmap to date, what challenges have emerged, and which opportunities could be tapped into for better results? 	Covered under EQ7	What opportunities could be tapped into for better results?
	<ul style="list-style-type: none"> To what extent does the GTFCC provide quality guidance (including development process and implementation), and how has it contributed to achieving results at the national level? 	Covered under EQ6	
Efficiency: How efficiently has the Roadmap been implemented by the GTFCC?	<ul style="list-style-type: none"> How efficiently has the Roadmap been implemented, in terms of: i) optimizing human and financial resource allocation to support countries in managing changing cholera risk profiles efficiently; ii) managing resources to deliver goals and maintain capacity in increasingly complex epidemiological scenarios; iii) monitoring implementation and responding to incoming information (e.g. risk-based decisions in response to changing circumstances), and iv) ensuring adequate resource mobilization and/or exploring the use of economic incentives or innovative financing mechanisms. 	Covered under EQ4 and EQ5.	Efficiency <ul style="list-style-type: none"> EQ4. To what extent are the GTFCC operational structures set up efficiently to support the objectives of the Roadmap? EQ5. How efficiently has the Roadmap been implemented by the GTFCC in terms of optimizing human and financial resource allocation to support countries in a changing cholera landscape?
Coherence: How coherently is the GTFCC working to optimize the implementation of the Roadmap strategy?	<ul style="list-style-type: none"> How successfully has the GTFCC, through its governance structures and mechanisms (including the Country Support Platform, the Independent Review Panel, and the Working Groups) promoted complementarity – and synergy/integration - of different actors' interventions? What is the observable added value of GTFCC members acting together? How well has the GTFCC, in particular through the Secretariat and Country Support Platform, coordinated and collaborated with other stakeholders to ensure coherent engagement at country level? In what ways has the GTFCC facilitated communication, knowledge sharing and capacity building among countries and partners, promoting a more coherent approach to cholera control? 	Covered under EQ3.	Coherence <ul style="list-style-type: none"> EQ3. To what extent has the GTFCC, through its governance structures and mechanisms, promoted complementarity, synergy and integration between different members' interventions at the global and the country level ? What is the added value of GTFCC members acting together?
Sustainability: What steps has the GTFCC taken to ensure the	<ul style="list-style-type: none"> To what extent does the Roadmap include a framework or exit strategy? Have steps been taken by the GTFCC Secretariat to ensure the sustainability of achievements post 2030? 	Covered under EQ8	Sustainability

OECD Criteria and related overarching question as per TOR	Evaluation sub-questions	Relevant Evaluation Question (EQ)	Updated evaluation question under each criteria
sustainability of its interventions under the Roadmap?	<ul style="list-style-type: none"> • How has the GTFCC, through its entities in particular the Secretariat and the Country Support Platform, supported countries' efforts to ensure longer term sustainability of interventions in terms of integrating both with country programmes and with other disease areas and approaches, and adapting to changing risk profiles and emerging cholera situations? <hr/> <ul style="list-style-type: none"> • To what extent are environmental aspects being considered for the future of global cholera prevention and control efforts? <hr/> <ul style="list-style-type: none"> • To what extent does the Roadmap support capacity building within communities and institutions to implement sustainable interventions? <hr/> <ul style="list-style-type: none"> • How well has the GTFCC Secretariat mobilized additional and required funding? 		<ul style="list-style-type: none"> • EQ8. What steps has the GTFCC taken to ensure the sustainability of its interventions under the Roadmap?
<p>Gender, equity and human rights (GER): To what extent has the Roadmap strategy included gender, equity and human rights concerns and how are they addressed in implementation?</p>	<ul style="list-style-type: none"> • To what extent has the Roadmap addressed GER concerns? <hr/> <ul style="list-style-type: none"> • How consistently and meaningfully are implementation activities informed by considerations of overall equity both globally (i.e. supporting work in areas where assistance is most needed) and at country level: i.e. to what extent: i) do data collection and analytical methods include disaggregated epidemiological and management data for vulnerability and social criteria (e.g. gender, equity, and geographic location) and ii) are such data and analysis used to inform decision-making and implementation? 	Covered under EQ9	<p>Gender, equity and human rights (GER)</p> <ul style="list-style-type: none"> • EQ9. To what extent has the Roadmap included GER concerns? To what extent have implementation activities factored equity considerations at the global and country level?

Appendix H **EVALUATION STEERING GROUP AND EVALUATION REFERENCE GROUP CONSTITUTION**

Appendix H provides a breakdown of the compositions of the ERG and ESG.

Table H.1: ESG and ERG composition

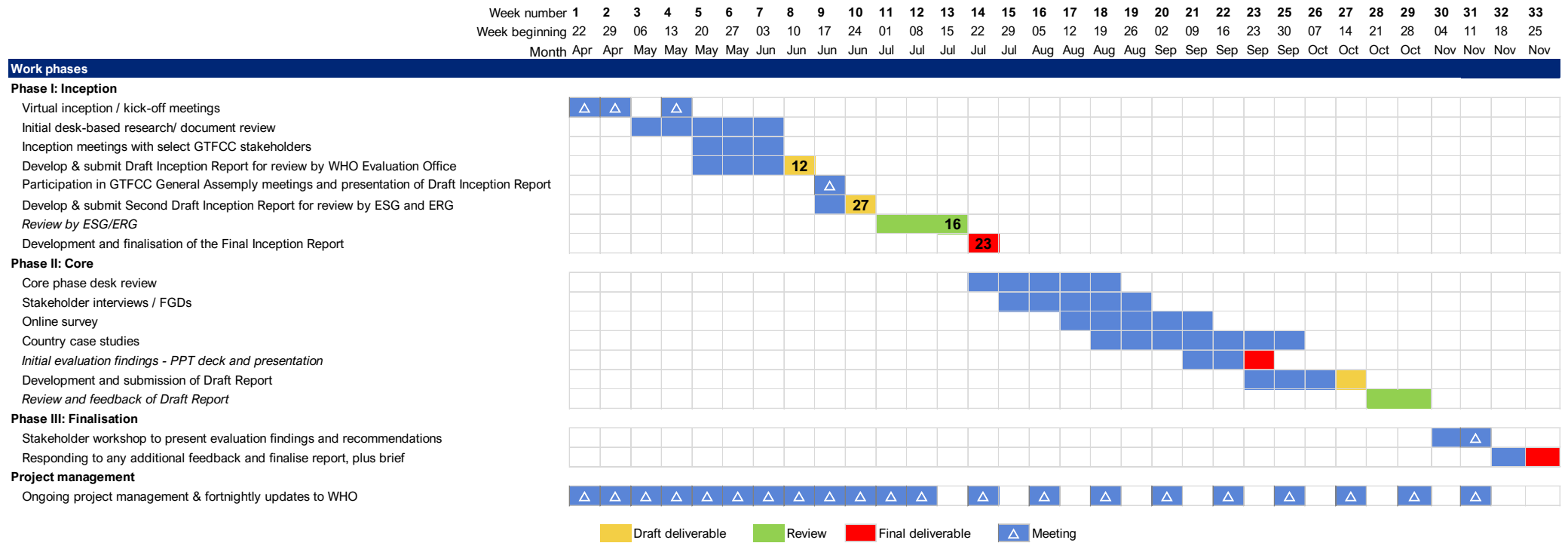
Organisation/Department	Name	Position
Evaluation Steering Group (ESG)		
South Africa Delegate (ESG Chair)	Frew G Benson	Clinical Executive, Rahima Moosa Hospital
CDC	Vikas Kapil	Global Immunization and Vaccines Division Lead
BMGF	Duncan Steele	Deputy director and Strategic Lead for Enteric Vaccines
BMGF	Tanya Shewchuk	Senior Programme Officer, Immunization team
IFRC	Maria Pinzon	Global WASH team leader
MSF	Daniela Garone	International Medical Coordinator
UNICEF	Douglas Noble	Associate Director, Public Health Emergencies Preparedness and Response
UNICEF	Elke Johanna de Buhr	Evaluation Specialist, WASH and Climate Change
Pakistan Delegate	Muhammad Kazi	Director General, Federal Directorate of Immunization
Evaluation Reference Group (ERG)		
GTFCC Secretariat	Philippe Barboza	Cholera team lead, Health Emergencies Programme
CSP (IFRC)	Annika Wendland	CSP Coordinator
US CDC	Xin Wang	TBC
US CDC	Thomas Handzel	WASH team lead
BMGF	Helen Matzger	Deputy Director, Vaccine Programs
Gavi	Allyson Russell	Senior Programme Manager, Outbreaks and Global Health Security
IFRC	Christopher Brewer	TBC
icddr,b	Dr Ashraful Islam Khan	Scientist, Infectious Diseases Division, icddr,b
MSF	Iza Ciglenecki	Operational Research Coordinator
UNICEF	Elke Johanna de Buhr	Evaluation Specialist, WASH and climate change
WHO HQ	Philippe Barboza	Head of Secretariat, GTFCC
WHO HQ	Emmanuel Baron	Epidemiologist. WHO HQ cholera programme

Organisation/Department	Name	Position
Zambia Delegate	Fred Kapaya	TBC
Pakistan Delegate	Rabail Javed	Deputy Director, Pakistan Health Research Council, Ministry of Health, National Cholera Control Strategy

Appendix I PROJECT WORKPLAN

Figure I.1 presents the workplan and key deliverable dates for this evaluation in a Gantt chart format.

Figure I.1: Workplan



Appendix J **CEPA QUALITY ASSURANCE POLICY**

This appendix provides further details on our approach to quality assurance for the assignment, over and above the specifics highlighted for quality assurance in Section 4.2.

J.1. CEPA QUALITY ASSURANCE POLICY

Overview

The products and services provided by CEPA are used by our clients as the basis for major decisions affecting their financial performance and public standing. The quality assurance policy at CEPA is to consistently produce products and services which are fit for this purpose, which clients perceive as meeting their most exacting standards and which will lead to an enhanced reputation and, where applicable, to continuing growth and increased profitability.

CEPA recognises that its reputation as a pre-eminent consultancy relies on its continuing to produce work to the highest standards in all respects. Maintaining and building on this reputation involves:

- recruitment and retention of highly qualified experts;
- maintenance and broadening of the expertise of all staff through training and professional development and through the accumulation of data and knowledge within the company;
- development and improvement of supporting tools, techniques, databases and management information systems for carrying out the company's work;
- commitment to maintaining an open, direct and informal organisational culture and to the generation and implementation of new ideas;
- continuous review of the company's markets, client requirements and its long-term strategy;
- efficient and effective management and direction of marketing, sales and execution, including enquiries, proposals and projects; and
- strict quality-control procedures of written deliverables through the work of qualified editorial staff.

The company commits all staff to implementing quality assurance procedures and achieving specified levels of quality and service at all stages of work affected by their activities. All members of staff are introduced to the key procedures as part of their structured induction into the company in their first two weeks of employment, and further formal and informal training is provided as part of the individual's development plan.

There are three key aspects of quality policy:

1. the role of the Project Manager and Project Partner in quality assurance;
2. the purpose and role of editorial staff in quality assurance; and
3. procedures to establish and maintain effective cross-project security.

J.2. THE ROLE OF THE PROJECT MANAGER AND PROJECT PARTNER IN QUALITY ASSURANCE

The management and direction of project execution are the responsibility of the appointed Project Manager and Project Partner respectively. The Project Manager is responsible for the day-to-day running of the project and the execution of tasks by the project team, while the Project Partner has overall responsibility for ensuring that project objectives are met, quality procedures are followed, and the client's requirements are satisfied.

Although all members of the project team take responsibility for the quality of project deliverables, the final responsibility for quality assurance rests with the Project Partner, who will ordinarily review all deliverables and attend

major client presentations. As well as being answerable to the client for the work undertaken, the Project Manager and Project Partner are accountable to CEPA's Chairman for the quality, schedule and profitability of the project, and for identifying risks and implementing remedial actions in a timely fashion as and when required.

In the current project, Kaveri Kumar (Team Leader) will assume the role of the Project Partner and Laura Grobicki will be the Project Manager.

J.2.1. The purpose and role of editorial staff in quality assurance

CEPA reports are reviewed by all team members prior to submission to ensure our high-quality standards are maintained. In addition, CEPA deliverables are also reviewed by an experienced staff member outside of the core team (taking into account any confidentiality requirements as detailed below) to serve as a 'double check', as well as for editorial purposes.

All junior staff at CEPA have undergone comprehensive training on report writing to cater to the different requirements of our clients.

J.2.2. Procedures to establish and maintain effective cross-project security

CEPA staff are highly aware of the need to respect client confidentiality both while work is being carried out on a project assignment, and once it is completed. All of the assignments CEPA has worked on in the past have at least some element where client confidentiality is paramount.

All of our internal IT systems are password protected and, if necessary, access to client project folders is only given to CEPA employees who are specifically working on that particular assignment. No CEPA staff member or Associate works simultaneously for projects that may be conflicted in interest. In addition, we instigate 'Ethical walls' in terms of internal discussions and filing systems.

The contracts of employment we have with our staff contain clauses pertaining to the need to respect the confidentiality of client sensitive information. CEPA's current portfolio of projects contains several highly confidential assignments for which we are contractually obliged to withhold even the name of the client from any of our marketing materials and from any conversations with people external to our business.