Whose Responsibility?

Executive Summary

Improving the Integrated Response to AWD/Cholera Outbreaks within Humanitarian Crises

A joint collaboration between the Global Health Cluster and Global WASH Cluster

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Executive Summary

Introduction and Methodology

1. Cholera and acute watery diarrhoea (AWD)[1] outbreaks remain a major public health threat during complex humanitarian crises and in the aftermath of major natural disasters. Many of the most severe outbreaks of the last decade have largely occurred within protracted and complex humanitarian crises.

2. There is wide recognition that the coordinated intersectoral response needs to be strengthened to more efficiently and effectively prevent or contain cholera outbreaks in future humanitarian crises. At the request of partners and staff, the Global Health and WASH Clusters decided to undertake this joint project **to develop strategies to improve the coordinated and integrated responses to AWD/cholera outbreaks in countries in humanitarian crisis**. It is envisaged that the final output of the project will be a joint operational framework that identifies and supports the key areas of integration and coordination, in support of a more effective response.

3. The Global Task Force on Cholera Control (GTFCC) strategy for cholera elimination focuses on 47 countries affected by cholera. Of these, **43% (20) have an ongoing (internal) humanitarian crisis and appeal**[2]. An additional 36% (17) have a refugee programme supported by the United Nations High Commissioner for Refugees (UNHCR)[3]. The **cholera burden** of those countries in humanitarian crisis represents at least **45% of both the estimated number of cases and deaths**[4]; those countries with a **refugee programme** represent an **additional 48%** of the estimated cholera cases and deaths. Countries in humanitarian crisis therefore represent both a significant proportion of the number of countries targeted, as well as of the global cholera burden.

4. In these contexts, humanitarian actors, coordinated under the IASC's humanitarian architecture and cluster approach, play a significant role in supporting national public health capacity to assess, plan and coordinate the implementation of preparedness and response (P&R) measures for cholera. Indeed, the humanitarian community often turns to the Health and WASH Clusters/sectors[5] to support the coordination and implementation of these actions and this is validated in the findings.

5. Ensuring that the cluster approach and in particular the Health and WASH Clusters, remain "fit for purpose" to support public health response to cholera outbreaks, requires a new operating framework to support a more integrated approach to cholera P&R.

6. The core functions of clusters cover a comprehensive range of responsibilities that fit around the humanitarian programme cycle[6], and are organised around its own international humanitarian architecture, an incident management system for the humanitarian sector[7].

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[1] Recognising that some countries use the term "Acute Watery Diarrhoea" (AWD) in place of "cholera". The term "cholera" will be used in the rest of the document to cover both.
[2] Source: Financial Tracking Service, OCHA www.fts.unocha.org
[3] Source: Global Appeal 2018-19, UNHCR http://reporting.unhcr.org/publications#tab-global_appeal. Where countries have both an ongoing humanitarian crisis/appeal and refugee programme, they were only counted once in those with an ongoing humanitarian crisis/appeal.
[4] Data on estimated country specific cholera cases and deaths from the Updated Global Burden of Cholera in Endemic Countries, Ali et al 2015 (also source data for the GTFCC Ending Cholera, Road Map to 2030)
[5] In the rest of the document, the term 'cluster' will be used to indicate clusters or sectors
[6] https://interagencystandingcommittee.org/system/files/hpc_reference_module_2015_final_.pdf
[7] https://emergency.unhcr.org/entry/256830/international-coordination-architecture-humanitarian-and-development

7. The methodology to review improving the integrated and coordinated response to cholera includes all aspects of humanitarian response that have an influence on the ability of the system to support an integrated and coordinated response, examining all aspects of the humanitarian incident management system (architecture) including: **(i) the critical enablers of leadership and accountability, coordination and information management; and (ii) the key strategic and implementation approaches that require integration and coordination throughout P&R**.

8. As such, the comprehensive nature of the findings reflects the identified barriers and gaps to an effective integrated and coordinated cholera response. The recommendations that inform the development of a Joint Operational Framework will be extracted in discussion with the Peer Review Group, and other recommendations followed-up in consultation with other entities whose mandates may best support their implementation.

9. The project identified a number of different components to research and gather data for the project and were adapted during the project in line with findings as the project progressed:

    - **Key informant interviews** with **60 people**
    - **Two country learning missions to Nigeria and South Sudan** including 60 individual interviews
    - **A review of 15 country AWD/cholera P&R plans** was carried out against a set of parameters, as indicators of preparedness/response plans that support a well-coordinated integrated and multi-sectoral developed P&R plan from the findings of key informant interviews and country missions that highlighted good practice and gaps
    - **Three online surveys** were shared in (18) countries with ongoing humanitarian responses and at risk of cholera: (i) a survey of Humanitarian Coordinators (HCs) on Leadership and Accountability (ii) a survey of Health and WASH organizations and Cluster/Sector coordinators working in cholera P&R and (iii) a survey on Information Management, examining different aspects of data and information management related to cholera
    - A **Peer Review Group** of field practitioners and experts from both the WASH and Health Sectors have supported developing approaches and reviewing findings.

10. This report is the final in a series of reports that have been written throughout the progress of the project[8], summarising the findings of the different components of research and outlining a way forward towards a joint operational framework.

Leadership, Accountability and Coordination

11. **Breaking silos.** In recent years, the fight against cholera has taken a greater multisectoral approach. The core of the GTFCC renewed strategy is to "break the silos at national and global levels to implement integrated, multisectoral actions in cholera hotspots", requiring multi-ministry involvement.

12. **Progress still needed for multisectoral planning**. Whilst it appears that almost all countries are preparing integrated, multisectoral plans, the reality of planning and implementation means that there is still a long road to travel. Survey respondents indicate that the Ministry of Water (MoW), or similar, were only involved in half of the cases of cholera P&R plans. The diversity of responses at country level suggest that 'working together' may range from being invited to meetings or that they are involved as real (equal) partners in the fight against cholera; only two thirds of P&R plans mentioned another ministry and only two had another ministry's logo on the front. Perhaps it is

[8] Reports for each of the surveys have been written and can be found in these links Humanitarian Coordinators Survey Report, WASH and Health Comprehensive Survey Report, Information Management Survey Report.

through **a real multisectoral approach to leadership**, rather than simply through multisectoral interventions, where a real integrated holistic approach will be championed.

13. **Constraints to a principled humanitarian cholera response.** To provide the most effective support to national response, the international humanitarian community needs to be well-organised, streamlined and prepared. The level of support to coordination, P&R for cholera outbreaks by the humanitarian community often reflects the context, capacity, operating environment and constraints to an effective principled humanitarian response. Concern was raised by some HCs of the alignments often made in humanitarian contexts by agencies and sectors with key government ministries, which may potentially compromise the ability of the humanitarian community to mount such a principled and effective response. There are strong suggestions that this ability should be reviewed regularly and humanitarian coordination and response systems adapted accordingly.
14. **Clarity of cluster mandate.** Whilst clusters have a mandate for P&R in humanitarian crises, for some, the Health and WASH Clusters' specific role in leading these for cholera within such crises is unclear; however, key informant interviews and the surveys indicate that this is assumed in many instances.
15. **Clarity in non-L3 infectious disease events in humanitarian contexts.** Whilst activation and procedures for an IASC (Inter Agency Steering Committee) Level 3 (L3) infectious disease event have been agreed, there is no such clarity for non-L3 situations. Bodies with a mandate for multisectoral coordination in humanitarian P&R are left to play a proactive or passive role in the multisectoral coordination of an infectious disease event within a humanitarian response, depending on individuals.
16. **WHO-UNICEF relationships.** A key enabler highlighted throughout this work was the quality of the relationship between WHO and UNICEF and the clarity of roles, with numerous calls for a global MoU between the two agencies.
17. **Clear leadership, accountability and coordination** within the humanitarian community were identified as critical gaps, significantly affecting the effectiveness and efficiency of cholera P&R. Surveys of HCs and Health and WASH field staff working in cholera-affected countries showed a **stark lack of consensus** of who was responsible to ensure the humanitarian community's cholera P&R.
18. **Interface of Emergency Operations Centres (EOCs) and humanitarian Incident Management Systems (IMS).** National (and internationally supported) EOCs/IMS and humanitarian IMS/coordination architecture are often overlapping and their interface unclear and confusing.
19. **Inaction, delays and gaps.** Overall, the lack of clear leadership, accountability, coordination and roles and responsibilities can result in inaction, limited preparedness and delays, and gaps in response. Some field responders suggest that **outbreaks last longer than they should** because of these coordination challenges, **perpetuating unnecessary increased risk of morbidity and mortality.**
20. Similarly, recent key evaluations call for a **"clarification of the international community's coordination processes and respective roles and responsibilities of the key entities"** and highlight that the "**mandates, roles, reporting lines of various coordination structures, including clusters, cholera task forces, and incident management systems urgently require clarification, harmonisation and agreement** by governments and partners".
21. **Clarity on the leadership and accountability framework provides the critical cornerstone** from which to: (i) develop an overall coordination framework within which humanitarian actors can efficiently operate and support a national response; and (ii) develop and implement joint operational guidance to improve the effectiveness of cholera P&R through a more integrated and coordinated approach, contributing to the overall elimination of cholera.

Cholera as a Multisectoral Issue

22. **Substantial gaps.** Despite efforts and progress in recent years, there are substantial gaps in an integrated multisectoral approach to cholera preparedness and response. Whilst there are some successes, there continues to be a lack of depth of understanding and application of an integrated approach, with a continued emphasis on treatment and limited focus on control measures.

23. **Health-WASH responsibilities are too simplistic.** The separation of cholera responsibilities into "Health" and "WASH" is too simplistic and gives the wrong focus. Instead of Health and WASH responsibilities, structuring overall P&R around needs and actions, and then looking at the range of actors and sectors that can support these, looking for synergies and collaboration among them, will achieve the best results.

24. **Stronger guidance towards cross-sector collaboration.** The pillared cholera IMS system, as with the cluster system, guides actors towards sector responses. Stronger guidance is needed towards collaborating cross-sectorally, harnessing the strengths and expertise of sectors into working group (WG) collaboration according to objectives and problems presented.

25. ***Perhaps it is only with multisectoral leadership that a more integrated approach will become institutionalised and sustained***.

Preparedness and Response Plans and Planning

26. **Finding time for cholera preparedness.** One of the greatest challenges drawn from interviews and country visits is the ability to be able to prioritise time and resources for cholera preparedness, amongst a long list of immediate priorities and deadlines. Preparedness processes were often reported as long and drawn out, with many plans not getting to finalisation.

27. **Varying formats and quality in P&R plans.** Cholera P&R plans take different forms, with varying content and quality with respect to providing a comprehensive foundation to an integrated response. There is a need for substantial guidance to direct planners and responders towards a process that is clear, inclusive and timebound, with a structure that ensures an integrated, multisectoral P&R framework that brings a sense of joint ownership and clear responsibilities; a plan that is resourced, monitored and used as it translates into the coordination and implementation of a truly effective integrated and multisectoral response.

28. **Linking interventions to objectives**. None of the country cholera P&R plans make the direct logical linkages between the objectives of morbidity and mortality reduction and which interventions contribute to which objective. Whilst this may not seem important, it reduces the opportunity to illustrate the necessary synergies between different sectors and actors to achieve the same objective. While to some this may be obvious, many responders are new to cholera and may not have the same depth of understanding.

29. **Adapting response strategies.** Whilst there are many different contexts and locations affected by outbreaks of cholera – i.e. urban, rural, population density, geography/physical access, security access, population types (sedentary, nomadic, civilian, military) – there is little evidence of different response strategies or scenario planning to reflect these different planning assumptions.

Early Warning

30. **SOPs to support early integrated response.** Getting a rapid and integrated response right at the beginning of an outbreak, even before it is officially declared, is crucial. It is important to have a comprehensive alert system that is able to pick up and record changes at the lowest level of health care, and one that is accessible to a key multisectoral group. Having SOPs that clarify who and how that group is informed is crucial, and very often missing. It is also crucial that when an alert is raised, there are clear SOPs that indicate immediate multisectoral actions to be taken, particularly prior to a declaration – to ensure a rapid response but also to reduce confusion and uncoordinated responses, as has been seen at country level.

Integrated Response Strategies – Evidence and Effectiveness: Informing Evidence-Based Integrated Strategies and Interventions

31. **Turning evidence into practice.** Improved cholera strategies and interventions that support more effective and integrated field response have been strengthened in recent years by evidence from further research, e.g. hotspot mapping and targeted household/neighbour interventions. However, they have not made their way into the hands of field practitioners to better understand and support technical intervention choices across sectors; nor have they significantly translated into revised country cholera strategies. If a collaborative multisectoral integrated approach is to be successful, it is critical that key stakeholders across sectors are aware of key evidence to fully advocate for a comprehensive set of integrated interventions.

32. **Practical strategies and interventions from evidence.** Effective strategies to interrupt cholera morbidity and mortality need to be extracted from academic papers and global strategies and be presented in such a way that makes the strategic and intervention implications plainly clear. Countries need to be supported to emphasise the gaps that exist in their own country analysis of cholera epidemiology and to translate those studies completed into revised strategies and interventions.

Integrated Response Strategies – Integrated Capacity to Respond

33. **Gaps in assessing integrated capacity.** There continue to be gaps in the assessment of the integrated capacity to respond to cholera. Only 1 of 15 cholera P&R plans actually examined a range of potential caseloads and considered what that meant in terms of capacity to respond, and this only looked at the treatment component. Thresholds for capacity to respond are not explicitly included in P&R plans, making it difficult to understand when additional/external support should be requested, and, indeed, exactly which type of support to request.

34. **Focus on treatment capacity.** Broader assessment of the capacity needed for an integrated response – capacity required, capacity in place and associated gaps – is rarely done in-depth. Mapping of supplies largely covers supplies for treatment, and seldom includes those needed for cholera control interventions. Perhaps this is because there are standard figures and supplies developed and available for treatment supplies, but not for control. Or perhaps it is due to a lack of knowledge and experience of a broader more integrated intersectoral approach and/or a sector bias of those who have tended to lead cholera P&R. Control interventions are also likely to be more expensive. Shifting to a more integrated approach to supply needs and response capacity will require further direction, guidance and support.

35. **Impact of funding on commitments to respond.** Assessments rarely consider how long agencies can commit their capacity. As a result, an overestimation can often be made in the assessment of actual deployable capacity, additional requests to donors for support and other preparedness plans, not actioned.

36. **Incorrect capacity mapping and appropriate decision-making.** If capacity assessments continue to solely focus on partial needs, an understanding of the ability to implement an integrated response will continue to be incomplete. Partial assessments may also potentially mislead decision-makers in the real ability to provide an integrated response to different sized outbreaks

Integrated Response Strategies – Roles and Responsibilities

37. **Confusion between IPC and WASH.** There is still some confusion surrounding IPC and WASH, with some recognising WASH in treatment facilities as a sub-set of IPC, while others see IPC as a WASH responsibility. In most cases, WASH as part of IPC is not indicated with clear responsibilities in cholera P&R plans. Linked to IPC, safe burial responsibilities for deaths in treatment facilities and communities continues to have gaps in responsibilities with obvious consequences.

38. **The broader issue of ensuring WASH services in health facilities spills over into the overall lack of clarity of responsibilities for the WASH component of infection prevention control (WASH-IPC) in cholera treatment facilities**. One sector (Health) can be seemingly allocated the responsibility but will often not prioritise or allocate necessary resources, and the other sector who has the technical expertise and the interest, but no mandate[9] or often resources. Global clarification of WHO's role in supporting WASH-IPC in treatment/health facilities and WASH in community settings in cholera outbreaks, as well as more broadly e.g. water quality.

Integrated Response Strategies – Implementation Approaches

Partnership

39. **Timely access to data.** In order to be most effective in an integrated response, there needs to be excellent communication and partnership between those working to address mortality and morbidity in treatment facilities and those working in communities with the same objective. The biggest frustration (and negative impact) for those working in cholera control activities was timely access to cholera data that directs them to response, giving these responders the impression that control activities are not as important or critical in the fight against cholera.

40. **Single agency or partnership implementation of integrated responses.** Communication and information sharing between these two groups works most efficiently if the same agency is responsible for the overall integrated response in the same geographic area, or if two (or more) agencies covering the different components of an integrated response work together in an agreed partnership – a partnership that outlines each responsibility and how information and data will flow between the agencies. In South Sudan, it was estimated that 80% of agencies implementing WASH were also implementing health activities, but often not in the same area. In other countries, even putting an individual link person inside the treatment facility to connect with the organization(s) doing control activities in the community has proved to improve the flow of information.

41. **Reducing transaction costs in multi-agency responses.** There are therefore significant opportunities to have a more efficient and effective integrated response through minimising the transaction costs between those working in treatment and control activities, or as a minimum, making these more efficient.

Rapid Response Teams (RRTs)

42. **Effective integration of RRTs into cholera response strategies.** RRTs are not always explicitly included as part of the response strategy of P&R plans. Their purpose and ToRs of their work are not always understood and their titles not always helpful in this endeavour; sometimes the actual existence of each RRTs is not known across sectors.

43. **Multisectoral nature of RRTs.** The benefit for RRTs to be multisectoral depends very much on the exact nature of what is being done, and whether coordination between responders, as well as with those in treatment facilities, is sufficient. Since any intervention working in the community is likely to involve encounters with potential cases, and require interaction with community leaders and affected families, having health personnel integrated was proposed (by operating teams intervening in the community) to be hugely helpful. There was, however, agreement that Outbreak Investigation, Case Investigation and Quality Monitoring/Technical Support Teams should be multisectoral as standard. The decentralisation of community response teams (household disinfection support, safe water and hygiene teams) that are linked to treatment facilities was proposed by responders as an effective model that supported communication and collaboration.

[9] Particularly from a point of view of entering health facilities

Outbreak and Case Investigations

44. **Consistent implementation of outbreak and case investigations.** Multisectoral outbreak and case investigations are critical at the onset of an outbreak and in new locations within an existing outbreak. Outbreak investigations are usually considered, and most reviewed cholera P&R plans include the need for them, although it is not always indicated how they will be implemented. Case investigations, crucial to informing the most effective control activities, were only considered in a third of plans, perhaps because there is no clear guidance on methodology - when they should be employed, and who should be involved – or perhaps case investigation is less considered as it involves commitment from those in treatment facilities and the results don't directly impact their treatment work.

Integrated Response Strategies – Technical Support (TS) and Quality Control (QC)

45. **Standardising integrated technical support and quality control.** Technical support (TS) and quality control (QC) are not always a standard part of a cholera response. Given that this is a support service to responders and QC can be viewed as 'policing'; this gap may also be a reflection of the unclear responsibilities and mandates of agencies (outside of government) to provide TS and QC. Whilst just over half of P&R plans mention 'supervisory visits' (although not stating who will make them), only one plan mentioned 'quality monitoring'. There is however, a clear need, and general agreement, that TS/QC to be provided through an integrated team for both treatment and control activities. The lack of TS/QC for WASH-IPC and WASH control activities and the unclear role and commitment of WHO to provide this, was raised on numerous occasions.

46. **One-stop shop for technical guidance.** It was found that many of the country P&R plans that included technical guidance were developing their own guidance, rather than using globally written guidance. Given that global technical guidance for both cholera treatment and control activities are scattered on different websites, it could be that not everyone is aware what is available to them; this should be easy to address.

47. **Consistent approaches to integrated technical guidance.** Interestingly, technical guidance around cholera treatment is described by the exact purpose of the guidance e.g. case management. This is not always the case when we review the IMS pillars eg where 'WASH' and is used rather than a title that describes its purpose related to cholera. This is confusing, and it is not always clear what the purpose of the WASH pillar is, or indeed why cholera control activities are simply described as 'WASH'.

Directing Integrated Response – Surveillance: Cholera Data Collection, Sharing and Analysis

48. **Timely access to data to target control activities.** As mentioned above under Partnerships, one of the biggest challenges for those responding with interventions to attempt to control cholera is getting timely access to case data to support targeted and household/neighbour responses. Practical reasons including capacity to process and clean data were also given as causes for delays in sharing data, although there are more opportunities to utilize existing IM capacity in-country from clusters and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), which are currently underutilized.

49. **Evidence and integrated interventions.** Many of the health as well as WASH responders interviewed were not aware of the of the importance and evidence base for household/neighbour interventions and therefore the critical need for timely access to locations of cases; several health responders also referred to some of the control interventions as 'not real WASH'. This lack of understanding and perceptions, as well as not having agreed data needs/analysis as part of preparedness, are likely to have influenced why responders working on *control interventions* don't

feel that their responses are seen as important and why rapid access to case location data is not consistently supported.

50. **Conceptual framework to support a shared cross-sector understanding of cholera.** Using available evidence (backed by GTFCC endorsements), a 'conceptual framework' for cholera would support a better shared cross-sector understanding of the importance of and support to targeted household actions to interrupt cholera.

51. **Need for integrated analysis of data as standard.** Almost all aspects of cholera data analysis (bar the purest case management and laboratory) would benefit from a more integrated and multisectoral approach to the analysis of cholera data, to produce more effective and collaborative solutions. Reviewed in-country single sector cholera analysis appeared to be missing key epidemiological analysis that may not have been missed if it had been done multi-sectorally. Understanding of how epidemiological trends (if analysed at the lowest administrative level) can support decision-making and prioritisation in locations where cases are on the rise and where the peak has not already passed, seems to be missing, impacting the effectiveness of interventions. In-country multisectoral cholera epidemiology training would support a greater shared understanding of what analysis can support decision-making and its application. Ensuring that surveillance and epidemiology capacity, and not submerged in a single pillar of case management and laboratory, would also support a greater integrated analysis – something a well-run EOC would address.

Response – Integrated Monitoring and Reporting

52. **Indicators to describe effectiveness of an integrated response.** Although attack rates are becoming more commonly reported, case fatality rate/ratio (CFR) remains one of the few indicators that has a benchmark and is consistently used to indicate the quality of the overall response. There is a need for a broader range of endorsed and promoted indicators to describe the integrated cholera situation and response.

53. **Reporting not integrated – impact on gap analysis.** Even where all sectors report into one compiled document, reporting on cholera remains largely done on a sectoral basis, and not reported in an integrated way; in some contexts, three reports were produced – Health, WASH and WHO. No reporting formats/tools were observed that linked cholera cases and interventions in geography, coverage and time, to facilitate analysis of gaps. A requirement for integrated monitoring and reporting would bring about greater integrated analysis.

Learning

54. **Simulations as standard.** Simulations that test systems, preparedness and the readiness of responses are not consistently implemented and almost never planned for in P&R plans. Interestingly, one HC reported that they were planning a simulation for the humanitarian sector, and cholera would be a component of this.

55. **After Action Reviews** (AARs) **as standard**. AARs are more consistently planned for, although less than 30%% of cholera P&R plans include the need for an AAR. However, almost half of all plans refer to some sort of learning having taken place prior to the plan, although it is not always clear what that learning involved, or if it had been incorporated into the P&R plan. Health and WASH survey respondent replies indicated that there was no consensus on whose responsibility it was to follow-up on actions from such learning events, with similar results to those given for who within the international humanitarian community was responsible to ensure an effective and timely (humanitarian) AWD/cholera P&R.

Recommendations

The full set of recommendations are included in the main report. Below is a list of the top 30 recommendations. As mentioned in the methodology, the recommendations address the identified barriers and gaps, some of which will be the mandates of other entities. It will be for the GHC, GWC and the Peer Review Group to agree how to take each recommendation forward.

It is important to emphasise that key recommendations related to leadership, accountability, coordination and roles and responsibilities need to be in place to provide a solid foundation from which other more operational recommendations can have the greatest impact.

	Recommended Action	Rationale	Phase
Leadership and Accountability			
1.	Request the IASC to consider clarification/guidance on leadership and coordination for infectious diseases in non-L3 scenarios	Humanitarian P&R architecture and responsibilities have been organised through the IASC, including the L3 declaration for infectious diseases. It would make sense that a gap in clarity of responsibilities in non-L3 situations be made clear by them	Foundation
2.	**MoU/LoU** between WHO and UNICEF	A framework of collaboration with which to set out guidance for field offices of the complementary multisectoral cooperation, areas of responsibility and technical cooperation	Foundation
3.	Checklist to support the **systematic analysis and review of humanitarian coordination and leadership** for cholera	To support regular analysis of coordination and leadership arrangements for effective, principled and multisectoral cholera response	Preparedness
4.	Develop **Scorecards** for key components of humanitarian cholera P&R to guide humanitarian leadership (HCs) and other stakeholders as to the status of P&R actions	Having an 'at a glance' way of rapidly assessing P&R progress and readiness would support senior leadership and those accountable in identifying gaps and taking action.	Preparedness
Cholera as a Multisectoral Issue			
5.	Development of a (multisectoral) **Conceptual Framework for Cholera**	Support understanding and institutionalisation of multisectoral coordination and response to cholera	Foundation
6.	Promote the organization, coordination and discussion of cholera P&R by objectives of reduction of morbidity and mortality, and remove referral to 'Health' and 'WASH'	Organising strategies to address cholera by 'Health' and 'WASH' interventions have left gaps and limited the interaction between Health and WASH, as well as other supporting sectors. Organising P&R interventions by their objective and where they take place could encourage a more multisectoral, integrated approach	Preparedness and Response
Coordination			
7.	Example organigram/coordination structure to clarify interface between EOC-IMS structure, humanitarian coordination at central and sub-national levels	Support government and humanitarian community to understand how efficient supportive linkages can be made between the different types and levels of multisectoral coordination for cholera, role of different actors etc.	Foundation
8.	**Short guidance** on role of **EOCs and IMS** in humanitarian contexts and the interface with international humanitarian coordination architecture	Provide consistent clarity and guidance to humanitarian actors on role of EOC and interaction with existing humanitarian architecture	Foundation
9.	Guidance on applying IMS cross-pillar/sector collaboration to ensure an integrated approach to all components of cholera P&R	The application of the IMS system used for cholera coordination would benefit from greater guidance on its application to support more integrated multisectoral coordination	Foundation
Preparedness and Response Planning			
10.	Template agreed for content of multisectoral P&R plans Including templates/guidance for integrated: (i) scenario planning; (ii) capacity assessment/gap analysis, 4W; (iii) response strategies; (iv) data	Support standardisation, improve quality of key content of P&R (Plans) by clarifying accountability and roles and responsibilities, improving 'implementability' and prioritisation of preparedness actions, 'monitorability' and funding of preparedness plans	Preparedness

	needs; (v) analysis needs; (vi) resource mobilisation; and (vii) preparedness plan		
Early Warning			
11.	**Example SOPs** to agree: (i) who should systematically receive alert information across sectors, target timeframe for receiving the information and how the message will be transmitted, e.g. WhatsApp or email, and by whom (ii) which actions should be taken by whom and when in the event of an alert and prior to a declaration of an outbreak	Streamline and systematise multisectoral sharing of alert information to the right people to promote rapid multisectoral action	Preparedness
Implementation Strategies – Objectives and Evidence			
12.	Ensure all cholera prone countries in humanitarian crisis have an in-depth study of cholera epidemiology	Support and reinforce an effective, efficient, multisectoral targeted and prioritised strategy to P&R (methodologies and examples already exist)	Foundation
13.	Request the GTFCC to clarify/endorse current evidence for targeted household/neighbour interventions and its importance as part of an integrated strategy to control cholera	Given the important technical role that the GTFCC is playing to support ending cholera, having clear guidance on the current evidence for control activities and the role they should play in informing interventions	Foundation
14.	(Annually updated) Cholera Field Note on Evidence-based Prevention, P&R Strategies	Ensure field responders are kept up to date with new learning and evidence in a digestible, summarised, practical form to inform understanding, agreement and support of all components of an effective integrated response	Preparedness
15.	Myth-buster field guidance that outlines those activities where there is evidence or strong concerns about the effectiveness of specific interventions	It's important across sectors that this is understood, as interventions are being recommended across the sectors of actions that are not seen to be effective, e.g. the Health Sector in some countries recommending chlorination of open wells whereas there is acceptance in the WASH sector that this is ineffective	Preparedness
Implementation Response Strategies – Capacity, Roles and Responsibilities			
16.	Multisectoral Capacity Mapping and Assessment Template to cover different response needs, covering multisectoral expertise, response personnel, supplies (community response and treatment facilities), logistics, and funding dates for capacity availability	Support a more realistic and up-to-date comprehensive multisectoral analysis of P&R capacity needed	Preparedness and Response
17.	Globally clarify IPC in cholera treatment facilities and agree in-principle guidance for roles and responsibilities	To gain consistency in how IPC is considered and addressed in an integrated way	Foundation
18.	WHO to clarify its accountability to support WASH-IPC in treatment facilities and WASH responsibilities, e.g. water quality in communities	There is often confusion about where in-country TS and QC should come from for WASH-IPC in treatment facilities, resulting in a gap	Foundation
19.	Develop templates/menus to support the assessment of supplies that could be needed for cholera control activities	Templates exist for calculating supplies for treatment and are sometimes used in P&R plans. There are no tools for assessing supplies for cholera control, which would be helpful in assuring a more integrated approach to assessing supply needs	Preparedness
Implementation Approaches and Quality			
20.	Guidance and promotion on: (i) single organizations taking on complete multisectoral treatment and control activities, or (ii) cross-sector partnerships to cover treatment and control activities in specific geographic areas (where single agencies cannot cover both)	Many agencies have both Health and WASH programmes, but often not in the same geographic location. Single agencies or partnerships can be more efficient by reducing transaction costs in supporting rapid access to data to inform control activities and a more appropriate, rapid and targeted multisectoral range of responses	Preparedness and Response

21.	Agree and locate all (multisectoral) cholera technical guidance for treatment and control in treatment facilities and communities and ensure they can be found in one place to then be disseminated	Many countries are developing their own technical guidance, sometimes unaware that guidance already exists	Foundation
22.	Promote integrated TS and QC teams as standard in response	Quality control and technical support is not always planned for as part of preparedness; given that many responding actors have little experience in cholera, technical support is critical	Preparedness and Response
Cholera Data, Information Management and Analysis			
23.	Template and example **mapping of multisectoral data and analysis requirements and responsibilities**: for different actors; for what purpose and timeframe; for who collects the data; for who provides any analysis; and for how it will be shared	To gain agreement ahead of an outbreak of all multisectoral data and analysis needs, and systems that need to be in place to share data with the right people at the right time, for a clear purpose	Preparedness and Response
24.	Promote agreements for multisectoral access to cholera case data as part of preparedness and rationale for importance	Agreeing access to data often happens in the middle of an outbreak and does not always give ample time to think through all that is needed; agreements on access to data as part of preparedness would make data more quickly available to the right people with the right assurances	Preparedness
25.	Develop integrated cholera epidemiology training for those working to combat cholera, e.g. half to one day for emergencies, three days in the preparedness phase	To support an integrated analysis of cholera data and enable full participation of those involved in the analysis of cholera data through addressing gaps in the understanding of cholera epidemiology	Preparedness and Response
	Monitoring and Reporting		
26.	Agree and promote a set (menu) of indicators and benchmarks that represent an integrated cholera response (morbidity and mortality for (i) treatment facilities and (ii) communities	Systematic monitoring of a set of indicators that represent the overall integrated response would support a more integrated analysis and promote a more coordinated integrated response	Preparedness and Response
27.	Example reporting product that links cholera cases and responses enabling analysis of geographic location, timing between cases and response, and type of response	Reporting of responses needs to be able to support an analysis of gaps which is currently missing from standard reporting; this can also be important for advocacy purposes. There are a few good operational examples from which we can learn and replicate	Preparedness and Response
28.	Promote a single multisectoral/agency integrated reporting system that links cases and responses	It's critical that cases and the interventions that are supporting the reduction of morbidity and mortality in treatment facilities and communities are linked together to have a better analysis of gaps and likely impact of interventions, and reduce multiple sector/agency reporting	Preparedness and Response
	Learning		
29.	Promote annual multisectoral desktop cholera simulations[10] as standard	To verify the functionality of different components and levels of cholera coordination and collaboration	Preparedness
30.	Promote, as standard, the implementation of early multisectoral AARs into the planning cycle of cholera response and clear accountability for its implementation and follow-up	Ensure learning from cholera P&R is a standard part of response and carried out early to capture sector and intersectoral learning experiences of staff who may leave when the response is scaled back	Response

[10] WHO have a dedicated team in HQ to support such simulations

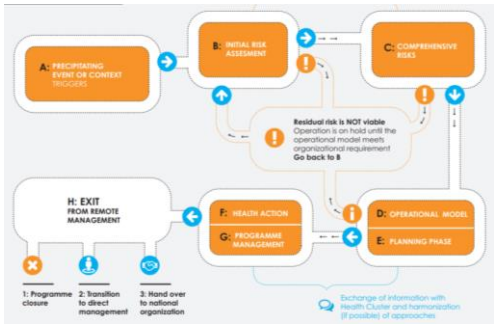
Way Forward

1. The recommendations proposed are made up of **two categories**:-
    1. **Leadership and accountability advocacy** recommendations
    2. **Operational recommendations**. Of the operational recommendations, two groups are identified:
        i. Recommendations that the Global Health Cluster (GHC) and WASH Cluster (GWC) can **implement directly** (as part of a Joint Operational Framework)
        ii. Recommendations that the Global Health and WASH Clusters will need to **advocate to, coordinate with, and in some instance collaborate with, other entities** to see them implemented

    Many of the operational recommendations will require several of the leadership and accountability recommendations to be in place for them to reach their full potential.

2. GHC and GWC Coordinators with the Peer Review Group to review all of the recommendations:
    i. Agree categorisation of recommendations and priorities
    ii. Agree a plan of action to move forward on those recommendations that require advocacy with humanitarian and other entities
    iii. Consider broader (online) field validation and prioritisation of recommendations
    iv. Dissemination strategy for findings and recommendations of project, including field as well as headquarters and senior humanitarian management as well as operational staff
    v. Agree subsequent plan of action to (simultaneously to leadership, accountability and other advocacy) move forward with the development of:
        i. an interim Joint Operational Framework (JOF) developed around the humanitarian programme cycle
        ii. interim associated tools and guidance (as identified in recommendations)
        iii. interim key messages for a range of operational decision-makers and responders
        iv. identify countries to field test interim JOF, tools, guidance and key messages

3. It is envisaged that the JOF will be made up of a series of **flow charts** and **scorecards** to describe and monitor the necessary key actions, highlighting specific areas that support an integrated and coordinated response. It is envisaged that this will include three frameworks that will link into an overall joint operational framework:



    i. essential foundational recommendations that need to be in place to provide an enabling environment for progress toward integrated and coordinated operational recommendations
    ii. Preparedness Framework
    iii. Response Framework