



Meeting the Fundamental Need for Water, Sanitation and Hygiene Services in Health Care Facilities

Meeting report

22-23 April 2014
Madrid, Spain

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1. Background

Available data suggest that water, sanitation and hygiene (WASH) services in health care facilities are inadequate in many countries. A forthcoming WHO report found that in Sub Saharan Africa only half of health care facilities have access to improved water sources. This figure masks large variations and does not address issues concerning quality, functionality and accessibility of services. Furthermore, little is known about the presence and conditions of sanitary facilities as well as safe disposal of medical waste.

The World Health Organization has recently declared improving WASH in health care facilities to be an urgent priority and has drafted a strategy to address WASH in health care facilities focusing on monitoring, implementation of WHO standards and advocacy. WHO and partners have increased their efforts to ensure that all health care facilities have at least a minimum level of WASH services.

The International Strategic Meeting on Improving Access to Water, Sanitation and Hygiene in Health Care Facilities was held from 22 to 23 April 2014 in Madrid, Spain. The meeting was hosted by the Ministry of Health, Social Services and Equality of Spain and coordinated by WHO and UNICEF with support from the UN-Water Decade Programme on Advocacy and Communication. The aim of the meeting was to bring together stakeholders from national and international organizations, administrations, academia, non-governmental organizations and donors, to commence a discussion on global, collaborative efforts to improve water, sanitation and hygiene in all health care facilities.

2. Objectives of the meeting

The objectives of this two-day meeting were to:

- Present global data on access, monitoring mechanisms and policies on WASH in health care facilities;
- Share country examples of successful approaches for improving WASH in health care facilities;
- Identify information and knowledge gaps; and
- Prioritize needs regarding WASH in health care facilities and strategize, through a draft action plan on how to address these among key actors.

3. Summary of Day 1 - Setting the scene for global action

Dr Maria Neira, Director of the Department of Public Health, Environmental and Social Determinants of Health, WHO and Mr Evariste Kouassi Komlan, Senior Advisor on Water, Sanitation and Hygiene, UNICEF welcomed participants. Dr Neira opened the meeting by highlighting the burden of disease associated with poor WASH conditions in health facilities and the importance of joining efforts to address the issue.

The first day of the meeting consisted of presentations on the following aspects: 1) Global status on WASH services in health facilities, existing monitoring initiatives, and national policies and plans 2) Country examples of initiatives aimed at improving WASH in health care facilities 3) Evidence gaps and 4) Opportunities for linkages with other initiatives.

3.1. Global status on WASH in health care facilities

Mr Ryan Cronk and Prof. Jamie Bartram from the Water Institute at the University of North Carolina, presented preliminary results from the WHO landscape report on WASH in health care facilities. The draft report, which analyzed 76 assessments from 40 countries, confirmed that coverage of water and sanitation services in health care facilities was low. For example, in Sub-Saharan Africa, only half of

health care facilities have access to improved water sources, a much lower figure than household-level coverage. The report summarized existing monitoring initiatives that collect data on WASH in health care facilities, including the Service Availability and Readiness Assessment, SARA (WHO), the Service Delivery Indicator Survey, SDI (World Bank), and the Service Provision Assessment, SPA (The DHS Program, USAID). The report highlighted differences in methodology and indicators between the different types of assessments. In terms of policies, an analysis of the UN-Water GLASS survey data revealed that country policies on WASH in health care facilities were often weak. For example, only 20 out of 74 countries reported having full policy plans with funding for WASH in health care facilities.

3.2. Monitoring mechanisms

Mr Bruce Gordon, on behalf of Ms Claire Preaud, WHO HQ, gave a brief overview of WHO's Service Availability and Readiness Assessment (SARA). SARA is a standard health facility assessment tool measuring the physical presence of services and the capacity to deliver those services. SARA collects nationally representative data building on experiences and best practices from other surveys such as SAM and SPA. It covers three main domains: 1) Service availability such as facility density, health personnel density and service utilization; 2) General service readiness reflecting the overall capacity to provide basic services at minimum standards; 3) Specific service readiness to provide interventions in key program areas such as family planning, malaria, tuberculosis, routine child immunization etc.

Dr Gayle Martin, from the Service Delivery Indicator Program (SDI), World Bank, presented the SDI methodology and tools. SDI collects nationally representative data to track service delivery performance. The methodology and the framework use a production function approach to service delivery along three dimensions: inputs, provider efforts and provider ability. Data from the survey can be analyzed to assess availability of water and sanitation services in combination, instead of availability of each service separately, or to explore service disparities between facility types and countries for example.

3.3. Examples of country initiatives

The aim of this session was to provide examples of national approaches and strategies that were adopted to improve WASH in health care facilities, including information on the processes and actors that were engaged, as well as the resources required. Examples were provided for five countries: Mongolia, Laos, Sierra Leone, Zambia and Nepal. Below is a brief summary of presentations:

Zambia

Dr Mathias Tembo, Tropical Diseases Research Centre of Ndola, Zambia.

Dr Tembo gave an example of an inexpensive approach to promote safe water and hygiene in rural health facilities. The intervention consisted of the provision of water stations, water treatment, soap, and the training of health workers. This was a pilot project implemented in eight rural facilities. The project was implemented by the Ministry of Health, Ministry of Water and Natural Resources and the Churches Health Association of Zambia (CHAZ), with support from the Centers for Disease Control and Prevention (CDC) and the Center for Faith-Based and Neighborhood Partnerships, Department of Health and Human Services (DHHS). The initiative was evaluated by comparing assessments before and after implementation. Data collection tools included health facility surveys and patients' surveys. Preliminary findings showed promising results in terms of uptake and patient satisfaction. The intervention is envisaged to be expanded to 150 facilities.

Sierra Leone

Dr Samuel Kargbo, Division for Reproductive and Child health, Ministry of Health and Sanitation, Sierra Leone.

The country has national policies on water and sanitation, but not specifically for health facilities. The MoHS recently developed policies and standards along with manuals and training tools to facilitate implementation of those standards. The initiative was led by the Reproductive and Child Health Division at the MoHS with external support and collaboration with NGOs for implementation on the ground. An innovative monitoring system was put in place. Facility Improvement Assessment Teams (FIT) were deployed to 65 health centers and 13 hospitals for quarterly or bi-annual assessments. The teams reported their findings directly at district level. The assessment tool was combined with a system of score cards in the form of traffic lights to monitor the facility status against set criteria. The score cards were used as a tool to review the situation and decide on the actions to take. The next steps for this initiative will be to demonstrate the effectiveness of the strategy, scale it up and collaborate with the Ministry of Energy to equip health facilities with solar panels for electricity.

Mongolia

Dr Oyuntogos Lkharusen, WHO country office, Mongolia.

Several health facility surveys were carried out in 2005, 2007, and 2010 with the aim of improving WASH in rural hospitals. Several development partners, including USAID and the United Nations Trust Fund for Human Security (UNTFHS), supported WHO and the Mongolian Ministry of Health to improve WASH services in rural hospitals from 2009 - 2013. The program focused on training hospital staff on environmental health and conducting a behavior change campaign to raise awareness of hygiene among communities. In 2013, Mongolia adopted the WHO Guidelines for Essential Environmental Standards in Health Care Settings. The new environmental health standards required WASH to be incorporated in the design of new facilities. The standards also focused on operations and maintenance and placed emphasis on improving WASH, health care waste management, and infection control in existing hospitals.

Nepal

Mr Bhim Acharya, Ministry of Health and Population, Nepal.

In 2011, WHO sponsored the Center for Public Health and Environmental Development (CEPHED) to do an assessment of 31 hospitals across all regions of Nepal. The assessment found that 84% of the hospitals had access to sufficient water but hygiene facilities were poor in 40% of the hospitals, and only 3% of sampled hospitals had a functional and well maintained system of waste water management. In Nepal, the Ministry of Health and Population is responsible for implementing WASH in health facilities, and actions on WASH are included as part of the Nepal Health Sector Programme II that runs from 2010-2015. MoHP has developed standards for the construction of new health facilities which cover waste management and hand washing stations, and has prepared healthcare waste management guidelines and an orientation manual.

Laos

Mr Soulivahn Soukkasavah, WHO country office Lao LPR.

In Laos, the ‘Strategy and Planning Framework for the Integrated Package of Maternal Neonatal and Child Health Services 2009-2015’ was recently developed. The project was funded by the Korea Foundation for International Healthcare (KOFIH) and was implemented in 25 health centres of the MNCH focus provinces. The strategy aimed to develop standards for the construction of health facilities including ensuring accessibility for patients with disabilities, functional amenities (toilets, washing areas), and allocation of budget for maintenance and repair. The department of Hygiene and Health Promotion has developed Environmental Health Standards for Health Care. This document provides guidance for hospitals and health facilities on essential environmental health; supports the integration of those

standards into national programmes; and guides training and capacity building on technical aspects in the local language.

Discussion

Overall, the different presentations shared commonalities. Although countries had policies on water and sanitation, they did not have clear strategies and targets that were specific to WASH in health care facilities. In some cases, multiple ministries were involved, thus raising the question of accountability. The types of approaches ranged from inexpensive measures that can be implemented in the short term, to interventions focusing on longer term infrastructural improvements. Some challenges were noted such as conflicting priorities within countries, sustaining funding for implementation, communication from local to national levels and coordination between different stakeholders.

3.4. Information and knowledge gaps

Evidence on the links between WASH and maternal health

Ms Yael Velleman, on behalf of Oliver Cumming, LSHTM, talked about the links between WASH and maternal and reproductive health. Despite a decline in maternal mortality over the last two decades, accelerated action is needed in order to meet the MDG target. A significant proportion of maternal deaths are caused by sepsis, some of which are associated with unhygienic delivery. The mechanisms through which WASH can impact maternal and reproductive health throughout life are complex. A framework was proposed to summarise those links through three lenses - biological, long term perspective and social and behavioural. The results from a recent systematic review suggested an association between poor WASH conditions and maternal mortality, although the evidence remains weak in light of the quality of the studies being reviewed. The presentation also described case studies in Tanzania where less than a third of all births (facility and domestic) were documented to occur in a WASH-safe environment.

Linking WASH with existing initiatives at the policy level

Ms Yael Velleman from WaterAid presented WaterAid's recent discussion paper making the case for including water, sanitation and hygiene in a comprehensive definition of universal health coverage (UCH). WASH is the foundation of health and must be considered a key aspect of UCH. WASH is often neglected as a political priority and UCH provides an opportunity to raise the profile of the issue. Ms Marta Seone from WHO HQ described recent health initiatives and talked about opportunities for linkages including the Global Action Plan to Prevent and Control Pneumonia and Diarrhoea (GAPPD), A Promise Renewed, Every Newborn Action Plan, State of the World's Midwifery Report, and the initiative on Ending Preventable Maternal Death.

Examples of tools for delivery and monitoring WASH in health care facilities

Ms Kate Robbs from the Center for Global Safe Water at Emory University presented two case studies in Honduras and Ghana. The aim of the project was to evaluate the performance and use of water treatment systems and their sustainability in hospitals. The researchers developed a sustainability metric that covers four domains of sustainability including technical feasibility, on-site capacity, accountability and institutional engagement. This metric can be applied to identify strengths and challenges to the sustainability of water treatment systems in health care facilities and provides a useful tool for long-term monitoring of those services.

Mr Dileep Mavalankar, from the India Institute of Public Health, presented preliminary results from the 'WASH and CLEAN' study. This is a research project conducted with Soapbox collaborative. The

objectives of this study were to develop a set of tools for measuring levels of WASH services and Infection prevention and control (IPC) measures, to pilot the tools in a small sample of maternity units in one state of India, and in two areas of Bangladesh, and to use the findings for the development of appropriate interventions. The presentation provided an example of innovative approaches to encourage health workers to change their behaviour, such as the use of photo-elicitation techniques, where participants are asked to react to photographic prompts to generate discussion, debate, and insights not gained through traditional “direct questioning” methods of data collection.

4. Summary of Day 2 – Agreeing a way forward

The second day consisted of plenary discussions and group sessions to determine key items to be included in a global action plan. The group discussions were organized around the following domains: advocacy, policies and standards, monitoring and research.

4.1. Identifying barriers, allies and knowledge gaps

The second day started with a panel discussion. The panel members were Samuel Kargbo (MoHS Sierra Leone), Matthias Tembo (MoH Zambia), Jamie Bartram (UNC), Merri Weinger (USAID), Soulivanh Soukkasah (WHO country office, Laos), Yael Velleman (WaterAid). Panel members were asked to reflect on the barriers to improving WASH in health care facilities, the allies and partnerships needed in order to raise the profile of the issue and the knowledge gaps that need to be addressed. Key discussions points are summarized below.

Barriers

- Countries are dealing with conflicting priorities. WASH should be considered at the outset of health programming.
- Donors’ projects have targets that do not always align with national priorities.
- Lack of capacity for implementation in countries. Emphasis should be placed on training staff, especially at the local level. Training should include aspects on operation and maintenance of WASH services.
- Significant gaps remain between WASH and health initiatives despite water, sanitation and hygiene being recognized as the foundation for health.
- The health aid architecture tends to use a vertical approach, but there is a need to embed WASH into existing health programs.
- Lack of coordination between donors on investments.
- The MDGs on water and sanitation did not have a clear target for health care facilities, which made it hard to find resources for activities in health care facilities. WASH in health care facilities should be included in post-2015 target setting.
- The issue of WASH in health care facilities falls between two sectors (WASH and Health) and there is often a lack of clarity over who is responsible and who should pay. Clarification on leadership and coordination roles and responsibilities is needed.
- Lack of sufficient evidence demonstrating benefits and value for money.
- Guidelines need to be made accessible for implementers and should include aspects such as planning, design and construction elements.
- Lack of sufficient resources allocated to WASH in health care facilities.
- Examples from India - some barriers include availability of cheap antibiotics, so medical staff prescribe antibiotics instead of addressing preventing infections through safer WASH conditions.

Engineers are interested in large engineering projects at the expense of water and sanitation sector; there is a lack of data on how this shift has had an impact on public health.

Allies/partnerships

- Facilitate coordination among donors.
- Support countries for inclusion of WASH in health care facilities in their country-level strategy.
- Work more closely with the ministries of health to integrate WASH in their programs.
- Consider new partnerships, for example with the private sector (example of a Unilever handwashing campaign in India)
- Generate more interest and local political commitment on the issue.
- Advocate for joint planning and financing between the different sectors.
- Include WASH in a broader environmental health perspective to avoid duplication of efforts.
- Partner with existing or recent initiatives that provides opportunities for accelerated steps forward (e.g. inclusion of WASH in vaccination campaigns).

Knowledge gaps

- Need for strengthening monitoring to track progress over time.
- Need for evidence on financial benefits associated with improving WASH in health care facilities.
- Need for success stories of sustainable and scalable efforts to show it is doable.
- Need for evidence to support the standards and target setting.
- Need to attach costs to implementation and scale-up plans for WASH in health care facilities.
- Need to understand what information key decision makers need.
- Use examples such as the WinS approach on WASH in Schools for national advocacy. In this example, national data on WASH in Schools were analyzed together with education performance indicators. The information was used to develop an advocacy brief with compelling arguments for national ministers.

4.2. Development of a draft action plan

Participants were divided into three groups to discuss key components and a set of activities to be undertaken under the broad categories of policy development and implementation, monitoring, advocacy and research. The table below summarizes the key action points discussed.

<p>1. Advocacy and Partnerships</p> <p>Leadership</p> <ul style="list-style-type: none"> ▪ At global and regional level <ul style="list-style-type: none"> ▪ Prioritize deliverables, actions and target audience. ▪ Bring additional global and regional partners. ▪ WHO/UNICEF joint statement on WASH to countries through national offices. ▪ Support countries for effective delivery of programs at scale. ▪ At national level

- Government can ensure that WASH in health care facilities is reflected in their national plans and policies
- Government can become champions to raise the profile of the issue on the political agenda

Partnerships

- Influence and/or develop partnerships with existing health initiatives: (e.g. Universal Health Coverage, A Promise Renewed, GAVI Alliance , Global Action Plan for the Prevention and Control of Pneumonia, Health care waste management initiatives, Green Guide for Health Care, Sustainable Energy for All, International Health Partnership, Protocol on Water and Health etc.)
- Influence and/or develop partnerships with existing WASH initiatives: (e.g. Water safety plans, Household Water Treatment and Safe Storage etc.)
- Develop strategies for alliances with unions, associations, ICM, global health workforce alliance, internally within own agencies, civil society, academics, food safety platforms etc.

Advocacy Strategy

Audience

- Adopt a segmented approach to advocacy with messages tailored to specific audiences at international, national and local levels.
- Target audiences include the health sector, stakeholders from other sectors (clean energy community, human rights community), international donors, civil society, health professional standard bodies (e.g. ICN), communities
- To build demand for good facility (consumers, health workers, communities as agents of change, patients and workers rights), private sector (e.g. health insurers, product suppliers (e.g. soap, disinfectants and cleaning supplies, chlorine manufacturers, sanitary hardware).

Messages

- Create simple and effective messages that are based on evidence for impact and economic benefits.
- Understand the decision making process for WASH in health care facilities and develop messages that are tailored to specific audiences (e.g. has the health sector forgotten WASH? Improving WASH in health care facilities to reduce maternal mortality, WASH in health care facilities as a strategic investment, WASH as an incentive to care retention, WASH as an indicator for quality of investments in health care facilities, use of WASH rather than antibiotics).

Delivery channels

- Develop a calendar of opportunities to raise the profile of WASH in health care facilities: Global days (e.g. World Water day, Global Handwashing day, World Toilet day etc.), WASH-related events and conferences, health-related events and conferences, business forums etc.
- Develop advocacy guides and create and supporting a network of advocates
- Create an information-sharing platform for exchanging knowledge, information and expertise for decision making (case studies, success stories, research findings, examples of national standards etc.).
- Use the WinS approach in schools for national advocacy
- Use health care facilities as a place to promote WASH

2. Standards and Policies

- International agencies to support overall coordination of efforts between countries and support development of their strategies.
- Support countries in the implementation of WHO *Environmental Health Standards in Health Facilities*; first understand the extent to which countries use those standards and identify potential barriers to using it.
- Develop practical tools for implementation of those standards: best practices on WASH, adapt the WHO *Environmental Health Standards* to allow countries to adopt a ‘laddered’ approach to improving health care facilities.
- Provide examples on how to integrate WASH in health policies, roadmaps to country implementation, inclusion of WASH in health care facilities as a basic infrastructural package.
- Develop mechanisms to verify compliance: accreditation of facilities, enforcement and support recognising the need for adopting an incremental approach to improving quality of services and to empower health facility staff.
- Governments to develop policies on WASH in health care facilities when they don’t exist or embed elements of WASH in other policies. Policies should be accompanied by a delivery structure: technical and financial resources, clarity on institutional and stakeholders roles and responsibilities (jurisdiction) at different levels, from national to facility level, capacity building and training, incentives etc.
- Setting up codes of practice on facility construction (review of construction design and maintenance standards, codes of practice, infrastructure for infection control)

3. Monitoring

- Establish a monitoring framework with a core set of indicators through local, national, and global levels
- Harmonize, strengthen, and cooperate with existing monitoring initiatives (e.g. SARA, SDI, JMP, HMIS)
- Establish country and global baseline on WASH in health care facilities
- Embed WASH in health care facilities in WASH targets and indicators post-2015
- Embed WASH in health care facilities in Universal Health Coverage monitoring framework
- Allocate resources towards monitoring and build capacity to ensure good quality data
- Develop indicators of WASH services quality and satisfaction among users in health care facilities
- Develop indicators for measuring sustainability of WASH services
- Develop checklist for health facility level monitoring based on national standards
- Monitor project implementation and document lessons learnt

4. Research needs

- Overall coordination of research and related activities by lead agencies
- Review raw HMIS data and examine hospital performance and WASH
- Understand decision makers’ motivation and priorities setting
- Document cost effectiveness of WASH investments in health care facilities
- Build evidence base on health impact of poor WASH conditions in health care facilities
- Identify drivers for behaviour change among health care facilities staff, patients and visitors
- Understand users’ perception and acceptability of WASH services in health care facilities

- Rationale for selection of monitoring indicators (evidence base, feasibility, cost etc.)
- Optimize hardware and infrastructure designs

5. Closing remarks and next steps

Dr Neira and Mr Bruce Gordon (WHO HQ) and Mr Evariste Kouassi Komlan (UNICEF) thanked the participants for a very productive meeting and rich discussions. In the post-2105 development context, the meeting started the journey towards the provision of universal access to safe drinking water and adequate sanitation at health centers. WASH and health professionals from national and international organizations, governments, academia, NGOs and donors came together and agreed on the urgent need for concerted efforts to improve water, sanitation and hygiene services in health facilities. Partners recognized the important role they have to play in raising awareness, producing knowledge, building political will, mobilizing resources and promoting action. Several countries at the meeting committed to becoming champions to raise awareness on the risks from inadequate WASH in health facilities. The meeting ended with a speech from Dr Ana Mato, the Spanish Minister of Health, Social affairs and Equality, who expressed her support of those efforts.

As next steps, the draft action plan will be developed further based on inputs from participants. The activities, roles and responsibilities will be discussed with key stakeholders over the coming months to prepare a more comprehensive global strategy. Teleconferences with a core group of partners will be organized in July to discuss the way forward.

6. Appendices

Appendix 1: Participants lists

Appendix 2: Agenda

Appendix 1. List of participants

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Appendix 2. Agenda

Meeting the fundamental need for water, sanitation and hygiene services in health care facilities

22-23 April 2014
Madrid, Spain

Objectives

- Present existing global data on access, monitoring mechanisms and policies regarding WASH in health care facilities;
- Share national examples of successful strategies and approaches for substantially improving WASH in health care facilities;
- Identify information and knowledge gaps and prioritize needs; and
- Develop draft global strategy and action plan among important actors.

Expected Outcomes

- Meeting report summarizing presentations and discussions;
- Global strategy on WASH in health care facilities; and
- Global action plan for 2014-2015, responsible actors, and funding needs.

Tuesday 22 April 2014

09h00-09h30	Opening remarks	Spanish Ministry of Health, WHO, UNICEF
9h30-10h30	Session 1: Global access and standards <ul style="list-style-type: none">• Introduction, meeting objectives and expected outcomes• Global status of WASH conditions in health care facilities <p>15 minute presentations followed by 30 min of discussion.</p>	Maria Neira, WHO HQ Ryan Cronk, UNC Moderator: Evariste Kouassi-Komlan, UNICEF
10h30-10h45	Coffee Break	
10h45-11h30	Session 2: Major monitoring mechanisms <ul style="list-style-type: none">• Service availability and readiness assessment (SARA)• Service delivery indicators (SDI) program <p>10 min presentations followed by 25 min of moderated discussion.</p>	Bruce Gordon (on behalf of Claire Preaud), WHO HQ Gayle Martin, World Bank Moderator: Jamie Bartram, UNC

11h30-13h00	Session 3: Country case studies <ul style="list-style-type: none"> • Zambia • Sierra Leone • Mongolia • Nepal • Laos <p>10 min presentations followed by 30 min of moderated discussion.</p>	Matthias Tembo, MoH Zambia Samuel Kargbo, MoH Sierra Leone Oyuntogos Lkharusen, WHO Cambodia Bhim Acharya, MoH Nepal Soulivanh Soukksavah, WHO Laos Moderator: Sophie Boisson, WHO HQ
13h00-14h00	Lunch	
14h00-15h00	Session 4: Gains from linking WASH improvements in health care facilities to health efforts <ul style="list-style-type: none"> • Linking WASH to improvements in maternal/newborn health • WASH and Universal Health Coverage • Integrating WASH with maternal and child health initiatives - vision for post-2015 	Yael Vellman, WaterAid on behalf of Oliver Cumming, LSHTM Marta Seoane-Aguilo, WHO HQ Yael Vellman, WaterAid
15h00-15h15	Coffee Break	
15h15-15h45	<ul style="list-style-type: none"> • Sustainability metric for WASH in health care facilities • Improving service uptake/delivery of care <p>15 min presentations</p>	Katherine Robb, Emory University Dileep Mavalankar, India Institute for Public Health Moderator: Corinne Wallace, UNU
15h45-16h00	Discussions and Wrap up	Bruce Gordon, WHO

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09h00-9h15	Summary of Day one	Rapporteurs: Andrew Trevett, Chander Badloe, UNICEF
09h15-10h30	Session 6: Developing a global strategy; agreed principles and components to address monitoring, standards/implementation and advocacy) 5 panelists, each speak for 3 minutes followed by moderated discussion on strategy	Moderator: Tom Slaymaker, WaterAid
10h30-10h45	Coffee	

10h45- 12h30	Session 6 continued: Global strategy Group work. Participants divided into three groups: <ul style="list-style-type: none"> - Monitoring - Advocacy - Policy development and implementation 	Moderator: Jamie Bartram, UNC Josefina Maestu, UNW-DPAC Pete Harvey, UNICEF
	Feedback from group and discussion	
12h30- 13h30	Lunch	
13h30- 15h00	Session 7: Workplan responsibilities, timeline and next steps Moderated group discussion	Moderator: Bruce Gordon, WHO HQ
15h00- 15h30	Wrap up and conclusion	Maria Neira, WHO