Meeting Report
Expert Group Meeting on Monitoring WASH in Health Care Facilities in the Sustainable Development Goals
WHO/UNICEF Joint Monitoring Programme for water supply and sanitation

Contents

Introduction .................................................................................................................... 2
Background .................................................................................................................... 2
Purpose ........................................................................................................................... 3
Expected outputs ............................................................................................................ 3
Document Structure ...................................................................................................... 3
Meeting Outcomes ....................................................................................................... 3
Recommended service ladders ....................................................................................... 3
Normative definitions of core indicators for “basic” service ........................................... 4
Recommended Core Questions ....................................................................................... 5
Mapping core questions to the service ladders ............................................................... 9
Way Forward ................................................................................................................ 11
Plans for additional modules ......................................................................................... 11
Group action items ....................................................................................................... 11
Individual action items ................................................................................................. 11
Annex 1: Recommended Expanded Questions ............................................................ 13
Annex 2. List of Participants ......................................................................................... 20
Annex 3: Meeting Agenda ............................................................................................ 21
Introduction

From June 22-23, 2016, an Expert Group Meeting on Monitoring WASH in Health Care Facilities in the Sustainable Development Goals was convened by the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (JMP) in New York. A group of 16 technical experts and six members of the JMP were in attendance. Three technical experts made remote inputs via Skype. A list of meeting participants is included in the annexes. The Expert Group Meeting was convened to consider how WASH services in health care facilities could be monitored in the era of the 2030 Sustainable Development Agenda.

Background

In recognition of the importance of water, sanitation and hygiene (WASH) in health care facilities, WASH in health care facilities (WinHCF) is implicitly and explicitly captured in the 2030 Agenda for Sustainable Development. The terms “universal” and “for all” in Sustainable Development Goal (SDG) Targets 6.1 and 6.2 implicitly highlight the need for expanding WASH monitoring from the household to non-household settings, such as health care facilities and schools, as we progress from the MDG to the SDG era (Table 1). Further, Target 6.2 specifically calls for “paying special attention to the needs of women and girls and those in vulnerable situations,” who are often a target population of health care, for example immunocompromised persons and expectant mothers. Target 3.8 calls for universal health coverage, with an emphasis on quality of services, for which WinHCF is of critical importance.

<table>
<thead>
<tr>
<th>Goals</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>6: Ensure availability and sustainable management of water and sanitation for all</td>
<td>6.1: By 2030, achieve universal and equitable access to safe and affordable drinking water for all</td>
</tr>
<tr>
<td></td>
<td>6.2: By 2030 achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations</td>
</tr>
<tr>
<td>3: Ensure healthy lives and promote well-being for all at all ages</td>
<td>3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all</td>
</tr>
</tbody>
</table>

In support of SDG monitoring and to allow for comparable data to be generated within and between countries, a core set of harmonized indicators and questions that address basic WASH services in health care settings is needed that will be applicable in all contexts. For national and sub-national monitoring with additional capacities and interests, an expanded set of questions can guide monitoring of additional criteria beyond the “basic” service level.

The Monitoring WASH in health care facilities task team is one of the four task teams working on the global action plan for WASH in HCF (the other three being advocacy, evidence and research, and facility-based improvements). The task team participated in a series of teleconferences, held between October 2015 and May 2016 to propose indicators and questions that are based on global norms¹ and look at existing questions in multi-national surveys and national monitoring systems (e.g. the WHO Service Availability and Readiness Assessment², the World Bank’s Service Delivery Indicators³, and the USAID-supported Service Provision Assessment⁴). The task team proposed a set of draft service ladders, core and expanded indicators and questions to be discussed at the expert group meeting.

---

² http://www.who.int/healthinfo/systems/sara_introduction/en/
³ http://www.sdindicators.org/
⁴ http://dhsprogram.com/What-We-Do/Survey-Types/SPA.cfm
Purpose

The purpose of this expert group meeting was to bring together a small group of WinHCF and monitoring experts to agree on final core indicators for “basic” water, sanitation, hygiene and health care waste management to support harmonized monitoring of WASH in HCF as part of the SDGs.

Specific objectives were:

- To review and refine the proposed service ladders and core and expanded indicators and questions for WASH in HCF
- To identify potential data sources and opportunities for field-testing indicators
- To discuss harmonization of definitions (e.g. facility levels) to allow disaggregation of data and data collection methodologies (e.g. censuses versus surveys)

Expected outputs

- Agreement on service ladders, and core indicators and questions for WASH in HCF monitoring, that are ready to be published in support of survey/questionnaire alignment with SDG monitoring
- A more comprehensive set of expanded indicators to undergo a second review process
- Agreed next steps for compiling additional modules (e.g. maternity wards)
- A meeting report summarizing the meeting outcomes and any remaining points of action.

Document Structure

This meeting report presents revised service ladders, core indicators for WinHCF and core question sets. These are followed by points of action, including opportunities for aligning surveys and Health Management Information Systems (HMIS) with the core (and expanded) questions. A set of expanded questions are included in Annex 1, followed by the list of participants (Annex 2) and meeting agenda (Annex 3).

Meeting Outcomes

Recommended service ladders

Similar to JMP monitoring of household WASH and proposed monitoring of WASH in schools (WinS), service ladders are proposed for monitoring WinHCF. The multi-level service ladders allow for progressive realization of the SDG criteria, enabling countries at different stages of development to track and compare progress in reducing inequalities. Separate ladders are proposed for water, sanitation, hand hygiene, and health care waste management. A fifth ladder for cleaning practices was discussed but requires further development. Within each category, the core service ladders include three levels: no service, limited service, and basic service. For countries where “basic” service is not an ambitious aim, an additional “advanced” service level is suggested. The criteria for the “advanced” service level are loosely defined and countries are encouraged to further define and quantify specific elements.

Globally comparable data required to monitor the core indicators for “basic” service are currently scarce; the first priority for monitoring will therefore be to collect information on “basic” water, sanitation and hygiene, as guided by the core question set. However, additional information needed to assess “advanced” service is found in the expanded question set and may be included in global monitoring in the future.

Each level is defined in the following graphic, followed by normative definitions of the indicators for “basic” services.
**Figure 1. JMP service ladders for monitoring WASH in health care facilities**

**Normative definitions of core indicators for “basic” service**

The core indicators define “basic” water, sanitation, hand hygiene and healthcare waste management facilities.

1: **The proportion of health care facilities with basic water supply**
Facilities where the main source of water is an improved source (W1), located on premises (W2), from which water is available at the time of the survey (W3), or if not, water is available from an alternative improved source (W4).

2: **The proportion of health care facilities with basic sanitation**
Facilities with improved toilets or latrines for patients located on premises (S1), that are functional at the time of visit, with at least one toilet designated for women/girls with facilities to manage menstrual hygiene needs (S2), at least one separated for staff (S3), and at least one meeting the needs of people with limited mobility (S4).

---

5 Improved water sources in healthcare settings include piped water, boreholes/tubewells, protected wells, protected springs, rainwater, and packaged or delivered water.

6 Improved sanitation facilities in healthcare settings include flush/pour flush toilets connected to a piped sewer system, septic tank or pit latrine; pit latrines with slab; ventilated improved pit latrines; and composting toilets. For the purpose of this document “toilets” is taken to mean any of these improved facilities.
3: The proportion of health care facilities with basic hand hygiene
Facilities with hand hygiene stations including a basin with water and soap, or alcohol-based hand rubs, present at critical points of care (H1) and within 5 m of toilets (H2).

4: The proportion of health care facilities practicing basic healthcare waste management
Facilities where waste is safely segregated in the consultation area (M1) and infectious (M2) and sharps wastes (M3) are treated and disposed of safely.

The Expert Group reviewed proposed indicators for basic cleaning services, but considered that the indicators and questions needed further development. The draft questions are included in Annex 1: Recommended Expanded Questions.

Recommended Core Questions

A set of core questions are recommended that are sufficient to generate data for the core indicators. These questions are the minimum needed to monitor WinHCF as part of the SDGs and are drawn from applicable standards, predominantly the 2008 WHO Essential Environmental Health Standards in Health Care, and relevant questions from existing survey instruments. The core indicators focus on a basic level of service which is universally applicable and relevant for national monitoring and international comparisons. Questions will be promoted for use in enumerator-collected surveys and health management information systems (HMIS) questionnaires which are filled out by health care workers. Questions should be suitable for use in both formats, where possible, but in some cases, different options may be necessary for enumerator surveys and for administrative questionnaires.

Water

<table>
<thead>
<tr>
<th>W1</th>
<th>What is the main source of water for the facility?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>Piped supply from outside the facility</td>
</tr>
<tr>
<td></td>
<td>Tube well</td>
</tr>
<tr>
<td></td>
<td>Borehole</td>
</tr>
<tr>
<td></td>
<td>Protected dug well</td>
</tr>
<tr>
<td></td>
<td>Unprotected dug well</td>
</tr>
<tr>
<td></td>
<td>Protected spring</td>
</tr>
<tr>
<td></td>
<td>Unprotected spring</td>
</tr>
<tr>
<td></td>
<td>Rain water</td>
</tr>
<tr>
<td></td>
<td>Tanker truck</td>
</tr>
<tr>
<td></td>
<td>Surface water (river/dam/lake/pond)</td>
</tr>
<tr>
<td></td>
<td>Other __________________ (Specify)</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
</tr>
<tr>
<td></td>
<td>No water source</td>
</tr>
</tbody>
</table>

Notes: The question refers to the source of water for general purposes, including drinking, washing, and cleaning. In case of water being available at multiple points, record the response closest to the outpatient area. Indicator in line with WHO/UNICEF definition of improved water sources.

<table>
<thead>
<tr>
<th>W2</th>
<th>Where is the main water source for the facility?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>On premises</td>
</tr>
<tr>
<td></td>
<td>Within 500 m</td>
</tr>
</tbody>
</table>
Further than 500 m
*No water source available*

**Notes**

**W3**

**Is water available from the main source at the time of the survey?**

**Responses**
- Yes, observed (skip to S1)
- Yes, reported but not observed (skip to S1)
- No (continue to W4)

**Notes**
Confirm that water is available from this source at the time of the survey, e.g. check that taps or hand pumps deliver water. Availability of water from off premises sources may be reported.

**W4**

**If water is not available from the main source at this time, what is the alternative source of water for this facility?**

**Responses**
- Piped supply from outside the facility
- Tube well
- Borehole
- Protected dug well
- Unprotected dug well
- Protected spring
- Unprotected spring
- Rain water
- Tanker truck
- Surface water (river/dam/lake/pond)
- Other __________________ (Specify)
- No alternative source available

**Notes**
Confirm that water is available from this source on the day of the survey, e.g. check that taps or hand pumps deliver water. Availability of water from off premises sources may be reported rather than observed.

**Sanitation**

**S1**

**Is there at least one usable improved toilet available for patients at the facility?**

**Responses**
- Yes, at least one usable improved toilet
- No, improved toilets are present but not usable
- *No, unimproved or no toilets at the facility*

**Observation**
Confirm that the toilets (or latrines) are usable.

**Notes**
Improved sanitation facilities include flush toilets, ventilated improved pit (VIP) latrines, pit latrines with slab, and composting toilets. For questions S1-S4 “toilets” is taken to mean any of these improved facilities. Usable means accessible, functional, and private.

To be included in an accompanying instruction manual: To be considered **usable**, a toilet should be functional and should provide sufficient privacy for users. In a functional toilet the hole or pit should not be blocked, water should be available for flush/pour flush toilets, and there should be no cracks, or leaks in the toilet structure. In order to provide sufficient privacy, the toilet stall should have walls without major holes, and a door which is unlocked when not in use (or for which a key is available at any time) and which can be locked from the inside during use.
S2  Is there at least one usable improved toilet designated for women and girls, which provides facilities to manage menstrual hygiene needs?

**Responses**
- Yes
- No, female-only toilets do not have menstrual hygiene facilities
- *No, there are no female-only toilets*

**Note**
- Refer to definition of usable improved toilets in S1. This refers to staff or patient toilets.
- A toilet can be considered to meet the needs of menstrual hygiene management if it meets both of the following conditions:
  - a bin with a lid on it within the cubicle
  - water and soap available in a private space for washing.

S3  Is there at least one usable improved toilet designated for staff?

**Responses**
- Yes, No

**Note**
- Refer to definition of usable improved toilets in S1.

S4  Is there at least one usable improved toilet that meets the needs of people with reduced mobility?

**Responses**
- Yes, No

**Note**
- Refer to definition of usable improved toilets in S1. This refers to staff or patient toilets.
- A toilet can be considered accessible if it meets relevant national or local standards. In the absence of such standards, it should meet the following conditions:
  - can be accessed without stairs or steps,
  - handrails for support are attached either to the floor or sidewalls,
  - the door is at least 80 cm wide, and
  - the door handle and seat are within reach of people using wheelchairs or crutches/sticks.

Hand hygiene

H1  Are there functional hand hygiene stations available at points of care on the day of the survey?

**Responses**
- Yes
- No, hand hygiene stations are available but not functional, or lacking materials
- *No, no hand hygiene stations are available*

**Note**
- Points of care are any location in the outpatient setting where care or treatment is delivered (i.e. consultation/exam rooms). For facilities with multiple consultation rooms, select one at random from the area where most general outpatient services occur to check for hand hygiene stations.

  A functional hand hygiene station may consist of soap and water with a basin/pan for washing hands, or an alcohol-based hand rub dispenser. If alcohol-based hand rub is used, healthcare staff may carry a dispenser around between points of care.

H2  Are there functional hand hygiene stations available at toilets on the day of the survey?

---

| Responses | Yes  
No, hand hygiene stations are available but not functional, or lacking materials  
*No, no hand hygiene stations are available*  
No  
, no hand hygiene stations are available |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Note</td>
<td>If a usable toilet was identified in question S1, it should be inspected for the availability of a functional hand hygiene station (soap and water with a basin/pan for washing hands), within 5 m of the toilet.</td>
</tr>
</tbody>
</table>

### Health care waste management

**M1** Is waste safely segregated into at least three labelled bins in the consultation area?

| Responses | Yes  
Bins are present but don’t meet all requirements (see Notes)  
No |
|-----------|--------------------------------------------------|
| Notes     | For facilities with multiple consultation rooms, select one at random from the area where most general outpatient services occur and observe whether at least three bins are in place to separate (1) sharps waste, (2) infectious waste, and (3) non-infectious general waste.  
The bins should be clearly labelled (either colour coded, written labels or signs), no more than three quarters (75%) full, and each bin should not contain waste other than that corresponding to their label. |

**M2** How does this facility treat and/or dispose of sharps waste?

| Responses | Autoclaved  
Incinerated (two chamber, 850-1000C incinerator)  
Incinerated (brick incinerator)  
Open burning  
Open dumping without treatment  
Chemical disinfection with hypochlorite  
*Not treated, but buried in lined, protected pit*  
*Not treated and added to general waste*  
*Not treated, but collected for medical waste disposal*  
Other (specify) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Note</td>
<td></td>
</tr>
</tbody>
</table>

**M3** How does this facility treat and/or dispose of infectious waste?

| Responses | Autoclaved  
Incinerated (two chamber, 850-1000C incinerator)  
Incinerated (brick incinerator)  
Open burning  
Open dumping without treatment  
Chemical disinfection with hypochlorite  
*Not treated, but buried in lined, protected pit*  
*Not treated and added to general waste*  
*Not treated, but collected for medical waste disposal*  
Other (specify) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Note</td>
<td></td>
</tr>
</tbody>
</table>
## Mapping core questions to the service ladders

Responses from the core questions can be mapped to the proposed ladders as shown in the following table. The “Advanced Service” level is to be defined at national level and is excluded from the table.

<table>
<thead>
<tr>
<th>Service level</th>
<th>W1</th>
<th>W2</th>
<th>W3</th>
<th>W4</th>
<th>S1</th>
<th>S2</th>
<th>S3</th>
<th>S4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Service</strong></td>
<td>Improved source</td>
<td>On premises</td>
<td>Available from main source at time of survey (W3) or water is available from an alternative improved source at time of survey (W4)</td>
<td>Improved facilities for patients located on premises and usable at time of visit</td>
<td>Sex-separated and have facilities to manage menstrual needs</td>
<td>At least one toilet designated for staff</td>
<td>At least one toilet meets the needs of people with limited mobility</td>
<td></td>
</tr>
<tr>
<td><strong>Limited service</strong></td>
<td>Improved water source</td>
<td>A “No” response for ANY (W2, W3, W4)</td>
<td>Improved facilities but not usable</td>
<td>A “No” response for ANY (S2, S3, S4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unimproved / No facility</strong></td>
<td>An unimproved or no water source (W1) OR An improved water source (W1) that is more than 500m from the facility (W2)</td>
<td>Unimproved or no facilities</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service level</th>
<th>H1</th>
<th>H2</th>
<th>M1</th>
<th>M2</th>
<th>M3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Service</strong></td>
<td>Hand hygiene stations (water and soap or alcohol based hand rub) at points of care</td>
<td>Hand hygiene (water and soap) available within 5m of toilets</td>
<td>Waste safely segregated in consultation room</td>
<td>Infectious waste treated and disposed of safely</td>
<td>Sharps waste treated and disposed of safely</td>
</tr>
<tr>
<td><strong>Limited service</strong></td>
<td>Hand hygiene stations at either points of care (H1) or toilets (H2), but not both</td>
<td>Bins are in place but not used effectively.</td>
<td>Waste is segregated but either infectious or sharps waste (or both) are not disposed of safely</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unimproved / No facility</strong></td>
<td>No hand hygiene stations available or available without soap or water or alcohol based hand rub</td>
<td>There are no bins for sharps and infectious waste</td>
<td>Waste is not safely treated and disposed</td>
<td>Waste is not safely treated and disposed</td>
<td></td>
</tr>
</tbody>
</table>

*Figure 3: Mapping core questions to the service ladders*
Methodological considerations: types of HCF assessments

Core and expanded indicators may be collected through a number of different assessments and surveys. Health care facility surveys can be nationally representative or sub-nationally representative; they can also measure all facility types, or they might focus on certain types (for example, facilities providing HIV services, surgical services or maternal care services).

<table>
<thead>
<tr>
<th>Level of country coverage</th>
<th>Health care facility types measured in instruments</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>All health care facility types</td>
</tr>
<tr>
<td></td>
<td>Subset of health care facility types</td>
</tr>
<tr>
<td></td>
<td><strong>Definition:</strong> Nationally representative surveys, censuses of all HCF types within a country</td>
</tr>
<tr>
<td></td>
<td><strong>Examples:</strong> SPA, SDI, HFC, SARA, HMIS, facility inventories, SAM</td>
</tr>
<tr>
<td>Sub-national</td>
<td>All HCF within a sub-region, program, project, or municipality</td>
</tr>
<tr>
<td></td>
<td><strong>Definition:</strong> subset of HCF within a sub-region, multiple districts, program, project, or municipality</td>
</tr>
<tr>
<td></td>
<td><strong>Examples:</strong> IMCI, QIQ, MMIS, ELMS, project monitoring</td>
</tr>
</tbody>
</table>

WHO Essential Environmental Health Standards in Health Care Facilities\(^1\) define three broad types of health care settings, 1) large health care settings providing a range of outpatient and inpatient care, 2) small health care settings providing outpatient care and outreach services, and 3) emergency or isolation settings. HCF facility definitions vary by instrument making comparisons between surveys and countries difficult. In addition, certain facility types are measured infrequently, for example, nursing homes, dental facilities, small private clinics and pharmacies. Most assessments consider hospitals (sometimes separated into national/referral and district/provincial) and smaller facilities, such as health center/clinic and health post. Some reports disaggregate results by hospital and non-hospital facilities.

**Sampling: censuses vs. nationally representative facility surveys**

There are advantages and disadvantages to using censuses versus nationally representative surveys, as with household surveys. Censuses are more expensive than representative surveys but provide a greater level of detail, which is valuable for targeting, disaggregation and sub-national reporting and comparisons. Some household surveys also sample HCFs from the same frame, for example the older World Bank LSMS from Cote d’Ivoire and Jamaica in the late 1980s and more recently the PMA 2020 project.\(^9\) PMA2020 uses a 2-stage cluster design, using urban-rural and major regions as strata. A sample of enumeration areas is then drawn and households and health service delivery points systematically selected from each enumeration area.

---

\(^8\) SARA surveys can be either national (e.g. Kenya) or sub-national (e.g. Zambia and Sierra Leone) and are therefore included in the table twice [http://www.who.int/healthinfo/systems/sara_reports/en/](http://www.who.int/healthinfo/systems/sara_reports/en/)

**Way Forward**

**Plans for additional modules**

Once the module for the OPD is finalised, the group will start working on additional modules. In the absence of data on outputs from all outpatient settings, it is important to consider if just one area (e.g. the maternity ward) would be enough to generate national estimates. Maternity areas are critical from a WASH perspective and may be a useful place to start. A patient satisfaction survey was also suggested, however this has many limitations. Firstly, satisfaction depends on expectation: very poor households might be satisfied with poorer services. Secondly, satisfaction can vary greatly according to when people are asked (i.e. on leaving a facility or after a number of days.) and finally, it is harder to get such data collection through the Institutional Review Board (IRB) for human subjects’ research.

**Group action items**

The following actions should be completed by 22 July, unless otherwise noted, to support timely dissemination of recommended indicators and questions.

1. **Circulate final core indicators for 4 of 5 ladders within 2 weeks of meeting (excluding cleaning)**
   a. Revised wording on selected questions
   b. Final version of core indicators ready by end of July
   c. Share core indicators with all members of monitoring task team for agreement
2. **Form a work stream on adapting core questions to an HMIS format**
   a. Liaise with DHS2 group
3. **Work stream on expanded indicators**
   a. Link with Quality of Care colleagues at WHO for QOC indicators
   b. Work with IPC on cleaning indicators (WHO, CDC, ICAN)
   c. Circulate current agreements on wording as starting point
4. **Subcommittee to link with groups working on facility classification, e.g. HDC**
5. **Work stream on module for maternity wards**
6. **Teleconference to discuss results in late August/early September**

**Individual action items**

The following summarizes the actions and opportunities for piloting identified by expert group members in a final roundtable before the closing of the meeting.

**WHO EURO:** In Kazakhstan, two regions are interested in looking more systematically at WASH in HCF and are interested in piloting the questions. This will also provide an opportunity to align the proposed questions with existing national monitoring mechanisms (e.g. HMIS, Annual Facility Inventories). In the week following the meeting, there is a meeting on the European Protocol, to be held in Geneva, with 53 member states. At the meeting a 3-year plan on WASH in HCF will be drafted and countries will be given the opportunity to volunteer to pilot the questions.

**UNC:** Fiji is planning a national assessment of WinHCF and has already integrated an earlier draft of the core questions into their draft survey instrument. UNC will follow up to find out how well the indicators are being received. There is also an opportunity to integrate the indicators into an urban WASH in HCF assessment in the Solomon Islands, UNC will follow up on the timeline of this work. In Malawi, a small scale assessment of 45 HCF in three regions is planned, which includes qualitative semi-structured interviews, and assessment of WASH and environmental health conditions. The work will start in August and be finished in December 2016.
UNICEF: will continue to engage with health colleagues in different regions. In WCARO, a number of countries have requested the global monitoring tool for use in the region. UNICEF SEARO will share the indicators and questions with national partners in South Asia. The indicators will be useful for aligning assessments (both national and regional). UNICEF Afghanistan will continue working with the Afghanistan government to update HMIS, which already includes some questions on water and sanitation.

SPA: Bangladesh and Haiti will be doing SPA surveys in 2017 and would be happy to pilot the core questions. They will also try to limit duplication with other surveys.

World Vision: WV has lots of examples of work on WASH in HCF in ten African countries, however they do not have many data points for HCF. They are in the process of finalizing a more robust WASH in HCF survey with 55 HCFs in Zambia, in partnership with Emory University. They are considering expanding this to other countries in southern Africa. WV have also been managing all the HCF in one island of Haiti and are now transitioning their management over to the government. They would be interested in using WASH FIT to support these facilities. WV also has the ‘Baby WASH coalition’, a key feature of which is the maternity module. WV would like to continue the discussion around this and are interested to suppor the JMP. Finally, the first phase of the WV WASH program plan which targets more than 26,000 schools and HCF is finishing this year. They are now going into the second phase of work and expanding into Asia. This will provide an operational opportunity to leverage work.

FHI360/AMDD: AMDD are revising their generic modules and would be interested in updating questions based on the discussions from this meeting (the modules are publicly available). Ghana is doing a second assessment soon, Ethiopia and Zambia assessments are on-going, and Nigeria may begin one shortly. Although they can’t change existing questions in ongoing assessments, they will make sure that WASH is analyzed and highlighted in subsequent reports. There may also be opportunities to carry out analyses on existing datasets.

PAHO: Pilot assessments using the PAHO Protocol are underway in Peru and will continue in the coming months. The assessment will then be extended to seven priority PAHO countries. There is a regional meeting in August in Cartagena, Columbia on WASH in the SDGs, with some time dedicated to WinHCF. All participants of the meeting are invited to attend.

SHARE: The government of Gujarat (India) are working with the MoH looking at WASH in outpatient areas so there may be opportunities to align the indicators. SHARE would be happy to support in the development of the maternity module.

CDC: is working on the Global Security Agenda, providing support at the national level on strengthening WASH and IPC guidance, primarily in the three Ebola countries and neighboring countries. Although funding is not confirmed, there are possible opportunities for work in Togo as well as Burkina Faso, Mauritania and DRC.

WaterAid: will share results of this work internally with WaterAid and continue to support this work both directly and indirectly through liaison with countries.

UNICEF: is working on an annual expanded HMIS in Papua New Guinea who are keen to include the new indicators. In Cambodia, work is ongoing on an inventory facility with WaterAid who are also interested in the indicators.

JMP: JMP have committed to maintain the momentum and will establish a global database for WinHCF over the next year. The JMP will continue discussions related to issues such as sampling and representativeness as they move toward generating estimates. The JMP will ask group members for additional support and input.

WHO: will provide feedback on the outcomes of the meeting to the three-Ebola countries who are in the process of finalizing a set of IPC/WASH indicators. They will also work with those responsible for HMIS to provide support on integration of indicators with HMIS.
Annex 1: Recommended Expanded Questions

The following questions provide a draft menu of options for countries to consider where there is greater capacity for monitoring. The expanded questions may be most valuable where there are national or sub-national priorities beyond the criteria for “basic” such as those where the focus is on providing “advanced services” according to national definitions. Questions are based on the global norms and other priorities that are not captured in the core questions. Where a question is not finalised, a comment is included in the note.

Question numbers are aligned with core questions (e.g. W for water, S for sanitation etc.). Questions beginning X indicate they are an Expanded Question.

**Water**

<table>
<thead>
<tr>
<th>XW1</th>
<th>Does the water available in the outpatient department meet national standards for <em>E. coli</em>, residual chlorine and Arsenic?</th>
</tr>
</thead>
</table>
| **Responses** | *E. coli*  
[Yes meet national standards, Tested but results not known, Not tested, No]  
Residual chlorine  
[Yes meet national standards, Tested but results not known, Not tested, No]  
Arsenic  
[Yes meet national standards, Tested but results not known, Not tested, No] |
| **Note** | Based on water at point-of-use. WHO guidelines recommend a standard of no detectable *E. coli* (or thermotolerant coliform) bacteria in any 100-mL sample of drinking water.\(^\text{10}\) WHO guidelines for free chlorine residual in drinking water at point of delivery states a minimum of 0.2 mg/L.\(^\text{10}\) This may be increased during emergencies (i.e. cholera outbreaks). Ask to see records of testing for purposes of quality assurance. If testing is done internally, ask staff to demonstrate how to measure chlorine. WHO guidelines on water quality recommend a standard of maximum arsenic level of 0.01 mg/L.\(^\text{10}\) Ask to see the records for quality assurance.  
*Add a footnote about parameters of local importance, and flexibility on parameters if this in a matrix.* |

<table>
<thead>
<tr>
<th>XW2</th>
<th>Is the water being treated onsite?</th>
</tr>
</thead>
</table>
| **Responses** | Yes, by boiling  
Yes, by UV  
Yes, by chemical disinfection.  
Yes, by coarse filtration (e.g. ceramic filter, sand filter)  
Yes, by membrane filtration (e.g. reverse osmosis)  
No |
| **Note** | Multiple answers may be chosen. |

<table>
<thead>
<tr>
<th>XW3</th>
<th>Are different water sources used for different purposes, e.g. drinking, washing and cleaning, medical procedures?</th>
</tr>
</thead>
</table>
| **Responses** | Yes, No  
If yes, explain. |

### XW4
Are procedures in place and followed consistently for keeping different water supplies independent and well identified?

**Responses**
- Yes, procedures in place and followed consistently
- Yes, procedures in place but not followed consistently
- No

**Note**
Only applies if response to XW3 is yes

### XW5
In the last two weeks, did the outpatient department have enough water for drinking, food preparation, personal hygiene, medical activities, cleaning and laundry?

**Responses**
- **Drinking:** [Yes sufficient quantity; No, minor water shortages; No, major water shortages]
- **Food preparation:** [Yes sufficient quantity; No, minor water shortages; No, major water shortages]
- **Personal hygiene:** [Yes sufficient quantity; No, minor water shortages; No, major water shortages]
- **Medical activities:** [Yes sufficient quantity; No, minor water shortages; No, major water shortages]
- **Cleaning:** [Yes sufficient quantity; No, minor water shortages; No, major water shortages]
- **Laundry:** [Yes sufficient quantity; No, minor water shortages; No, major water shortages]

**Note**
To be considered “enough water”, the quantity of water available should meet national standards. Where national standards do not exist, use the WHO guideline of 5 litres per outpatient consultation (and 0.5-5 litres/consultation for dry or supplementary feeding centres; 15 litres/consultation for wet feeding centres).

To calculate if the outpatient department meets standards, the amount of water available per day should be divided by the number of litres per consultation required by standards multiplied by the average number of daily consultations. Where direct measurement is not possible, the amount of water available compared to the amount of water required by standards, can be estimated.

### XW6
In the previous two weeks, was drinking water from the main source available for staff, patients and carers throughout each day?

**Responses**
- Yes
- No

**Note**
To be considered available, water must be available from a piped water system or safely stored in a covered container with a tap in the outpatient area, and it must be available to staff, patients and carers throughout each day in the previous two weeks.

### XW7
Is there routinely a time of year when the facility has a severe shortage or lack of water?

**Responses**
- Yes
- No

**Note**
To be considered available, water must be available from a piped water system or safely stored in a covered container with a tap in the outpatient area, and it must be available to staff, patients and carers each day of the year.
<table>
<thead>
<tr>
<th>XW8a</th>
<th>Is there at least one drinking water point within the outpatient area?</th>
</tr>
</thead>
</table>
| **Responses** | Yes  
No  |
| **Note** | Drinking water may be provided from a piped water system or via a covered container with a tap where there is no piped supply. Drinking water points should be clearly labelled and accessible at sitting level. |

<table>
<thead>
<tr>
<th>XW8b</th>
<th>Is there at least one drinking water point within the outpatient area accessible to people with limited mobility?</th>
</tr>
</thead>
</table>
| **Responses** | Yes  
No  |
| **Note** | Drinking water may be provided from a piped water system or via a covered container with a tap where there is no piped supply. Drinking water points should be clearly labelled and accessible at sitting level. |

**Sanitation**

<table>
<thead>
<tr>
<th>XS1</th>
<th>Are toilets visibly clean?</th>
</tr>
</thead>
</table>
| **Responses** | Yes  
No  |
| **Note** | Clean means with no excreta, blood or body substances that could pose a human health risk. Assess this question at the same time as assessing S1. |

<table>
<thead>
<tr>
<th>XS2</th>
<th>Do the toilets have adequate light, including at night?</th>
</tr>
</thead>
</table>
| **Responses** | Yes  
No  |
| **Note** | There should be sufficient general or overhead light to see all areas within the toilet stall at night, as well as in areas that users will travel to and from the toilets, particularly if not located within the health facility (e.g. if outside). |

<table>
<thead>
<tr>
<th>XS3</th>
<th>Are toilets available no more than 30 metres from consultation rooms?</th>
</tr>
</thead>
</table>
| **Responses** | Yes  
No  |
| **Note** | This question refers to improved, usable toilets. |

<table>
<thead>
<tr>
<th>XS4</th>
<th>How are faecal wastes managed in improved toilets?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responses</strong></td>
<td>Flush to sewer, onsite storage in septic tank, onsite storage in latrine, don’t know</td>
</tr>
</tbody>
</table>
**Note**  
This question refers to all improved, usable toilets.  
*Make similar to WinS version: e.g. Are latrines or septic tanks emptied (or latrines safely covered) when they fill up?*

<table>
<thead>
<tr>
<th>XS5a</th>
<th>In the past year, has there been any flooding on the grounds?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responses</strong></td>
<td>Yes, No</td>
</tr>
<tr>
<td><strong>Note</strong></td>
<td>Add definition of flooding.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>XS5b</th>
<th>If so were toilet blocks flooded?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responses</strong></td>
<td>Yes, No</td>
</tr>
<tr>
<td><strong>Note</strong></td>
<td>Add definition of flooding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>XS6</th>
<th>Were any signs of open defecation observed during the facility visit?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responses</strong></td>
<td>Yes, No</td>
</tr>
</tbody>
</table>
| **Note** | Alternative question: Are patients practicing open defecation?  
Alternative question: Is open defecation practiced in or near the facility? (If using this, agree on definition of what ‘near’ the facility means?) |

### Hygiene

The following draft indicator was proposed by the task team but not agreed during the meeting, therefore it is included here for further development.

**Indicator**: The proportion of facilities practicing basic cleaning routines. Facilities where all toilets, floors and surfaces are cleaned, at least once a day or when soiled, with water and detergent.

<table>
<thead>
<tr>
<th>(X)H0</th>
<th>Are the health care facility floors, surfaces and toilets cleaned at least once a day with water and detergent and/or whenever they are soiled?</th>
</tr>
</thead>
</table>
| **Responses** | Yes, cleaned every day with water and detergent  
Cleaned with water and detergent, but less than once a day  
No |
| **Note** | If facilities are cleaned without detergent, or if not all the facility is cleaned, including toilets, mark “No” |

<table>
<thead>
<tr>
<th>XH1</th>
<th>Is the outpatient area visibly clean?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responses</strong></td>
<td>Yes, No</td>
</tr>
</tbody>
</table>
| **Note** | The outpatient area should be visibly clean, free from dust and soil, free from general clutter (e.g. unnecessary or unused equipment or furniture).  
*Consider a question based on SPA’s index for cleanliness* |
**Floor**: swept, no obvious dirt or waste  
**Counters/tables/chairs**: wiped clean-no obvious dust or waste  
**Needles, sharps outside the sharps box**  
**Bandages/infectious waste lying uncovered**  
**Walls**: significant damage  
**Doors**: significant damage  
**Ceiling**: water stains or damage

<table>
<thead>
<tr>
<th>XH2</th>
<th>Is soiled linen produced in the outpatient area pre-disinfected and washed in water?</th>
</tr>
</thead>
</table>
| **Responses** | Yes  
Soiled linen is washed in water, but not pre-disinfected  
No |
| **Note** | *Pre-disinfection in the standards applied to linens to be used in operating theatres. Seek guidance if there are appropriate guidelines for routine linens.* |

<table>
<thead>
<tr>
<th>XH3</th>
<th>Is the soiled linen used in the outpatient area kept in separate, sealed, marked bags for transport and storage?</th>
</tr>
</thead>
</table>
| **Responses** | Yes  
Yes, but not labelled/marked  
No |
| **Note** | |

<table>
<thead>
<tr>
<th>XH4</th>
<th>Are bed linens changed between patients and whenever soiled with body fluids?</th>
</tr>
</thead>
</table>
| **Responses** | Yes  
They are washed whenever soiled, but not always between patients  
No |
| **Note** | Soiled linen should not be sorted in patient care areas, and should be handled with minimum agitation to avoid releasing pathogens. Soiled linen should be cleaned and autoclaved before being used again. |

<table>
<thead>
<tr>
<th>XH5</th>
<th>At each hand hygiene stations and/or patient waiting areas is there a hygiene promotion poster?</th>
</tr>
</thead>
</table>
| **Responses** | Yes at each assessment site  
Yes, but only some  
No |
| **Note** | |

<table>
<thead>
<tr>
<th>XH6a</th>
<th>Can clinical staff demonstrate the 5 Key Moments(^{11})?</th>
</tr>
</thead>
</table>
| **Responses** | Yes, all clinical staff  
Yes, some but not all staff  
No |

\(^{11}\) [http://www.who.int/gpsc/tools/Five_moments/en/](http://www.who.int/gpsc/tools/Five_moments/en/)
<table>
<thead>
<tr>
<th>Note</th>
<th>Adapted from IPC and WASH Ebola 3-country indicators</th>
</tr>
</thead>
</table>

**XH6b** Can clinical staff demonstrate appropriate hand hygiene techniques?

| Responses | Yes, all clinical staff  
Yes, some but not all staff  
No |
|-----------|--------------------------------------------------|

**Note** Adapted from IPC and WASH Ebola 3-country indicators

**XH7** Are all cleaners, kitchen staff and waste technicians trained in essential cleaning and infection prevention techniques?

| Responses | Yes, all cleaners are trained received it  
Yes, some but not all staff have received it  
No training program currently available |
|-----------|---------------------------------------------------------------------------------|

**Note** Ask to see training program materials.

*Need operational definition of essential techniques if this question is kept*

**XH8** Are there sufficient cleaning materials at the facility?

| Responses | Yes, all cleaners are trained received it  
Yes, some but not all staff have received it  
No training program currently available |
|-----------|---------------------------------------------------------------------------------|

**Note** *Need to decide suitable wording for the question*

---

**Health care waste management**

**XM1** In the exam room, if there is a sharps bin, are functional needle cutters or hub cutters available next to the bin?

<table>
<thead>
<tr>
<th>Responses</th>
<th>Yes, No</th>
</tr>
</thead>
</table>

**Note** Observe if any method of needle destruction, such as a “needle destroyer”, “needle cutter”, “hub cutter” or similar.

**XM2** Are bins out of reach of patients and visitors, particularly children?

<table>
<thead>
<tr>
<th>Responses</th>
<th>Yes, No</th>
</tr>
</thead>
</table>

**Note** Patients and visitors, particularly children should not be able to access the waste containers and thus they should be kept out of reach.

*Consensus was not reached: there was a long debate about how to measure something being ‘out of reach’ and whether this was operationally possible*

**XM3** How often is non-sharp infectious waste collected from the outpatient ward?

| Responses | More than once per day  
Once per day  
Less than once per day |
|-----------|-------------------------|

<table>
<thead>
<tr>
<th>XM4</th>
<th>Are the sharps containers collected from the ward when they are three quarters (75%) full?</th>
</tr>
</thead>
</table>
| Responses | Yes, always  
Yes, but not always  
No |
| Note | If possible, check if sharps containers are overflowing. |

*Agreed to have this reviewed by survey experts*

<table>
<thead>
<tr>
<th>XM5</th>
<th>Is infectious waste transported in separate dedicated containers from non-infectious waste within the facility?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Note</td>
<td>Agreed to define criteria for containers based on norms at a later date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>XM6</th>
<th>Is there a designated area where infectious waste is safely stored while awaiting treatment/disposal?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Note</td>
<td>Agreed to define safely stored based on norms at a later date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>XM7</th>
<th>How long is infectious waste stored before treatment/disposal?</th>
</tr>
</thead>
</table>
| Responses | Less than 1 day  
1-2 days  
2-3 days  
More than 3 days |
| Note | If infectious waste is collected at different frequencies depending on the time of year, record the higher frequency (shortest length of time) |

<table>
<thead>
<tr>
<th>XM8</th>
<th>How is general (non-hazardous) waste treated or disposed?</th>
</tr>
</thead>
</table>
| Responses | Regular pick up of the municipality or transport by the facility to the public disposal site  
Irregular and insufficient pick up by the municipality  
Disposal on the premises of the facility  
Piled but not buried at the facility  
Buried and regularly covered with soil at the facility  
Open burning on the premise of the facility |
| Note | General waste refers to non-infectious, non-hazardous waste |

*Question parked for further discussion*

<table>
<thead>
<tr>
<th>XM9</th>
<th>Are fenced and protected areas available for the storage of waste awaiting removal from the facility and for the disposal pits if applicable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Note</td>
<td>Need to add a note on treatment area</td>
</tr>
</tbody>
</table>
Annex 2. List of Participants

**JMP**
- Rob Bain
- Christie Chatterley
- Arabella Hayter
- Guy Hutton
- Rick Johnston
- Tom Slaymaker
- Lydia Abebe
- Paul Ametepi
- Tim Brewer
- Ryan Cronk
- Erin Flynn
- Fabrice Fotso
- Malick Kante
- Emily Keyes
- Andrea Martinsen
- Teofilo Monteiro
- Ben Nemser
- Dan Irvine
- Henk van Norden
- Nasratullah Rasa
- Christophe Rockmore
- Kate Robb
- Oliver Schmoll
- Ruth Stringer
- Kavitha Viswanathan

**UNC**
- Paul Ametepi
- Ryan Cronk
- Erin Flynn
- Emily Keyes
- Andrea Martinsen
- Ben Nemser
- Dan Irvine
- Henk van Norden
- Nasratullah Rasa
- Christophe Rockmore
- Kate Robb
- Oliver Schmoll
- Ruth Stringer
- Kavitha Viswanathan

**ICF**
- Tim Brewer

**WaterAid**
- Tim Brewer

**FHI 360 / Columbia (AMDD)**
- Emily Keyes
- Andrea Martinsen
- Teofilo Monteiro
- Kate Robb

**CDC**
- Andrea Martinsen

**PAHO**
- Teofilo Monteiro

**SDI**
- Ben Nemser
- Dan Irvine
- Henk van Norden
- Nasratullah Rasa
- Christophe Rockmore
- Kate Robb
- Oliver Schmoll
- Ruth Stringer
- Kavitha Viswanathan

**WHO 360 / Columbia (AMDD)**
- Emily Keyes
- Andrea Martinsen

**WHO Energy**
- Michaela Pfeiffer

**WHO IPC**
- Michaela Pfeiffer

**WHO SARA (presented remotely)**
- Kavitha Viswanathan

**WHO 360 / Columbia (AMDD)**
- Emily Keyes
- Andrea Martinsen

**WHO Energy**
- Michaela Pfeiffer

**SDI**
- Waly Wane

**Terre des Hommes**
- John Brogan

**FHI 360**
- Patsy Bailey

**WHO**
- Jean-Charles Albert Dubourg
- Chaitali Chatopadhyay
- Alison Macintyre
- Michaela Pfeiffer
- Julie Storr
- Waly Wane

**UNICEF WCARO**
- Fabrice Fotso

**UNICEF Afghanistan**
- Nasratullah Rasa

**UNICEF ROSA**
- Henk van Norden

**UNICEF**
- Ben Nemser
- Dan Irvine
- Henk van Norden
- Nasratullah Rasa
- Christophe Rockmore
- Kate Robb
- Oliver Schmoll
- Ruth Stringer
- Kavitha Viswanathan

**Health Care without Harm (participated remotely)**
- Ruth Stringer

**WHO SARA (presented remotely)**
- Kavitha Viswanathan

**Health Care without Harm (participated remotely)**
- Ruth Stringer

**Health Care without Harm (participated remotely)**
- Ruth Stringer
### Annex 3: Meeting Agenda

**Day 1: Wednesday 22 June 2016**

<table>
<thead>
<tr>
<th>Session</th>
<th>Item</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30</td>
<td>Arrival; morning coffee</td>
<td></td>
</tr>
</tbody>
</table>
| 9:00 - 9:30 | **Introduction** | Moderator: Tom Slaymaker  
Rick Johnston |
| 9:00 - 9:30 | • Meeting objectives  
• Brief introductions  
• Background on global monitoring of WASH in HCF and progress to date (10 min) |  |
| 9:30 – 11:00 | **Overview of existing survey instruments and tools** (10 min per presentation) | Moderator: Rick Paul Ametepi  
Kavitha Viswanathan  
Ben Nemser  
Teofilo Monteiro  
Malick Kante  
Arabella Hayter |
| 9:30 – 11:00 | • SPA  
• SARA  
• SDI  
• PAHO Protocol  
• AMDD  
• WASH FIT  
Plenary discussion |  |
| **COFFEE BREAK** | |  |
| 11:20-12:00 | **Overview of settings ladders and indicators** | Moderator: Arabella Christie Chatterley  
Rick |
| 11:20-12:00 | • Overview of agreed ladders, indicators & questions for WASH in Schools (10 min)  
• Presentation of proposed service ladders and core and expanded indicators (30 mins) |  |
| 12:00-13:00 | **Survey methodology** | Moderator: Guy Hutton  
Ryan Cronk |
| 12:00-13:00 | • Facility classification  
• Weighting  
• Censuses vs surveys |  |
| **LUNCH** | |  |
| 14:00-15:15 | **Group work (1): core and expanded indicators** | Group moderators: Rick  
Arabella  
Tom |
| 14:00-15:15 | • Water and cleaning  
• Sanitation and hygiene  
• Health care waste management and quality |  |
| **COFFEE BREAK** | |  |
| 15:30 - 16:40 | **Group work (2): core and expanded indicators** | Group moderators: Rick  
Arabella  
Tom |
| 15:30 - 16:40 | • Water and cleaning  
• Sanitation and hygiene  
• Health care waste management and quality |  |
| 16.40-17:00 | **Feedback, conclusions and wrap up** | Arabella |
### Day 2: Thursday 23 June 2016

<table>
<thead>
<tr>
<th>Session</th>
<th>Item</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:45 - 9:00</td>
<td>Recap of Day 1 &amp; objectives for Day 2</td>
<td>Christie</td>
</tr>
<tr>
<td>9:00 - 10:00</td>
<td><strong>Group work (2): core and expanded indicators</strong></td>
<td>Group moderators: Rick, Arabella, Tom</td>
</tr>
<tr>
<td></td>
<td>• Water and cleaning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sanitation and hygiene</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health care waste management and quality</td>
<td></td>
</tr>
<tr>
<td>10:00 - 10:45</td>
<td><strong>Water and cleaning</strong></td>
<td>Moderator: Tim Brewer</td>
</tr>
<tr>
<td></td>
<td>• Presentation of group work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discussion</td>
<td></td>
</tr>
<tr>
<td>11:00– 11:45</td>
<td><strong>Sanitation and hygiene</strong></td>
<td>Moderator: Teofilo</td>
</tr>
<tr>
<td></td>
<td>• Presentation of group work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discussion</td>
<td></td>
</tr>
<tr>
<td>11:45 – 12:30</td>
<td><strong>Health care waste and quality</strong></td>
<td>Moderator: Fabrice Fotso</td>
</tr>
<tr>
<td></td>
<td>• Presentation of group work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discussion</td>
<td></td>
</tr>
<tr>
<td>13:30 - 14:30</td>
<td><strong>Beyond readiness</strong></td>
<td>Moderator: Oliver Schmoll</td>
</tr>
<tr>
<td></td>
<td>• Output and outcome indicators</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Differences between HMIS and facility assessments</td>
<td></td>
</tr>
<tr>
<td>14:30 - 15:15</td>
<td><strong>Next steps</strong></td>
<td>Moderator: Arabella</td>
</tr>
<tr>
<td></td>
<td>• Plans for additional modules</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Potential piloting opportunities</td>
<td></td>
</tr>
<tr>
<td>15:30 – 16:00</td>
<td>Parking lot</td>
<td>Moderator: Tom</td>
</tr>
<tr>
<td>16:00 – 16:30</td>
<td><strong>Summary recommendations and action points</strong></td>
<td>Moderator: Rick</td>
</tr>
<tr>
<td></td>
<td>Close of meeting</td>
<td></td>
</tr>
</tbody>
</table>

**COFFEE BREAK**

**LUNCH**

**COFFEE BREAK**