Report on the Third Meeting of the Child Health Accountability Tracking and Technical Advisory Group (CHAT-TAG)

11-12 December 2019

Eden Palace au Lac Hotel

Montreux, Switzerland
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Executive Summary

❖ CHAT aims to take a leadership role in recommending standard health indicators for children aged 1 month to 9 years. It works within an analytical framework that is based on the common evaluation framework with the categories of inputs, processes, outputs, outcomes and impact. CHAT advises WHO and UNICEF, sharing its work via reports and peer reviewed journal articles.

❖ Phase 1 of CHAT’s work is the identification of child health indicators that can be used at the global level for monitoring purposes, with a focus on survive and thrive dimensions. A second aim is to propose a research agenda and make recommendations about how to fill identified gaps in global knowledge/indicators.

❖ Phase 2 will be the identification of a core set of child health indicators that can be used at the regional (and potentially national) level for monitoring and planning purposes, with a similar focus on the survive and thrive dimensions. Consideration will be made on how the recommended set of indicators should be adapted based on the epidemiological and demographic context (including nutritional status) and the strength of the health and health information systems.

❖ Phase 3 will identify a core set of indicators relevant to special populations e.g. vulnerable children in conflict situations or humanitarian crises.

❖ An overview of relevant global monitoring indicators that are currently in use within global health was prepared between January and May 2019.

❖ At the June 2019 CHAT meeting, sub-sets of these indicators were allocated to three working groups (Acute and Prevention; Promotion and Development; and Chronic diseases, Injuries, Violence and Disability) for evaluation in terms of relevance, availability of global data, validity and overlap/duplication. Between June and December 2019, the groups worked on the evaluation of the indicators by teleconferences, email and in person during the December meeting of CHAT.

❖ Duplicate indicators were removed from the review. The groups then selected the priority indicators for each of their areas of interest and checked them for overlap and validity. Each group adopted a process that involved applying explicit criteria, including equity, to map their respective indicators. At intervals during the meeting, feedback was obtained from other CHAT members when each group presented their process and progress to the other groups in order to cross validate their decisions.

❖ Cross cutting indicators, e.g. birth registration, will be reviewed by all of the CHAT members.

❖ Data gaps and potential research topics will be communicated to the global health community. It is essential that child-related information should be extracted from all health datasets to validate disease-specific indicators in child health.

❖ Global indicators may change over time as new threats to children’s health emerge.

❖ Presentations on how CHAT fits into the global child health agenda and on how effective coverage and quality of care can be monitored were made by Theresa Diaz and Melinda Munos, respectively.

❖ The workplan for CHAT during 2020 was agreed upon and the CHAT governance documents were approved.
The next CHAT teleconference will take place in mid-late January 2020. A face to face meeting of CHAT will take place in June/July 2020 in New York, USA (dates and location TBD).
Introduction

Jennifer Requejo welcomed the members of the Child Health Accountability Tracking and Technical Advisory Group (CHAT-TAG) to Montreux, Switzerland, where the group’s third in-person meeting took place 11-12 December 2019. The list of participants can be found at the end of this document (Page 13). Everyone introduced themselves and stated if they had any conflict of interest (COI). No COIs were declared.

Kate Strong reiterated the mission of CHAT: to identify standardized, priority indicators that can be used to track the health of children aged 1 month to nine years. The work will be carried out in three phases:

- **Phase 1:** identification of child health indicators that can be used at the global level, with a focus on Survive and Thrive dimensions which have been set by Global Public Health Initiatives (i.e. Global Strategy, SDG 3, Countdown to 2030). In addition, CHAT will propose a research agenda that will fill identified gaps in global knowledge/indicators.
- **Phase 2:** identification of child health indicators that can be used at the regional (and potentially national) level, with a similar focus on Survive and Thrive dimensions. Recommendations will be made for how to adapt the list of indicators based on the epidemiological context (including nutritional status), demographic factors, and the strength of the health and health information systems.
- **Phase 3:** Identification of a core set of child health indicators for use among special populations e.g. vulnerable children in conflict situations or humanitarian crises.

Files that were shared during the meeting can be accessed in the CHAT Dropbox (https://www.dropbox.com/sh/hq6xmnbbtbblmgw5/AABguEoWD0zdyyo_kWdrAOd2na?dl=0).

A cube matrix was developed at the first meeting of the group in November 2018 to provide a framework for the scope of child health and well-being indicators across ages from 1 month to 9 years. For example, if data are currently only available for Indicator X in children aged <5 years, CHAT may recommend that information on this indicator for children across the age range should be collected, if the indicator captures information about an intervention that is relevant to children across the 1 month to 9 year age range. This will be determined by looking at causes of child deaths and burden of disease data.

It was agreed that the group would benefit from access to relevant papers on a regular basis, especially if summaries of the papers are provided. The CHAT group has been added to the mailing list of the Child Health Task Force.

CHAT aims to take a leadership role in the field of health and well-being indicators for children. It works within an analytical framework that is based on the common evaluation framework with the categories of inputs, processes, outputs, outcomes and impact. CHAT advises WHO and UNICEF, sharing its work via publications, including commentaries and peer reviewed journal articles.
Feedback from Working Groups

Overview: Kate Strong and Jennifer Requejo

An overview of relevant monitoring indicators that are currently in use within global health was prepared by Holly Newby early in 2019. At the meeting held in New York in June 2019, CHAT divided into three working groups each focused on a sub-set of the indicators with the goal of prioritising them. The first step for each group was to agree on a list of criteria for evaluating the indicators, such as relevance, availability of global data, validity and overlap or duplication. Between June and December 2019, the groups worked on their criteria for prioritisation of the indicators by teleconferences and email. Further refinement of the process took place during the December meeting of CHAT. After three sessions of group work, representatives of the groups reported back to CHAT in plenary sessions.

Some issues, such as birth registration and WASH (Water, Sanitation and Hygiene), were acknowledged to be important but could not be solely allocated to one working group. These were defined as cross-cutting indicators for review by all of the CHAT members.

An important question is whether education, poverty and pollution fall within CHAT’s global remit. After extensive discussion, CHAT came to the conclusion that, although, these factors are important for child health, they are well covered by other global health technical advisory groups. CHAT will make reference to these other groups in the final product of the mapping work, and will also ensure the recommendations from the group are informed by and linked to the GAMA and MONITOR indicator lists.

For many of the global indicators, data are available for the < 5 year old age group but are lacking for the 5-9 year age group. CHAT will highlight the need to collect relevant data on morbidity and service coverage for this neglected age group. The burden of disease differs across regions and varies depending upon the age of the child, with children living in low and middle income countries (LMIC) more likely to die from infectious diseases compared to children in high income countries (HIC). The majority of research into poverty-related diseases is undertaken in Africa and Asia and so limited data are available for Latin America, Central Asia and Europe. High income countries (HIC) often do not use the established global indicators for child health, or only use them to a limited extent, because the indicators are not applicable to their regions. CHAT noted that indicators that focus on the occurrence of childhood cancers, disabilities or certain preventable diseases, such as measles, are relevant to HICs as well as LMICs.

The CHAT members agreed that it was essential to set a deadline for the completion of the recommendations for a core set of child health indicators for global monitoring. They accepted that the indicators may change over time as new threats to children’s health emerge and new evidence is generated, and that the core set may need to be revised periodically.

Acute and Prevention: Joanna Schellenberg (chair), members included Melinda Munos, Marzia Lazzzerini, Pavani Ram

The Acute and Prevention group initially evaluated 79 global indicators. The group agreed on key criteria for the evaluation process and piloted their selection procedure. Initially, the phase 1 criteria were leading cause of disease, disability, injury or death; effectiveness of an intervention where relevant; based on conceptually clear and standardised global data; and validity. Balance across the range of indicators and non-overlap were assessed in phase 2.
After the pilot stage, the following phase 1 criteria were chosen: leading cause of disease, disability, injury or death; effectiveness of an intervention where relevant; Tier 1 classification; and validity. Tier 1 indicators for the Sustainable Development Goals (SDGs) were selected wherever possible because they are based on conceptually clear and global data, which have been collected in a systematic way. If Tier 1 indicators were not available for a healthcare issue, the group noted the gaps in information that need to be filled by research. Balance and non-overlap between indicators were assessed in phase 2 of the process.

The Chronic disease group re-allocated a number of indicators to the Acute and Prevention group. Some were accepted by the group, but 12 indicators, mainly those that dealt with chronic conditions, were sent back to the Chronic disease group for evaluation.

During the plenary sessions, the Acute and Prevention group reported that they had only focused on Tier 1 indicators and had reduced the number of indicators from 79 to a total of 14 child-specific, high priority indicators (Figure 1). Four of the indicators focused on mortality; two on nutrition; two on vaccines (one general indicator and one on measles [administration of the second dose of the vaccine]); one on care-seeking for pneumonia; one on treatment for diarrhoea; and four on malaria (the aim is to reduce this number to one indicator for prevention, one for diagnostics and one for first line treatment). The group would like to add ‘continued feeding’ to treatment with oral rehydration salts and zinc (ORS + zinc) for the diarrhoea indicator; data will be required to validate this revised indicator.

Measles was included because it is a growing problem globally (both HICs and LMICs); is an important cause of mortality (2% of deaths) after the top five causes of death in children aged 1 month-9 years; and can be considered as a ‘herald’ vaccine for coverage of vaccination. Care-seeking for pneumonia was chosen as an indicator for this infection because the denominator for monitoring treatment for pneumonia is difficult to measure. An indicator for care-seeking for fever/meningitis is under consideration.

Figure 1: Summary of workflow by Acute and Prevention group

Recommendations for the indicators will be made and then discussed with global health experts/groups where necessary, taking into account that CHAT-TAG member are experts in
their monitoring area. All of the indicators will be reviewed through the lens of equity. The working group identified several data gaps, such as detailed health data for children aged 5-9 years; and a validated treatment indicator for pneumonia.

**Promotion and Development: Ambrose Agweyu (chair), members included Ralf Weigel, Cynthia Boschi-Pinto (unable to attend), Zeina Jamaluddine, Abdoulaye Maiga, Kate Strong, Pavani Ram**

The Promotion and Development group developed, piloted and implemented a prioritisation tool. They initially defined four essential criteria (credibility, availability, validity and stability of the definition of the indicator over time) and six complementary criteria (effectiveness, ease of measurement, equity, coverage of age groups, child centeredness, type of indicator). The validity criterion was subsequently moved from the essential criteria to the complementary criteria, while the child centeredness criterion was dropped.

All indicators under consideration had to meet all essential criteria before the complementary criteria were applied. A scoring system (from 1 to 3) was used to weight the complementary criteria. Cumulative scores were determined for each indicator: indicators that scored 15-18 were deemed high priority; 11-14 were moderate priority; and 6-10 were low priority. The scoring system was evaluated in a pilot phase. The group also resolved that it would be necessary to review the rankings assigned as a final step.

Initially, the group evaluated 50 indicators: four members each worked on a subset of these indicators, applying the scoring matrix, identifying duplicate indicators and data gaps concurrently. Each member then presented their findings with the rest of the group for discussion. During the plenary sessions, the representative of the group explained that they had refined the scoring matrix, re-classified a number of indicators and eliminated duplicate indicators. Indicators that were relevant to the transform agenda were not considered because the focus was on the survive and thrive agendas. Twenty eight unique indicators were chosen for prioritisation using the scoring tool. The main areas covered were nutrition/growth; nurturing care; early child development; and prevention of violence/maltreatment.

Two challenges identified by the working group were the lack of stability in measuring data for certain indicators; and the timeframe during which an indicator was measured compared to when the intervention has an effect e.g. exclusive breastfeeding takes place during the first six months of life, but its benefits extend into childhood. For the purposes of mapping, it was decided that each indicator should be measured at the point of delivery and not when it has an impact, but that recognition of the long-term effects of such indicators would be highlighted in the accompanying narrative. Many of the indicators that are relevant to the transform agenda have a delayed effect and/or are related to policy decisions (e.g. school provision/attendance). Missing indicators were identified and assigned to the research agenda.
The Chronic diseases, Injuries, Violence and Disability working group identified seven criteria for the choice of indicators in their area of interest: leading cause of morbidity/mortality; effective intervention exist; child centred; fills a gap for older children (5 to 9 years); feasibility; source/frequency of data collection; and type of indicator (i.e. impact, outcome or input). They used a scoring system (0-3) to rank the indicators in order of importance. On pragmatic grounds, they deferred considerations about the validity of, and the balance between, different indicators. Their main focus was on the Survive and Thrive agendas which have been set by Global Public Health Initiatives (i.e. Global Strategy, SDG 3, Countdown to 2030).

Two members of the group acted as assessors and evaluated the indicators identified as being relevant to chronic diseases, injuries, violence and disability: 32 were considered important by both assessors. The discrepancies between the assessors were often based on geographical differences: for example, childhood TB is not a major health issue in Japan, but it is in South Africa. Hence, one assessor ranked the TB indicator as more important than the other assessor did. A third assessor is reviewing and ranking the indicators using the scoring system developed by the group so that the assessments can be compared one to another.

Three types of indicators were reviewed initially: four covered inputs; 15 were outcomes; and 45 were impact indicators. The majority of indicators covered health status, nutrition and risk factors. The group noted that indicators related to disability and general morbidity are absent from existing frameworks: there are considerable data gaps in these areas that should be filled by research. It is unclear which groups should review certain indicators e.g. does harsh discipline fall under promotion of health or injuries?

Several tasks were undertaken during the CHAT meeting, including:

- revision and finalization of the evaluation tool;
❖ reclassification of the indicators (99 were considered relevant to survive, 64 to thrive, 7 to transform);
❖ scoring individual indicators; removal of duplicate indicators;
❖ choice of priority indicators; and
❖ identifying data gaps.

The group noted the low number of thrive indicators but accepted that many of these indicators are outside of CHAT’s remit. Indicators for asthma are missing.

The number of criteria was reduced from seven to five: leading cause of death, disease, injury or disability OR effectiveness; child centred; age focus; feasibility; and type of indicator. Duplicate indicators were removed. The weighting of scores was revised and scores were allocated to the indicators.

The working group observed that many health data sets are not child-focused; for example, data on TB and HIV are often not disaggregated by age and so child-related information should be extracted from the datasets to validate disease-specific indicators. In some regions, monitoring congenital malformations is challenging, even if the malformations are visible. If the malformations are internal, e.g. cardiac abnormalities, it is almost impossible to gather accurate data about these conditions. To resolve the challenge of missing indicators the group plans to identify proxy conditions for chronic disease using years lived with disability (YLDs); to identify any indicators for these proxy conditions in the current list of indicators; apply the evaluation criteria to assess the suitability of these indicators; and highlight gaps where no indicators exist.

**Synthesis across the working groups**

It was acknowledged that the majority of indicators focus on impact and outcomes rather than outputs or inputs, and that this is because comparable, standardized data is more readily available for impact and outcome level indicators and because phase 1 of the CHAT work is on developing recommendations for a core set of indicators for global monitoring. Later phases of work will examine the output, process and input indicators. The burden of various diseases and the effectiveness of interventions are important criteria: more data are required in these areas. The balance between different diseases and conditions, harmonisation and validity will be addressed once a first list of global indicators has been developed. Data gaps and potential research topics will also be communicated to the global health community.
CHAT in context: Theresa Diaz

Theresa Diaz presented a summary of CHAT’s role in global health context (slides available at https://www.dropbox.com/sh/hq6xmnbttbImgw5/AABguEoWd0zdyo_kWdrAOD2na?dl=0). She stressed the need to consider the demographics of, plus mortality and morbidity in, children aged 5-9 years. Information on morbidity (e.g. disease prevalence/incidence or injuries from road traffic accidents or drowning) and YLDs in children aged 1 month to 9 years will also be important. Data on coverage of service use/care, immunization, health service visits (by well and sick children) are needed: there should be an emphasis on improving HMIS in order to generate data for this age group.

Over the next 25 years, changes in the age distribution will result in the majority of children living in Africa and Southern Asia, while the proportion of older adults in the population will increase in the rest of the world. In HICs, the major causes of death in children aged 5-9 years are injuries and congenital abnormalities; and they are infections (especially HIV) and injuries in LMICs. The top five causes of morbidity in this age group are anaemia, congenital abnormalities, skin diseases, asthma and uncorrected vision problems.

Theresa Diaz showed a timeline of key global initiatives and events in maternal and newborn health. She suggested that a similar timeline could be created for childhood health initiatives. The CHAT group were enthusiastic about this idea and a consultant will be commissioned to create a timeline.

An overview of research papers and supplements that will be published in 2020 was presented. Background papers and summaries or copies of key papers, plus information on Countdown to 2030, will be placed in the CHAT Dropbox. There is an international drive towards improving the quality of the global health data that is collected and how it is analysed in a systematic way: CHAT can play a role in this initiative.
Effective coverage and quality of care: Melinda Munos

Melinda Munos provided an overview of her ongoing research into developing effective coverage cascades for the care of sick children (slides available at https://www.dropbox.com/sh/hq6xmnbbtBImgw5/AABguEoWDOzdoyo_kWdrAOd2na? dl=0 but they are not for distribution). The research objectives were to develop operational effective coverage cascades for selected service areas and countries; and to identify data gaps, methodological choices and challenges, and interpretation issues. This presentation focused on ‘malaria case management’ and ‘sick child care’ as examples of service areas.

A conceptual cascade of care was developed for both service areas. Available data and indicators were mapped along the cascade of care. Readiness and quality of care indices for malaria case management and sick child care were developed using recent SPA/SARA and DHS/MICS data from selected countries in various regions of the world. Obtaining sufficient high quality and comparable data from different countries was challenging and restricted the choice of countries for the research project. Ideally, a single data source would be used to track a child as he or she moved through the cascade of care. However, this was not feasible at the national level. It is possible that this process could be performed at the facility level provided the unit has good data collection methods and sufficient resources.

Constructing the cascade of care for both service areas has provided insights into the level of readiness to manage malaria cases and sick children. Significant service gaps and ‘bottlenecks’ were observed in certain countries. Determining the quality of care is a major challenge which can only be overcome if relevant and valid data are available. Interpreting the cascade of care for single illnesses may be more feasible than trying to interpret data for combinations of conditions or for the overall term of ‘sick child care’.
Next steps

**CHAT 2020 work plan**

Jennifer Requejo presented the proposed work plan for CHAT in 2020 (Figure 3, PowerPoint slides available in Dropbox). The mapping of the Global Accountability indicators (Phase 1) will be finalized and submitted to the Secretariat by the first week of February 2020. A manuscript will be drafted by the Secretariat by the third week of February and this will be reviewed by CHAT members (comments by first week of March). The manuscript will be finalised by the Secretariat and the co-chairs, and submitted to Lancet Child and Adolescent Health by the end of March. A separate piece on the research agenda will also be prepared.

*Figure 3: Proposed work plan for CHAT in 2020*

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<tr>
<td>■ Mapping of indicators</td>
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<td>- Phase 1: Global Accountability initiative indicators</td>
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<td>- Phase 2: Regional indicators</td>
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<td>■ Mapping of child health related initiatives</td>
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<td>■ Creation of repository for articles on child health and well-being</td>
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<td>■ Quality of care/effective coverage workstream for child health</td>
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<td>■ CHAT meeting in June/July</td>
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Phase 2 will focus on the preparation and validation of regional child health indicators. The Secretariat will develop terms of reference (TORs) by the end of December 2019 in order to identify a consultant who can do the initial mapping work. The consultant should be in place in mid-January 2020. The indicators would be reviewed by CHAT and the aim would be to develop a publication based on this work.

It was agreed that a repository of relevant publications would be helpful for CHAT’s work. One option would be for CHAT to hire a consultant to manage the repository and provide summaries of key papers. Another option would be to link to existing resources, such as the literature service provided by the Child Health Taskforce.

The creation of a quality of care group within CHAT was supported unanimously. CHAT members could volunteer to be part of this subgroup, which will liaise with the existing quality of care group in the WHO.

The next CHAT teleconference will take place in mid-late January 2020. A face to face meeting of CHAT will take place in June/July 2020 in New York, USA (dates and location TBD).

**Governance**

The CHAT governance documents were formally adopted by the group on 12 December 2019. The issue of rotating CHAT members and co-chairs in future years will have to be addressed.
Acknowledgements

The Secretariat thanked USAID for their support of CHAT's activities.
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