Report of the fifth meeting of the WHO Strategic and Technical Advisory Group of Experts for Maternal, Newborn, Child and Adolescent Health and Nutrition, 10-12 May 2022
Report of the fifth meeting of the WHO Strategic and Technical Advisory Group of Experts for Maternal, Newborn, Child and Adolescent Health and Nutrition, 10-12 May 2022
Abbreviations and acronyms .......................................................... vi
Executive summary ................................................................. vii
Background .................................................................................. 1
Opening session ............................................................................. 3
Updates from previous STAGE recommendations ....................... 5
  Kangaroo mother care: update on global position paper, implementation strategy and next steps .......................................................... 5
  Private sector engagement for delivering quality maternal, newborn, and child health services: update .......................................................... 7
Innovations in maternal health and scaling up for country impact ....... 9
Measuring the public health impact of adolescent health and well-being interventions .......................................................... 11
Supporting countries who are transitioning to midwifery models of care .......... 15
Summary of STAGE prioritization exercise .................................... 19
Closing session and next steps ....................................................... 21
Annexes ......................................................................................... 23
  Annex 1. STAGE meeting agenda .................................................. 23
  Annex 2. WHO progress report on STAGE recommendations from meetings held in November and April 2021 .................................................. 26
### Abbreviations and acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAP</td>
<td>American Academy Of Pediatrics</td>
</tr>
<tr>
<td>BMGF</td>
<td>Bill &amp; Melinda Gates Foundation</td>
</tr>
<tr>
<td>BMS</td>
<td>Breast Milk Substitutes</td>
</tr>
<tr>
<td>EPMM</td>
<td>Ending Preventable Maternal Mortality</td>
</tr>
<tr>
<td>ENAP</td>
<td>Every Newborn Action Plan</td>
</tr>
<tr>
<td>KMC</td>
<td>Kangaroo Mother Care</td>
</tr>
<tr>
<td>MNH</td>
<td>Maternal And Newborn Health</td>
</tr>
<tr>
<td>MNCAHN</td>
<td>Maternal, Newborn, Child And Adolescent Health And Nutrition</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, Newborn And Child Health</td>
</tr>
<tr>
<td>PSE</td>
<td>Private Sector Engagement</td>
</tr>
<tr>
<td>STAGE</td>
<td>Strategic And Technical Advisory Group Of Experts</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific And Cultural Organization</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Executive summary

The World Health Organization (WHO) convened the fifth meeting of the Strategic and Technical Advisory Group of Experts (STAGE) on a virtual platform on 10–12 May 2022. The meeting participants included 25 STAGE members who were joined by WHO staff at headquarters and regional offices, and 50 observers from partner organizations.

Following opening remarks by Dr Soumya Swaminathan, Chief Scientist, WHO, Dr Anshu Banerjee, Director, Maternal, Newborn, Child and Adolescent Health and Ageing (MCA), provided feedback on WHO activities in response to STAGE recommendations from the meetings convened in April and November 2021.

Professor Caroline Homer, Chair of STAGE, welcomed everyone and described the way in which the meeting had been planned. She highlighted that, this time, the co-chairs of the two workstreams along with select STAGE members provided inputs to the WHO technical teams while preparing the background for the new agenda items.

The WHO teams sought guidance from STAGE on the following issues: innovations in maternal health and scaling up for country impact; supporting countries who are transitioning to midwifery models of care; and assessing the impact across the life course of preventive adolescent health and well-being check-ups. In addition, updates were provided for two topics from previous meetings: kangaroo mother care: update on global position paper, implementation strategy and next steps; and private sector engagement for delivering quality maternal, newborn, and child health services.

Professor Homer provided a brief summary of the prioritization exercise with STAGE members. This had involved first shortlisting and then selecting five priority topics from 50 topics on maternal, newborn, child and adolescent health and nutrition (MNCAHN) related issues that WHO had received as part of an online survey. She highlighted that this survey was one method of identifying topics for STAGE, while WHO, STAGE members and partners were welcome to raise issues that they would like STAGE to discuss and to provide guidance on.

These topics were presented during the STAGE sessions, which were open to STAGE members, partners and observers. The guidance or recommendations were further refined during the closed sessions of STAGE members, which were held after each day’s meeting.

At the closing session, Dr Francesco Branca, Director, Nutrition and Food Safety (NFS), Dr Craig Lissner, Acting Director, Sexual Reproductive Health (SRH), and Dr Anshu Banerjee, Director, MCA, thanked STAGE for their guidance and assured continued updates to STAGE on topics relevant to their departments. Professor Homer thanked everyone, especially all the STAGE members and partners for their continued support.

The closed sessions of STAGE were used to refine the draft recommendations and to discuss next steps. The main recommendations of STAGE are summarized below. The full recommendations are given in the relevant sections of this report.

Innovations in maternal health and scaling up for country impact

- WHO to support countries to implement life-saving commodities to improve maternal and newborn health and well-being and reduce stillbirths.
- WHO will establish a working group under STAGE with key partners, professional organizations and other stakeholders, including country representation. The working group will identify life-saving maternal and newborn health commodities and will guide the development of an implementation strategy for scaling up across different country contexts as part of strengthening health systems in line with WHO recommendations.
- STAGE requests WHO to present at a subsequent meeting the full scope of the maternal and newborn health innovation pipeline for commodities/medicines/devices.
Assessing the impact across the life course of preventive adolescent health and well-being check-ups

- WHO identifies critical components and organizational models for adolescent health care to inform policy-makers, as part of the child health redesign agenda.
- WHO develops a conceptual framework and measures to assess the impact across the life course as well as the intergenerational impact of context-specific adolescent health and well-being preventive check-up visits.
- WHO develops an investment case that accounts for the life-course impact of preventive care in adolescence, and in particular of preventive well-adolescent visits.
- WHO makes every effort to expand the Y-check research program to all regions and use the Y-check and other similar context-specific implementation research programmes as an opportunity to validate the applicability of the conceptual framework, critical components and organizational models as recommended above.
- WHO updates the adolescent health research priorities 2015, including research priorities for preventive well-adolescent visits.

Supporting countries who are transitioning to midwifery models of care

- WHO to support countries that wish to transition to a collaborative midwifery model of care, requiring professional midwives, with policy advice and implementation guidance. This transition and the model of care will depend on the context of the country health system and should be aligned with integrated health workforce solutions.
- WHO to convene a STAGE working group, bringing together key stakeholders, ensuring midwifery representation to develop implementation guidance to support countries within 6–12 months of their transition (before, during and after) to a midwifery model of care, including collaborative teamwork, networks of care, leadership, and engagement of private and non-profit-making (3rd) sector.

The working group should also develop an agenda for evaluating the implementation of midwifery models of care in different country health systems.
- STAGE endorses the WHO community of practice platform to establish a continued learning agenda on transitioning to midwifery models of care, which links to ending preventable maternal mortality (EPMM)/Every Newborn Action Plan (ENAP) and other global programmes.

In terms of next steps, Professor Homer reminded the group that STAGE will work within two broad workstreams – the Evidence and Guidelines for Impact, and Health Systems for Impact. Each workstream is led by two co-chairs and they will co-opt STAGE members as required for discussions on topics for the STAGE meetings. Various working groups with or without external experts may be formed under these workstreams and will report back to STAGE at subsequent meetings.
Background

The WHO departments of Maternal, Newborn, Child and Adolescent Health and Ageing (MCA), Nutrition and Food Safety (NFS) and Sexual and Reproductive Health (SRH) convened the STAGE for its fifth meeting, which was held on a virtual platform from 10 to 12 May 2022. During the three days, 25 of the 31 STAGE members were joined by WHO staff at headquarters and regional offices, and 50 participants from partner organizations as observers.

From January 2022, discussions were held within the WHO Secretariat to identify potential topics for this meeting. These were then discussed internally, and the technical teams developed concept notes. The WHO technical teams presented and discussed their topics with a smaller group of STAGE members, comprising STAGE chair, co-chairs of the two workstreams – Evidence and Guidelines for Impact (EGI) and Health Systems for Impact (HSI) – and a few STAGE members who were co-opted based on their topic expertise. This subgroup provided detailed comments to WHO technical leads through a series of meetings to enable them to clarify their presentations and questions to STAGE. Draft recommendations for each topic (maternal health innovations; midwifery models of care; and measuring impact of adolescent health well-being interventions) were then developed by the STAGE subgroup for presentation to STAGE. In addition to the three new topics, updates on two topics – kangaroo mother care (KMC) and private sector engagement – were also developed as agenda topics for the STAGE meeting.

The agenda items for the meeting were finalized in discussion with the STAGE Chair (Annex 1). WHO technical leads prepared presentations for each of the selected topics and organized the background documents for guidance from the STAGE. All background documents including specific questions for the STAGE members were sent to STAGE members one week prior to the meeting. During the open sessions, WHO technical leads made presentations that included the specific questions for guidance from STAGE. A STAGE member from the respective subgroup presented the draft recommendations for discussion with STAGE members, representatives of WHO regional offices, United Nations (UN) partners and participants. The guidance or recommendations were revised based on these discussions and then refined further based on comments and discussions during the closed sessions of STAGE members at the end of each day.

All 25 STAGE members attending the meeting confirmed that they had no significant changes in their declarations of interest. One member had a potential conflict with one of the agenda topics, as she was also on the team developing part of the documents. She did not participate in the discussion of this topic other than to provide clarifications when required.
Dr Soumya Swaminathan, WHO Chief Scientist, opened the meeting. She welcomed the STAGE members and partners to the fifth meeting of the STAGE and conveyed her pleasure to be part of the meeting, as she was much involved in the setting up of STAGE. She underscored the continued impact of the COVID-19 pandemic on mothers and children, and she hoped that the lessons learned along the way will help us do things differently and will prepare us better for future crises. She thanked members for the useful recommendations that ranged from specific interventions like kangaroo mother care, possible and severe bacterial infections to broader issues like private sector engagement and the maternal and child health redesign. She highlighted the role of the Science Division that helps to improve coordination both in house and externally to build more efficient responses, while also using lessons learnt to better use technology and research and development to identify gaps in health products and efficiently use digital tools to reach the unreachable populations. She also referred to the smart guidelines that WHO is developing, which make it more dynamic, as the living approach uses emerging evidence to update specific recommendations. She reiterated the support of the Science Division for the work done by STAGE and highlighted the need to bring more innovations into the field to support countries that are in greatest need. She also highlighted the five priorities for the Director-General for the next five years: healthy lives and well-being; universal health coverage; learning from the pandemic to prepare for the future; strengthening research, data, innovations and digital health; and strengthening WHO itself. She thanked Professor Homer for her support and reiterated the support of the Science Division for STAGE.

Professor Caroline Homer, STAGE Chair, thanked Dr Swaminathan for her remarks and especially for the support from the Science Division, and she echoed the welcome to STAGE members and partners in the virtual space. She reminded everyone of the continued struggle with the pandemic and the added insecurity (human and food) caused by the war, making these last two years unlike any others in the recent past.

She described the way in which the meeting had been planned, with a smaller group of STAGE members, including the co-chairs of the two workstreams – EGI and HSI – and a few who were co-opted based on their topic expertise, forming the core groups to provide inputs to the WHO technical teams. This subgroup, through a series of meetings during March and April 2022, helped the technical teams to develop the questions for STAGE and also drafted the recommendations for each topic to be presented to STAGE. She also referred to her meeting with the Director-General in February to debrief him on the STAGE recommendations from the November 2021 meeting. She then listed the topics that would be presented during this meeting, starting with the update from the KMC on the global position paper and implementation strategy, which were part of STAGE recommendations from April 2021, followed by another brief update from private sector engagement as requested by STAGE, also from April 2021. Day 2 of the meeting would include a presentation on innovations in maternal health followed by a presentation on measurement of impact of adolescent health well-being interventions. The last day would have a presentation on midwifery models of care followed by her presentation on the prioritization exercise that STAGE did to identify priority topics for the next few years.

She then invited the Director of MCA Dr Anshu Banerjee to summarize WHO’s work in following up on the recommendations made by STAGE at its previous meetings.

Dr Banerjee requested that, although all members at the meeting had confirmed they had no significant conflict of interest, they identify any conflicts prior to any of the sessions at the meeting.
With regard to updates, he mentioned that the detailed progress report would be attached to the STAGE report (Annex 2). He started by reminding everyone about the four topics that were presented at the November 2021 meeting:
1. Outpatient management of possible severe bacterial infections (PSBI); 2. the Global Action Plan for Anaemia; 3. Post neonatal mortality as part of maternal and child health redesign; and 4. Improving breastfeeding and mitigating the impact of marketing of breast milk substitutes.

In response to the three recommendations on PSBI, he mentioned that the guidelines on PSBI management are being updated and are expected to be completed by end of this year. The KMC working group that was formed earlier will transition into the PSBI working group as recommended and will focus on prevention and management strategies for PSBI. Discussions are underway with donors and partners regarding the third recommendation on need for investments in research and innovation.

In response to recommendations on the Global Action Plan for Anaemia, WHO is working on a comprehensive plan that will cover mothers, children and adolescents. A working group as recommended is being finalized.

With regard to post neonatal mortality, WHO established a risk stratification working group, which is conducting data analysis of risk factors for childhood mortality and wasting. Various technical consultations and national and regional workshops are being planned. To enable identification of households at risk, a microplanning tool is being developed that is similar to the reach every district microplanning tool developed by the immunization group.

The issues of breastfeeding and regulating the marketing of breast milk substitutes (BMS) were raised at the Global Nutrition for Growth Summit in December 2021, and commitments were made by various countries. In addition, WHO has a series of papers that are expected to be published in the *Lancet*. Various research papers relating to contextual factors already exist, and social media is also being used to highlight the impact of marketing of BMS. A study from eight countries along with a report on digital marketing was released; however, lack of sustained funding remains an issue.

Work on recommendations from April 2021 and prior meetings continues. It includes updating of guidelines, a scientific brief on sexual reproductive health needs during COVID-19, 40 case studies highlighting responses by various governments, and collation of lessons learned by 15 countries. In addition, tools to assess the quality of digital health interactions between health workers and parents/caregivers are being developed.

The recommendations for KMC included the development of a global position paper on KMC and implementation guidance, which has been completed; an update would be presented at this meeting. Similarly, an update on the work undertaken under private sector engagement for maternal and child health would be presented later at the meeting.

Recommendations relating to the maternal child health redesign were being addressed by: 1) the framework publication *Investing in our future: A comprehensive agenda for the health and well-being of children and adolescents*, which was published in November 2021; 2) a technical consultation on a number of contacts and a package of interventions to support well child and adolescent health and well-being programming, which was completed in 2021; 3) WHO being part of the technical advisory group for the next global status report on school health and nutrition; 4) WHO, jointly with the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the United Nations Children’s Fund (UNICEF), developing a web platform to support the monitoring of the status of school health in countries; 5) a technical consultation on maternal health well-being being planned for later in the year.
Updates from previous STAGE recommendations

Kangaroo mother care: update on global position paper, implementation strategy and next steps

Background

This session was designed to provide a detailed update on the recommendations from STAGE that had requested the formation of a working group to develop a global position paper and an implementation strategy for the kangaroo mother care (KMC) model. On behalf of the working group, co-chairs Dr Gary Darmstadt and Professor Betty Kirkwood provided a brief update on the global position paper and implementation strategy.

STAGE in one of its previous meetings (April 2021) recommended that a working group be constituted on KMC to facilitate consensus and buy-in on implementation strategies so that all governments and partners can act in a harmonized way to maximize impact. The terms of reference were to produce three outputs:

- a global position paper on KMC summarizing the evidence and strategies for implementing KMC;
- KMC implementation guidance covering different levels of health services adaptable to different country contexts based on systematic reviews of experience of scale-up and integrating effective strategies into maternal and newborn health (MNH) programmes; and
- recommendations for a continued learning process while integrating KMC with other key newborn care interventions within routine health systems at scale.

The working group had wide representation from STAGE members, country programme managers, UN agencies, bilateral development agencies, donor agencies, professional bodies, parents groups and experts. The group had held several virtual meetings to build consensus on a process for developing deliverables, to draft the paper and to develop the implementation strategy. The current draft versions were shared with STAGE members for their inputs.

The next steps for the working group are to finalize the global position paper and implementation strategy, disseminate these widely, prepare additional outputs (KMC practice guide and multimedia communication strategy) and develop recommendations for a continued learning process. Inputs from partners were also solicited.

Discussion

The discussion among STAGE members focused on the need for guidelines, integrating KMC into routine care and improving health infrastructure. Members highlighted the need to consider the mother–newborn dyad and embed KMC into routine care; measure, while linking, individual-level data; and integrate at country level. The need to include midwives and other frontline staff for continuity of care was also suggested. One of the members highlighted the need to be specific on how this would be different from what was introduced earlier (2013 document on “consensus on KMC acceleration”) and the need to identify unique elements in this case study of KMC that will ensure this process is likely to work, for example, that some pilot case studies would be needed to ensure there is acceptance among the health workers and the community. Members also reiterated the need to consider the additional resources and health systems capacity required for scale-up and also to make a case for investment for improving MNH care in both high- and low-income countries.

WHO regional offices also supported the need to embed KMC into routine newborn care to get more political support in countries. The role of professional associations, universities and academia was also highlighted, as there was an urgent need to review and include KMC in pre-service education, in-service training manuals etc. Members thought implementation guidance would be important for countries.
Partners reiterated the need to put the mother at the centre of the intervention, to make maternal and neonatal mortality as indicators of society, and to have politicians on board to invest in the health sector. Some discussed the need for dissemination strategies, for example, 3–4-minute, high-quality videos with infographics and mothers who have given KMC in different cultural contexts. Partnership for maternal, newborn and child health (PMNCH) indicated its support for the development of such infographics and a social media toolkit for KMC advocacy in support of the implementation guide. Others suggested to develop a webinar on KMC with the leaders of health care professional organisations. Blogs like “The Conversation” along with regional workshops/webinars would be useful.

One of the partners suggested that a spectrum of solutions should be presented for MNH care as we simultaneously push for appropriate funding for the full investment case and build environment and community demand. Some partners provided examples of successful KMC models: British Columbia University Hospital of Vancouver and Madrid have changed their units to ensure non-separation. The Karolinska Institute in Sweden has long experience of KMC at level 4, including of iKMC. The Bill & Melinda Gates Foundation (BMGF) has made investments in MASS (Model of Architecture Serving Society) Design Group and the Institute of Healthcare Improvement to develop model architectural templates for improved maternal and newborn care, including KMC and fostering zero separation. Others highlighted the need to introduce KMC in the neonatal unit as a policy decision, starting with the provision of comfortable chairs to allow mothers to stay as long as possible and ensure clean water and food. However, ensuring the infrastructure requirements for companionship during labour and birth has been really difficult, so there was apprehension that iKMC may encounter similar issues. An example of success is the recent initiative in India to improve quality of care in public child health care facilities – Musqan – that has introduced KMC to eligible neonates as an essential indicator for achieving standards for quality certification of the facility. The consensus was that there is need for a whole systems approach, not just single building blocks.

In response to the various queries, comments and suggestions, the WHO team and STAGE working group co-chairs acknowledged the need for massive work to bring about the proposed transformation in newborn care. The new evidence supports that KMC ought to happen everywhere – immediately after birth, continued in intensive care settings and continued into the community. This calls for a huge change, analogous to oral rehydration salts (ORS) in the management of diarrhoea, which will require partners and professional associations coming together with new investments, and with government support.

Dr Rajiv Bahl clarified that the new guidelines on KMC have already been developed and are currently in the process of approval by the Guidelines Review Committee and expected to be published in a couple of months. He also mentioned that pilot studies will be initiated in seven districts of four countries. Janna Patterson announced that the American Academy of Pediatrics is hosting a town hall and will work with professional bodies to popularize the evidence of effectiveness of KMC.

Professor Kirkwood highlighted the need for a sophisticated dissemination strategy, and she requested support from all partners for this. Members agreed that political economy factors for success such as political priority, a common definition, consensus on narrative, and getting all stakeholders involved are all critical factors for transformative change.

The discussions in the closed session focused further on the need for an integrated approach for KMC implementation by bringing funders and key stakeholders together to make this transformation in newborn care. The importance of governance and accountability was highlighted, as these would impact implementation (as was demonstrated in the implementation studies). STAGE members also emphasized the need for WHO to take the leadership role in KMC implementation. However, caution was also raised to ensure there are resources available within WHO to take on additional responsibilities, and STAGE can help to prioritize what is important for WHO.
Private sector engagement for delivering quality maternal, newborn, and child health services: update

Background

During its April 2021 meeting, STAGE had recommended to WHO that a working group be formed for private sector engagement (PSE) work on maternal, newborn and child health (MNCH) services and updates of the work be presented to STAGE.

Dr Blerta Maliqi, MCA/WHO, provided a brief first update on the various activities that had been started as part of this work and focused on:

- PSE for MNCH working group (part of the PSE for Universal Health Care (UHC) Connector)
- knowledge base development
- engaging with countries
- ideas for next steps.

The PSE for MNCH working group (WG) was launched on 8 December 2021, includes over 21 partners (country representatives, private sector representatives, consumer and community groups, professional associations, bilateral and multilateral organizations, UN agencies, donors, and academia/experts) and sits within the WHO’s Country Connector. The WG has agreed to pursue three strategic objectives: partnership, learning and best practices, and implementation support.

As part of knowledge base development, a scoping review was conducted to identify different mechanisms for engaging the private sector to deliver MNCH services and their relation to the six private sector governance behaviours. These mechanisms are expected to inform country-level implementation as well as issues of equity.

In terms of engaging with countries and implementers, informative policy dialogues on PSE to deliver quality of care for MNCH in Ghana and Nigeria contributed to the development of new guidance on conducting dialogues to engage the private sector in quality of care using MNCH as an entry point. WHO expects to take this work forward in five countries.

The next steps will involve strengthening of the WG and its contribution to the Country Connector; working with partners and country teams to learn from implementation; continuing to build the knowledge and evidence base; and potentially involving STAGE in identifying some of the gaps. In addition, the group will focus on advocating for and identifying additional resources to support the WG for the next 3–5 years.

The discussion was very brief. One of the STAGE members enquiring about the role of faith-based organizations. Dr Maliqi shared the example from Ghana, where the Ministry of Health has a special relationship with the Christian Health Association of Ghana to deliver services to underserved communities. The session concluded with the understanding that WHO will continue to provide updates to STAGE as required.
Innovations in maternal health and scaling up for country impact

Background

Dr Allisyn Moran, MCA/WHO, in her presentation on “Innovations in maternal health and scaling up for country impact” provided context and positioned innovations and commodities in an effort to eliminate preventable maternal mortality and to improve maternal and perinatal health and well-being. The levels of maternal and newborn mortality, morbidity and stillbirths continue to be unacceptable, with 800 maternal deaths, 5400 stillbirths, and 6500 neonatal deaths occurring each day. Reduced mortality and improved health and well-being depend on several factors, including eco-social determinants, family, individual and biomedical factors, biomedical conditions and the health system. The presentation highlighted that commodities can greatly contribute to reducing mortality and improving health and well-being. In this context, WHO established a living guideline system that monitors the scientific literature and provides up-to-date recommendations to prevent and treat leading biomedical causes of maternal mortality.

The UN Commission on Life-Saving Commodities for Women and Children highlighted the importance of critical medicines and devices, including oxytocin, misoprostol, and magnesium sulfate. Since 2012, WHO has recommended a set of other commodities in addition to those noted by the UN Commodities Commission. Nevertheless, implementation at the country level has varied for many reasons.

WHO currently recommends oxytocin, heat-stable carbetocin, ergometrine, misoprostol, tranexamic acid, and non-pneumatic antishock garments for postpartum haemorrhage, and calcium and aspirin, antihypertensive drugs and magnesium sulfate for pre-eclampsia/eclampsia. Each of these commodities has a specific clinical indication; some are on national policy or essential medicine lists; and all have implementation issues and bottlenecks. For this presentation, heat-stable carbetocin, calcium and aspirin were chosen as examples. When the UN Commodities Commission met, these three commodities were not part of the WHO recommendations. Each has the potential to save lives but is not always available at the national level.

It was proposed that WHO should build on the UN Commodities Commission’s work to prioritize commodities for country impact. It will be important to assess barriers/bottlenecks and develop solutions, assess ongoing initiatives and programmes, and support countries in large-scale implementation with partners. The presentation ended with a final remark on the importance of assessing the pipeline for new commodities, drugs, devices and medicines, and that this initiative could help direct research and development efforts towards reducing maternal mortality and improving well-being.

Professor Sir Sabaratnam Arulkumaran presented the draft recommendations and then Professor Homer opened the session for inputs from STAGE members, WHO regional offices, and partners.

Discussion

STAGE members were appreciative of this effort to highlight commodities that, though essential and available, are not always available at scale as part of health systems in many countries. The fact that there has not been much progress in developing new medicines for maternal health in recent years was highlighted, partly due to the exclusion of pregnant women from clinical research studies. One of the members mentioned that Stanford University is leading an initiative to scale up aspirin use during pregnancy to prevent pre-eclampsia and preterm birth among high-risk women statewide. The BMGF recently awarded a grant to three countries for calcium and aspirin implementation research.

The role of omics and artificial intelligence (AI) was also presented by other members who suggested that AI will soon inform new diagnostics and therapeutics for pre-eclampsia, preterm birth and newborn conditions, transforming the ability to predict, diagnose and, ultimately, use in therapeutics.
Another member mentioned that for interventions on pre-eclampsia, there is a clear link to early newborn deaths and stillbirths and suggested that, along with estimates of maternal lives saved, it is important to consider, when applicable, estimates of the impact on stillbirths and on newborns.

In terms of implementation, many members highlighted the need to consider country context (heterogeneity of countries); the levels of care, availability, and quality of products; supply chain; the parts of the health system that would be affected by the implementation of the commodities; the type of personnel required to deliver them; and provider reluctance. Some members provided examples of hospitals with ample availability of recommended commodities but health providers who do not always follow treatment protocols. To improve quality of care and increase uptake of these commodities, the importance of involving multiple stakeholders was emphasized. These include obstetric and midwifery professional associations; pharmacy advisory committees; therapeutic regulatory agencies; and pre-service training institutions. In addition to pharmaceuticals, it would be useful to consider nutrition products and other supplies needed for providing basic care, including baby weighing scales.

Understanding demand for commodities and how it is linked to respectful care, for example, availability of basic necessities such as water and sanitation facilities, is important. Commodities are essential but not sufficient to achieve impact at scale, so besides increased attention to these, other implementation challenges going forward will need to be overcome for the provision of commodities to translate into impact, especially among women who are disproportionally at risk.

Another area to be considered is the possible interaction between certain commodities and multiple micronutrient supplementations, particularly a possible interaction between iron supplementation among non-anaemic women and the risk for pre-eclampsia.

Members agreed that the creation of an innovation working group would be useful, which would include members with varied expertise who will consider commodities and the challenges of implementation at country level.

In response, the WHO teams thanked all STAGE members and meeting participants for the rich discussion and noted that all suggestions would be considered, especially during the formation and then the deliberations of the working group.

Following the main open session, a closed session with the participation of STAGE members was held to refine the draft recommendations. Several of the members reiterated their comments, including the importance of the topic, the need to build on the previous UN Commodities Commission efforts, the need to consider barriers and bottlenecks and to estimate the impact of their implementation at the country level for selecting the commodities that would be prioritized. The group finalized the recommendations and decided that the working group will define the scope of work for the group.

**STAGE recommendations:**

1. WHO to support countries to scale up life-saving commodities to improve maternal and newborn health and wellbeing and reduce stillbirths.

2. WHO to establish a working group under STAGE with key partners, professional organizations and other stakeholders, including country representation. The working group will identify life-saving maternal and newborn health commodities and will guide the development of an implementation strategy for scaling up across different country contexts as part of strengthening health systems in line with WHO recommendations.

3. STAGE requests WHO to present at a subsequent meeting the full scope of the maternal and newborn health innovation pipeline for commodities/medicines/devices to improve maternal and newborn health and well-being and reduce stillbirths.
Measuring the public health impact of adolescent health and well-being interventions

Background

Dr Valentina Baltag, MCA/WHO, provided a brief presentation on “Assessing the impact across the life course of preventive adolescent health and well-being check-ups”. The presentation outlined that adolescence provided a critical opportunity to intervene, and that previously WHO articulated, and STAGE endorsed, the need to establish well-child and adolescent visits beyond established postnatal and vaccination visits and school entry check-ups. However, to date, there is little evidence on the impact of preventive visits in children and adolescents, which raises important conceptual, methodological and measurement challenges.

One of the major challenges is the difficulty of measuring the impact of preventive visits, for various reasons, for example long time periods between exposure to the preventive intervention and occurrence of the potential manifestation of a disease such as a noncommunicable disease. Furthermore, definitions of what impact might mean can vary. For example, in the new adolescent well-being framework that consists of five domains (good health and nutrition; connectedness, positive values and contribution to society; safety and a supportive environment; learning, competence, education, skills and employability; agency and resilience) the definition of impact might be different depending on the sector/domain perspective. The presentation also outlined that an evidence base needs to be built to convince policy makers and donors to invest in preventive adolescent visits.

The MCA/WHO-led Y-check project was presented as an example of building the evidence base for adolescent check-up visits. It is a research programme implemented in Ghana, the United Republic of Tanzania and Zimbabwe that aims at evaluating the success of check-up visits with referral if indicated. The programme is provided to children aged 10–12 and 16–17 years in schools and communities, and it screens for high burden conditions. The project has three phases: Phase 1 was completed in 2019 and was formative research to assess acceptability and perceived feasibility; Phase 2 is ongoing and is an evaluation of the population-based coverage of check-ups that can be achieved in a routinely delivered programme, their cost and health impact; and Phase 3 is under planning.

The presentation ended with two questions to STAGE on how to:

• develop a conceptual framework and measures to assess the impact of adolescent health and well-being preventive check-up visits across the life course; and

• continue to work on identifying critical components and organizational models for well-adolescent visits to inform policy-makers, as part of the child health redesign agenda.

Based on the discussions in the STAGE subgroup, Dr Caroline Kabiru presented the draft recommendations to STAGE and Dr Homer opened up the session for discussion.

Discussion

The STAGE members appreciated the focus on adolescent health and especially on the need to develop a framework to enable better measurement of the impact of preventive and well-being interventions on adolescent health. Members reiterated the difficulty in measuring the impact of preventive interventions and highlighted the need to include the influence of media and social media. Many members indicated that a life-course perspective should be taken, including also looking at pre-adolescents and at what has happened before the age of 10 years in terms of development, provided this influences adolescence. One member indicated the need to include the importance of the connectedness domain in the well-being framework, including support from parents and the need to engage them. Many members indicated the need for engaging adolescents and young
people in the process of developing the framework. Another member suggested that there should also be a training component (potentially involving a multidisciplinary team) in the framework and an investment case.

In terms of well-being check-ups, while schools might serve as an entry point for preventive adolescent health visits, several members highlighted the need to include both adolescents at school as well as those out of school, and therefore deliver check-ups at school and in the community (and potentially also in churches and mosques). There should also be a focus on how the adolescent health care system functions and its building blocks, including screening, diagnosis, referral, treatment, since there is a lot of so-called unfinished work. In doing so, attention should be put on what has been learned in the past regarding delivery of health care to adolescents, with special attention to their potential preference of doing digital rather than face-to-face health visits.

In terms of measurement, it was suggested that efforts should always make direct links between inputs/processes, outputs, outcomes and impact. Others highlighted the need to ensure that most vulnerable population groups are included (and that this is measured specifically), even if overall coverage might seem to improve. It was also suggested that measurement efforts should build on existing work, including on instruments such as the Measurement of Mental Health Among Adolescents at the Population Level (MMAP).

Discussion on the Y-check project led to several suggestions:

- The Y-check project should consider the ‘3Ds’ (data, devices, digital) and the recommendations should be linked back to efforts undertaken as part of the child health redesign and the continuum of care to clarify how much of the Y-check research focuses on mental vs physical health.
- The project should be implemented more broadly globally, not only in African countries.
- The project should be context-specific, including, for example, in terms of advising adolescents.
- Some research results could be modelled to see what might be achieved; this would make it easier to provide recommendations.
- The research should focus on well-being more broadly rather than just health and should consider programmes to promote empowerment, especially for vulnerable adolescents.
- More information on the methodology and the different steps of the Y-check project should be provided.

Other meeting participants supported the comments made by STAGE members and added that, for greater impact on adolescent health and well-being, the collaboration between the health and education sectors needs to be institutionalized; contextual factors of adolescents, such as education, relationships with parents, peer influence, influence from teachers, and also digitalization, need to be considered and further studied; and the relationship between the provider and the young person needs to be considered carefully to ensure uptake of the services.

Many partners suggested that the Y-check project should be placed firmly within the WHO’s universal health coverage agenda. The WHO regional office team highlighted that, potentially due to an overload on initiatives, uptake of adolescent health interventions in countries is slower than update of interventions for younger children. Therefore, it will be important to go step by step and not overwhelm countries. It will also be important to work out the immediate impact of adolescent check-ups, for example on potential reduction of violence.

The technical team (including a STAGE member) provided some remarks and responses. The team also informed everyone that the Global Accelerated Action for the Health of Adolescents (AA-HA!) is currently being updated and broadened in scope to include all aspects of well-being; 67 countries are already doing routine adolescent check-ups, but these are not consistent. Often, they are only a battery of measurements with no consultation between a health care provider and the adolescent.
In terms of the Y-check project, the team said that Phase 2 has just started, and that training is an integral part of the Y-check study. The conditions that are screened for in the Y-check study are those for which concrete interventions exist, and the screening includes preventive measures but also conditions needing treatment. In the three participating countries of the Y-check study, a large proportion of adolescents is not in school and, therefore, delivering the health and well-being check-ups in the community setting alongside the school setting is very important. The Y-check study in Zimbabwe seeks the engagement of young people and various ministries as much as possible. A digital health club to facilitate the link between young people and health information will also be piloted in the Y-check study. The Y-check implementation research will also analyse adolescent and provider experiences of the check-up.

The team highlighted that given that many measures of adolescent health and well-being outcomes have not been previously validated, what is needed most is to convince relevant stakeholders that check-ups during adolescence are necessary. An investment case is needed, particularly for countries that are not doing anything yet. They acknowledged that, in many settings, there is currently little investment in the broader ecosystem of adolescent health and well-being. A link with wider health systems strengthening will be made, including strengthening of digital systems, linking with school health services, and making efforts to include all adolescents. In the context of the child health redesign, development of guidance for well-childcare contacts is on the agenda, and the work will build on the Y-check project and learn from it. The primary request from STAGE was for general support for an adolescent health check-up visit.

Following the main open session, a closed session with participation of STAGE members was held to refine the recommendations.

WHO and STAGE have recommended establishing well-child and well-adolescent visits to provide systemic and systematic opportunities to address health and well-being, provide anticipatory guidance on developmental transitions and age-specific needs, and ensure timely interventions to address both conspicuous health problems and additional needs for adolescents, including those who are the most marginalized and the most disadvantaged, and at the greatest health risk.

STAGE recommendations:

STAGE recommends therefore that, in collaboration with partners including adolescents and young people, parents/guardians, and schools:

1. WHO identifies critical components and organizational models for adolescent health care (including well-adolescent visits and school health services) to inform policy makers, as part of the child health redesign agenda;

2. WHO develops a conceptual framework and measures to assess the impact across the life course as well as the intergenerational impact of context-specific adolescent health and well-being preventive check-up visits;

3. WHO develops an investment case that accounts for the life-course impact of preventive care in adolescence, and in particular of preventive well-adolescent visits;

4. WHO makes every effort to expand the Y-check research programme to all regions and uses the Y-check and other similar context-specific implementation research programmes as an opportunity to validate the applicability of the conceptual framework, critical components and organizational models as recommended above; and

5. WHO updates the adolescent health research priorities 2015, including research priorities for preventive well-adolescent visits.
Supporting countries who are transitioning to midwifery models of care

Professor Homer welcomed everyone to the last day of the STAGE meetings and thanked them for their contributions. She wished everyone a happy International Nurses Day while reminding everyone of the key role nurses play in the delivery of health care. She introduced the topic of the day, which focused on midwifery models of care, and stated that – as a trained midwife – this topic was close to her heart but that there was no conflict of interest, as her expertise in the topic enabled her to contribute to the discussions like other experts who contribute to their areas of expertise. Therefore, with that acknowledgement, she continued to chair this session and invited Ms Fran McConville to present the topic to STAGE.

Background

Ms Fran McConville, MCA/WHO, provided a summary of the work done and emphasized the need for WHO to support countries who are already transitioning to midwifery models of care. The presentation outlined the ongoing burden on maternal and newborn mortality and stillbirths. WHO currently recommends that all births are assisted by skilled health personnel to improve outcomes. Most countries use a mix of multiple providers for maternal and newborn care, including obstetricians and gynaecologists, nurses, nurse midwives, midwives, and others (State of the World’s Midwifery 2021). This often results in poor quality, discontinuous routine care by multiple providers with varying competencies, and inadequate links with the broader health system, communities, and families. To improve skilled care during pregnancy and childbirth and for the newborn, many countries have made the policy decision to transition to a midwifery model of care as part of an integrated health workforce solution.

All countries in the WHO South-East Asia Region except Thailand decided to make this shift, which involves development of a cadre of professional midwives. Ms McConville provided examples of various countries that are on this path, but at various stages. This policy decision includes the development of a professional midwife cadre, distinct from a cadre of nurses. Transitioning to a midwifery model of care refers to the process through which countries transition over time from no midwives to well-functioning systems in which midwives are educated, regulated and work within an enabling policy health system environment, in line with recommendations from the WHO Strategic Directions for Nursing and Midwifery and the State of the World’s Midwifery 2021.

She also presented some of the current challenges in education/training (lack of international standards, lack of clinical mentorship), environment (lack of support at the heath system level), support (gendered hierarchies), and finances (low wages) that hinder midwives in their day-to-day work (Midwives voices, Midwives realities, WHO 2016).

Midwives can provide over 80% of skilled care during pregnancy and childbirth, and a recent modelling exercise demonstrated that a substantial increase in coverage of midwife-delivered interventions (25% increase every five years to 2035) could avert 40% of maternal and newborn deaths and 26% of stillbirths (Nove et al., 2021). However, the 2021 State of the World’s Midwifery report estimated a global shortage of 900,000 midwives. Evidence also indicates that care provided by midwives improves outcomes, reduces unnecessary medical interventions and increases satisfaction. A model of midwife-led continuity of care in four high-income countries (Australia, Canada, Ireland, The United Kingdom of Great Britain and Northern Ireland) was associated with reduced preterm birth, reduced fetal loss, fewer neonatal deaths, fewer episiotomies, and reduced caesarean section rates but higher rates of satisfaction (Sandall et al., 2016).
The Consortium on Safe Labour studies (United States of America) confirms that midwifery practice in a labour and birth setting is associated with positive outcomes. Having a midwife during labour and birth was associated with lower rates of interventions (episiotomy, induction) and higher rates of spontaneous vaginal births. Women in settings without midwives had increased rates of caesarean births, compared to women who gave birth in settings where midwives practice (King et al., 2020).

In a randomised controlled trial in China, a model of care was implemented in which received routine antenatal care from a named midwife who also provided continuous one-to-one labour care. Women in this intervention group were more likely to have a vaginal birth, higher satisfaction and less anxiety compared with women who received antenatal care from several different providers including obstetricians and nurses (Gu et al., 2013). In another trial in Mexico, rural health clinics that added a midwife or an obstetric nurse had an increased update of favourable practices, reduced harmful practices, and increased numbers of women attending for antenatal visits, compared with health clinics with a physician-led model of obstetric care (Walker et al 2013).

Ms McConville then highlighted the current WHO recommendations: “Midwife-led continuity-of-care models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for pregnant woman in settings with well-functioning midwifery programmes.” (Context-specific recommendation, 2016 ANC, 2022 PNC).

WHO currently maintains a community of practice (CoP) for nursing and midwifery. The CoP is a dedicated place for all agencies and stakeholders to meeting and a mechanism through which countries can find and receive information and provides a platform for a shared learning agenda. The CoP was launched in early May by Dr Tedros, and there are already over 2000 members with an ambitious target to reach 10 000 by the end of the year and 1 million in 5 years’ time.

Ms McConville ended her presentation with three questions to STAGE:

1. How can WHO most effectively support countries that have made a policy decision to transition to midwifery models of care, aligned with integrated health workforce solutions? Many countries are asking for support and there is no structured and comprehensive process.

2. What is the best mechanism for WHO to be most effectively supporting countries and who should be engaged?

3. How can WHO support a learning agenda around midwifery models of care, make this a global topic and through which platforms?

Dr Jane Sandall, STAGE member, presented the draft recommendations developed by the subgroup of STAGE members and then Professor Homer opened the meeting for discussion.

Discussion

STAGE members congratulated MCA/WHO on an important presentation that highlighted the role of midwives and the need to support countries who have made a policy decision to transition to a midwifery model of care within an integrated health workforce solution. Most members broadly endorsed the recommendations, with additional remarks/considerations. They highlighted the importance of midwives working collaboratively in a team of providers that includes obstetricians, nurses, etc. to address continuity of care for women and newborn and to prevent stillbirths. It will be important to manage power dynamics and promote collaboration across cadres. Most agreed that country context was essential at all stages of the transition, with buy-in from governments to ensure that the policy and legal environments would support and enable midwives to perform within their scope of practice. Similarly, support of the professional associations was also mentioned as an important factor, both for training and for employment opportunities.

Some members also suggested the need to include the voice of midwives and women in the development of implementation strategies, while also highlighting the importance of rigorous evaluation of different models for continued learning across contexts. Community of practice for nursing and midwifery is a great initiative, and members felt it could potentially be used to train
a resource base to support countries along the transition process and planning. Members agreed that the working group could focus on many of these areas, especially the continuity of care that is provided by midwives, before, during and after delivery, and also on training models, regulations and legal frameworks.

Members from the WHO regional offices reiterated many of the issues around the need for a collaborative approach, need for regulations and need for improved training platforms that offer practical training along with theoretical knowledge. Members from the Health workforce team highlighted the importance of an integrated health workforce and mentioned that they generally do not focus on a single cadre but the health workforce as a whole that deliver services. They supported the collaborative models of care that many STAGE members mentioned, which will ensure that midwives are part of a team and are adequately supported and empowered through education and through regulation.

Partners also reiterated some of the issues, and one of them suggested that networks of care support a collaborative practice and can be an approach to support the transition to midwifery models of care. A partner also suggested the possible linkages with the World Bank and Global Financing Facility that could support countries with funding for midwives training and employment opportunities. In addition, bringing in private practice with free groups that are self-sustaining through fee-for-service models, similar to that which exists for physicians, may also be explored.

The WHO team thanked the members and others for their inputs and agreed with most of the suggestions, many of which were already reflected in the draft recommendations, which would be refined further to reflect many of these comments.

The STAGE recommendations were finalized based on the inputs from the discussion in the open and closed sessions:

**STAGE recommendations:**

1. WHO to support countries that wish to transition to a collaborative midwifery model of care, requiring professional midwives, with policy advice and implementation guidance. This transition and the model of care will depend on the context of the country health system and should be aligned with integrated health workforce solutions.

2. In line with the Member States endorsement of the Strategic Directions for Nursing and Midwifery at the World Health Assembly 2021, WHO to convene a STAGE working group bringing together key stakeholders, ensuring midwifery representation to develop implementation guidance to support countries within 6–12 months of their transition (before, during and after) to a midwifery model of care, including collaborative teamwork, networks of care, leadership, and engagement of private and non-profit-making (3rd) sector. The working group should also develop an agenda for evaluation of implementation of midwifery models of care in different country health systems.

3. STAGE endorses the WHO community of practice platform to establish a continued learning agenda on transitioning to midwifery models of care, which links to ending preventable maternal mortality (EPMM)/Every Newborn Action Plan (ENAP) and other global programmes for improving continuity of maternal and newborn care and improving outcomes and prevention of stillbirths.
Professor Homer provided a summary of the prioritization exercise that was conducted in 2021 through an online survey sent to STAGE members and partners to identify priority MNCAHN topics for STAGE. She reminded STAGE members of their mandate, which includes identification of research and policy gaps, and addressing implementation issues, and to generate consensus on discordant topics.

The online survey focused on identifying topics (using what, why and how questions) that had significant impact on maternal, newborn, child and adolescent health and nutrition outcomes, with a focus on survive and thrive and topics that have a potential to be transformative or a game changer. The survey yielded 50 responses that were collated by the STAGE secretariat into topics and then reviewed by a subgroup of STAGE members, resulting in a short list of 13 broad topics. WHO technical teams provided information about the status of work at WHO in relation to the 13 topics, explaining which ones were already taken care of, and on which ones work was ongoing. This was shared with all STAGE members, and they were asked to pick their top five topics.

The top five topics were: climate change, networks of care, use of technology for referral links, mental health for children and adolescents, and innovations in maternal and newborn health. The other areas included mental health for mothers, hospital-based newborn care, issues in fragile and conflict settings, post neonatal mortality, midwifery, wasting guidelines, and oxygen use for child health. Professor Homer highlighted that some of these topics, such as innovation in maternal health and midwifery, were part of this meeting. She also indicated the breadth of some of the topics like climate change, networks of care, and the need to identify specific areas that STAGE can contribute to. Some of this will be discussed within the two STAGE workstreams and in workings groups and will be part of the next few STAGE meetings. She reminded and reiterated to the group that this survey was just one way of soliciting topics from the larger MNCAHN community. Topics will and can come to STAGE from WHO technical teams, STAGE members, and partners.

Professor Homer opened the session for a brief discussion and one of the members wanted some clarity on networks of care. Dr Allisyn Moran, WHO, clarified that work is ongoing, with scoping reviews and collation of experiences from countries to build an evidence base on the concept. A network of care is defined as follows.

Networks of care for maternal and perinatal health is a collection of public and/or private health facilities and health workers deliberately interconnected to promote multi-disciplinary teamwork and collaborative learning to provide comprehensive, equitable, respectful, person-centred care from home/community to primary, secondary and tertiary levels. A functional network of care results in collaborative and coordinated continuity of quality and respectful care to ultimately optimise linkages for efficient and resilient health systems.

Another member indicated the need for avoiding duplication between referral networks and networks of care, as they are interlinked. One of the partners highlighted the need for some WHO guidance on digital technology, use of artificial intelligence etc. in health care. WHO teams clarified that there is some work ongoing within the Department of Digital Health, including development of an application to guide clinicians. The Mental Health Department has provided some tools for primary care workers and agreed that there is the potential for more work. Colleagues also referred to work on telemedicine to support countries in evaluating existing applications at country level. There was some discussion on the role of STAGE to discuss and advise on emergent or urgent issues like food security related to war or pandemics. Dr Branca agreed that there may be a role for advisory groups; it is, however, important to understand the context and the kind of contribution expected to identify the right type of advisory group within appropriate mechanisms.
Profesor Homer thanked all the participants especially STAGE members, WHO colleagues, UN and other partners who continued their support and participation on Zoom platform at this meeting. She reminded everyone that the meeting report would be finalized and published on the STAGE website with the recommendations and guidance from STAGE. She also said that she would be meeting the Director-General to share the outputs of this meeting.

Dr Branca echoed Professor Homer’s appreciation, thanking the STAGE members and Chair for their recommendations and guidance, especially for those on anaemia. He reminded the group that the working group will be formed soon, and he looked forward to their inputs. The Global Action Plan on Anaemia is a deliverable for WHO and an avenue for advocacy, so the advice from STAGE was timely, as it is not just about iron deficiency anaemia, but all forms of anaemia and how treatment can be integrated into other packages for mother and child.

Craig Lissner, Acting Director, SRH, also thanked STAGE members for the advice and guidance and all partners for the interesting discussion. He specifically thanked UNDP, UNICEF and UNFPA, who are partners of the Human Reproduction Programme (HRP) on research, development, training and human reproduction. He indicated that STAGE guidance feeds into the work of the HRP, especially for work in maternal and newborn health. He reminded everyone that from 1 July SRH will have the new director, Dr Pascale Allotey, who will lead the work of the department.

Dr Anshu Banerjee also joined others in thanking STAGE members and the co-chairs of the KMC working group, who presented their work on the first day of the meeting. Although it was clear that there are still many challenges in implementing KMC, he was confident that, with continued discussions, it would be possible to overcome the challenges and help countries to implement KMC. He also referred to the update on PSE, which will continue as it is clear that the private sector has a major role to play in delivery of services. He then specifically thanked the subgroup members who provided inputs into the new topics on the agenda for this meeting (maternal health innovations, midwifery and adolescent well-being). He thanked STAGE for their advice on health commodities like calcium and aspirin; in developing a framework for the evaluation of adolescent preventive interventions; and in helping to take the midwifery agenda forward.

Professor Homer closed the session and thanked the partners for their support and appreciation, WHO technical leads and the STAGE secretariat and that she looked forward to meeting all again from 15 to 17 November for the next STAGE meeting.
# Agenda for virtual meeting

## Day 1: 10 May 2022 (all time in CET)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Duration</th>
<th>Purpose (Chair/Lead)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13:00</td>
<td><strong>Opening Remarks</strong>&lt;br&gt;Soumya Swaminathan, Chief Scientist, WHO&lt;br&gt;(3 min)&lt;br&gt;Caroline Homer, Chair, STAGE (5 min)</td>
<td>30 min</td>
<td>Welcome and Update&lt;br&gt;(Chair STAGE)</td>
</tr>
<tr>
<td></td>
<td><strong>Update and Follow-up of November 2021 STAGE recommendations</strong>&lt;br&gt;Anshu Banerjee, Director MCA (10 min)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:30</td>
<td><strong>Kangaroo Mother Care, Update on Global Position Paper and Implementation Strategy: Next Steps</strong>&lt;br&gt;Zulfi Bhutta, member STAGE</td>
<td>1 hr 30 min</td>
<td>Discussion&lt;br&gt;(Chair STAGE)</td>
</tr>
<tr>
<td>15:00</td>
<td><strong>Private Sector Engagement for delivering quality maternal, newborn, and child health services: Update</strong>&lt;br&gt;Blerta Maliqi, MCA/WHO (15min)</td>
<td>30 min</td>
<td>Information</td>
</tr>
<tr>
<td>15:30</td>
<td><strong>Wrap up for open session</strong>&lt;br&gt;Caroline Homer, STAGE Chair</td>
<td>5 min</td>
<td>Wrap up</td>
</tr>
<tr>
<td>15:40</td>
<td><strong>Closed session</strong>&lt;br&gt;STAGE members</td>
<td>20 min</td>
<td>Decision making&lt;br&gt;(Chair STAGE)</td>
</tr>
<tr>
<td>Time</td>
<td>Session</td>
<td>Duration</td>
<td>Purpose (Chair/Lead)</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>13:00</td>
<td>Innovations in Maternal Health and scaling up for country impact</td>
<td>1hr 30 min</td>
<td>Discussion and Decision making (Chair STAGE)</td>
</tr>
<tr>
<td></td>
<td>Allisyn Moran, MCA/WHO (15min)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:30</td>
<td>Measuring the public health impact of adolescent health and wellbeing</td>
<td>1 hr 25 min</td>
<td>Discussion and Decision making (Chair STAGE)</td>
</tr>
<tr>
<td></td>
<td>interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Valentina Baltag, MCA/WHO (15 min)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:55</td>
<td>Wrap up for open session</td>
<td>5 min</td>
<td>Wrap up</td>
</tr>
<tr>
<td></td>
<td>Caroline Homer, STAGE Chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16:00</td>
<td>Closed session</td>
<td>30 min</td>
<td>Decision making (Chair STAGE)</td>
</tr>
<tr>
<td></td>
<td>STAGE members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session</td>
<td>Duration</td>
<td>Purpose (Chair/Lead)</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>13:00</td>
<td>Supporting countries to transition to midwifery-led continuity of care</td>
<td>1 hr 30min</td>
<td>Discussion and Decision making (Chair STAGE)</td>
</tr>
<tr>
<td></td>
<td>Fran McConville, MCA/WHO (15 min)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:30</td>
<td>Prioritization Exercise: Priority Topics for STAGE</td>
<td>30 min</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Caroline Homer, STAGE Chair (10 minutes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:00</td>
<td>Wrap up of Day and Meeting</td>
<td>10 min</td>
<td>Closure of meeting</td>
</tr>
<tr>
<td></td>
<td>Caroline Homer, STAGE Chair; Anshu Banerjee, Director MCA; Francesco Branca, Director, NFS; Craig Lissner, Director a.i., SRH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15</td>
<td>Refining recommendations and next steps (closed session)</td>
<td>60 min</td>
<td>Discussion (Chair STAGE)</td>
</tr>
<tr>
<td></td>
<td>STAGE members</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MCA:** Maternal, Newborn, Child and Adolescent health and Ageing  
**SRH:** Sexual and Reproductive Health and Research  
**NFS:** Nutrition and Food Safety
Annex 2. WHO progress report on STAGE recommendations from meetings held in November and April 2021

This is the third progress report on recommendations and feedback to STAGE. Full Recommendations are in the November 2021 STAGE meeting report.

<table>
<thead>
<tr>
<th>STAGE Recommendations (November 2021)</th>
<th>Progress Made (May 2022)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient management of possible severe bacterial infections</strong></td>
<td></td>
</tr>
<tr>
<td>WHO guidelines on inpatient and outpatient PSBI management should be updated using the standard WHO guidelines development process.</td>
<td>Guidelines update started, expected to be completed by end of 2022. Scoping meeting of the Guidelines Development Group held in February</td>
</tr>
<tr>
<td>A STAGE working group on PSBI prevention and management should develop consensus around an implementation strategy among all relevant agencies and stakeholders to support acceleration of an integrated strategy for the care of sick or small newborns. The strategy should include safeguards to ensure quality of care, and include strengthening of health systems (supply chains, reporting mechanisms, monitoring and evaluation, etc.).</td>
<td>KMC working group will soon finish its work and will be reformulated into PSBI WG</td>
</tr>
<tr>
<td>STAGE recommends investment in research and innovation, including to improve precision in diagnosis of infections, accuracy of clinical algorithms, surveillance for antimicrobial resistance, and prevention of newborn infections</td>
<td>Discussion with donors and partners initiated</td>
</tr>
</tbody>
</table>

**Anaemia: global action plan**

The global action plan should cover children, adolescent girls, and women of reproductive age, and should be comprehensive and ensure community engagement.

The process for developing a Global action plan on the prevention and management of anaemia has been initiated. Technical focal points of WHO Departments of NFS, SRH, MCA, GMP and NTD have formed a working group for its development and are working to further define its scope, which includes children, adolescent girls and women.
The plan should be multisectoral in design and include implementation with the health sector as well as food systems and agriculture, and education and social affairs. A multisectoral plan for delivery of interventions will be developed that will involve health and other sectors.

Form a STAGE working group to review the current evidence on actions to address anaemia and involve STAGE members in reviewing the progress of the global action plan on anaemia, and in identifying the gaps (diagnosis, safety and toxicity of iron, current guidance, etc.). Members of a working group on anaemia have been proposed and Terms of reference are being developed.

Keep STAGE informed on the integration and implementation of strategic plans and actions (coordination within countries, mapping of platforms to deliver interventions, including digital, etc.). STAGE will be kept informed as work progresses.

**Redesign of maternal and child health: addressing post-neonatal child mortality**

WHO should invest in understanding the risk stratification at multiple levels, household, individual, programme, and the broader context (fragile areas/states). Risk stratification strategies should look at vulnerable households for delivery of focused household pre-emptive interventions.

WHO has established a Risk Stratification Working Group (RSWG) that is conducting an individual-data pooled analysis (IDPA) of risk factors for childhood mortality and wasting. The aim is to identify actionable predictors of mortality that can improve screening and management of children presenting with acute illness.

A second phase of work is also envisaged in 2023 to conduct an IDPA to identify predictors of impaired childhood development that will be similarly used to improve screening and management tools.
<table>
<thead>
<tr>
<th>Strategies should recognize the clinical, social, environmental, administrative, and economic risk factors but the agenda should remain focused on concrete actions to protect, prevent, and treat particularly the children who receive zero services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This work builds on the underlying ideas and concepts of the child health redesign and may drive a paradigm shift toward better differentiated management approaches for infants and young children at highest risk of mortality and identification of those at risk of impaired development.</td>
</tr>
</tbody>
</table>

## Improving breastfeeding and mitigating the marketing of breast-milk substitutes

<table>
<thead>
<tr>
<th>Importance of breastfeeding and the need to regulate the marketing of BMS must be raised to the highest political level considering the multisectoral dimensions of the issue. WHO to undertake political economy analyses of multiple barriers in selected countries to build the case for breastfeeding promotion, protection, and support.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The importance of breastfeeding was a major theme highlighted at the Global Nutrition for Growth Summit in December 2021 and many countries announced public commitments to substantially increase their rates of breastfeeding. The commitments made at the Summit have been summarized in the <a href="https://www.n4g.org/">N4G Compact</a>. Nine of the registered commitments are on the marketing of breast-milk substitutes. A <a href="https://www.n4g.org/2021-global-summit">side event</a> for the Summit did focus on breastfeeding and the Code and can be watched online.</td>
</tr>
</tbody>
</table>

The research presented to STAGE was publicly disseminated in February and April 2022, and WHO Member States were directly briefed on it.

A series of papers on the importance of breastfeeding and on the marketing of BMS have been submitted to the Lancet for publication later this year. These papers also address structural and policy barriers to improving breastfeeding practices. Additional manuscripts have also been submitted to other journals that further elaborate country case studies.
| Need further research to better understand the social norms and values, health status (anemia, etc.), work and economic demands which are impacting women’s opportunities and decisions | The rationale for this research is not clear. There is a large existing literature on the contextual factors that shape decisions on infant and young child feeding. The Lancet paper referred above will add to this literature. The greater challenge is the implementation of the action that can change these influences. |
| WHO to explore and use marketing models to increase societal support for breastfeeding and eliminate BMS marketing. | WHO is using social media strategies to increase societal support for the elimination of BMS marketing. Launches of the two reports - Multicountry study and Digital Marketing of BMS - were both live streamed and there were postings on twitter, facebook, and instagram. A broader campaign is under consideration. However, funding is needed – likely budget $1m-$1.5m -to support a time-bound marketing model approach. It is estimated that the formula industry spends $3-5b per year on marketing of BMS, more than WHO’s entire operating budget. This suggests that competing directly with industry on promoting breastfeeding is unlikely to be successful. |
| To establish a STAGE working group on BMS and breastfeeding. | To discuss further the strategic value of such a working group. There is already a joint WHO-UNICEF and civil society coalition of nearly 30 international organizations – the Global Breastfeeding Collective - that focuses on advocacy to promote BF and mitigate the influence of BMS marketing. WHO also coordinates a network of organizations providing assistance to national MOHs to support Code legislation (NetCode partnership). There are regular meetings with the Global Breastfeeding Collective, NetCode, the BMGF/Meridian BMS marketing workgroup, a BFHI advisors group, and multiple workgroups formed to develop and disseminate the various research streams. |
Annex 2 (cont.). WHO directors’ progress report to STAGE on recommendations from meeting of April 2021

<table>
<thead>
<tr>
<th>STAGE Recommendations (April 2021)</th>
<th>Progress (November 2021)</th>
<th>Update (May 2022)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mitigating the impact of COVID-19 on MNCAHN service provision and use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHO and partners to support Member States to develop, a timely and coordinated response to health emergencies and crises to ensure that the response addresses both the direct, and the indirect impact of COVID-19 on populations at risk. Coordination is expected to start at WHO between the emergency response structures and other programmes.</td>
<td>WHO/MCA has shared the findings from Phase 1 of the WHO Mitigation of Effects of COVID-19 on MNCAH initiative across relevant departments of WHO. Phase 2 of the initiative in 15 countries across 6 WHO regions is focusing on national efforts within the 15 countries to integrate across health areas and health structures. These will be widely disseminated.</td>
<td>Phase 2 of the COVID-19: Mitigating indirect impacts on MNCAH and ageing services three-level WHO initiative continues through June 2022 with support to 15 countries to continue work related to strengthening governance and integration of essential services MNCH into country emergencies and resilience plans and strengthening routine data and use of information for decision-making. Countries are currently synthesizing lessons learned, and organizing regional discussions.</td>
</tr>
<tr>
<td>A sustained commitment to strengthen health management information systems (HMIS) and surveillance in countries to ensure reporting of granular, sensitive data, including on the work of private providers and nongovernmental entities.</td>
<td>WHO has responded to country requests for capacity strengthening in interpretation and use of RHIS data through interactive orientation sessions in October 2021. A Report related to improving analysis and use of routine data has been published.</td>
<td>WHO/MCA is leading the update of the WHO/UNICEF guidance document Analysis and use of Health facility data – Guidance for RMNCAH programme managers to focus its scope on MNCAH indicators, incorporate lessons learned in monitoring utilization of MNCH services during COVID-19 and add an annex on data quality issues in MNCAH HMIS data. Relevant content of the guidance will be reviewed by existing TAGs to WHO on measurement of MNCAH (e.g MoNITOR, CHAT) and other partners.</td>
</tr>
<tr>
<td></td>
<td>WHO commissioned a review of how HMIS has been used to monitor MNCAHN service disruption during COVID-19. WHO is now developing an overall strategy on HMIS/RHIS to which MCA will contribute.</td>
<td>Through the COVID-19: Mitigating indirect impacts on MNCAH and ageing services three-level WHO initiative, country data summaries are being finalized for 12 countries, presenting together COVID-19 data, public health and social measure timelines, MNCAH HMIS dashboards, WHO EHS pulse survey results related to MNCAAH for each country.</td>
</tr>
</tbody>
</table>
To continue to work with partners to identify, document and share experiences and lessons from countries that are meeting national policy objectives to reduce SARS-CoV-2 infections while also maintaining essential MNCAH services. At global level, WHO to collate and synthesize studies of critical interventions for anticipating needs and maintaining essential MNCAH services during shocks.

Work is ongoing, as part of Phase 2 of the COVID-19 project and through sharing of lessons learned.

In depth reports will be developed for actions identified by each national technical working group as key in their effort to maintain essential MNCAH services. For release in February 2022.

WHO has conducted a scoping review of the literature on interventions and service delivery modifications implemented to maintain essential RMNCAH services during past disasters, humanitarian emergencies and other disruptive events, including SARS and COVID-19.

WHO is conducting a scoping review of service delivery modifications and innovations for ensuring access and quality of SRH services during the COVID-19 pandemic. In addition, WHO will be collating country case studies and issuing a call from implementers to understand experiences of service delivery modifications that may not have been captured through a formal literature search.

Working with UNFPA, SRH contributed to the development of a technical brief (Not on pause: Responding to the SRH needs of adolescents during the COVID-19 pandemic) and supported its dissemination and building capacity in its use: https://www.unfpa.org/sites/default/files/resource-pdf/Not_on_Pause.pdf

The in-depth reports are under development through the Phase 2 of the COVID-19: Mitigating indirect impacts on MNCAH and ageing services three-level WHO initiative and will be published and available by June 2022.

WHO/MCA published the scoping review in November 2021; it is available through the link provided. Presentations were made to both WHO partners and external partners.

SRH gathered nearly 40 case studies of the responses of governments, non-government organizations and the private sectors, sometimes working together, to respond to the SRH needs of the COVID-19 crisis.

Health systems analysis and evaluations of the barriers to availability, utilization, and readiness of sexual and reproductive health services in COVID-19 affected areas is also underway.
<table>
<thead>
<tr>
<th>Who is to continue to work with partners engaged with adolescents to identify any vulnerability that might have been exacerbated by COVID-19.</th>
<th>MCA is working with internal groups (e.g. SAGE, IVB department) to make sure the needs of vulnerable children and adolescents are reflected in the upcoming <em>Interim statement on COVID-19 vaccination for children and adolescents</em>, and that the indirect effects of control measures on children and adolescents are being recognized and mitigated by national response strategies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRH supported EMRO in carrying out studies of the indirect effects of COVID-19 on adolescents. SRH works with research institutions – Population Council, GAGE, Johns Hopkins Bloomberg School of Public Health and Rutgers - to distill research findings on the indirect effects of COVID-19 that influence SRH as well as the methods that have been used.</td>
<td>The SRH Department then initiated a discussion with GAGE, Population Council, Rutgers, and Johns Hopkins Bloomberg School of Public Health to bring together the findings of their studies in this area, and to develop a joint strategy to advocate for attention and investment in this area.</td>
</tr>
<tr>
<td>Work on strengthening Self-care in MNCAH is ongoing. A digital adaptation kit for self-care interventions is expected to be finalized by Jan 2022. Furthermore, in the development of the 2021 guideline on self-care interventions, two systematic reviews on self-monitoring blood glucose and on self-monitoring of blood pressure during pregnancy, to expand the evidence-base were done in collaboration between MCA, SRH and NFS and ROs.</td>
<td>AHO/MCA worked with WPE to update the guideline for the use of masks in community settings and it included considerations for children. The updated version was published on 22 December 2021- <a href="https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC_masks-2021">https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC_masks-2021</a></td>
</tr>
<tr>
<td></td>
<td>WHO/MCA is currently working to update the Q&amp;A on COVID-19 and adolescents.</td>
</tr>
<tr>
<td>WHO is to establish a working group composed of experts in digital health and MNCAHN to identify what contribution WHO can make to country programmes to assess how digital health tools can effectively improve MNCAHN outcomes.</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>This work is also ongoing, including activity at regional levels including mapping of use of digital technology for MNCH as well as WHO HQ efforts.</td>
<td></td>
</tr>
<tr>
<td>WHO/MCA is developing a tool to assess the quality of digital health interactions between health workers and women/parents/caregivers/families for MNCH. As part of the first phase of this work, we are conducting a series of discussions with experts and subsequently a working group will be established.</td>
<td></td>
</tr>
<tr>
<td>WHO/MCA is publishing a guide on How to plan and conduct teleconsultations with children and adolescents.</td>
<td></td>
</tr>
<tr>
<td>WHO/MCA is continuing work to develop a tool to help assess the quality of digital health interactions between health workers and women/parents/caregivers/families for MNCH. A first draft of the tool was developed in Q1 2022 and will be refined through review from a group of experts (who provided inputs into its development in the end of 2021) in Q2 2022.</td>
<td></td>
</tr>
<tr>
<td>In December 2021, WHO/MCA published a guide on How to plan and conduct teleconsultations with children and adolescents, available at the link provided.</td>
<td></td>
</tr>
<tr>
<td>SRH has been collaborating with the WHO Department of Digital Health and Innovations in the development of a consolidated telemedicine guidance across SRH, NCDs, and other disease areas, which is expected to be published in May 2022. This guidance will also reflect the recently published guide for teleconsultations with children and adolescents.</td>
<td></td>
</tr>
</tbody>
</table>

### Evidence and guidelines for impact: Kangaroo mother care

<table>
<thead>
<tr>
<th>STAGE should create a working group on kangaroo mother care (KMC) to facilitate consensus and acceptance of strategies. The working group will prepare a global position paper on KMC and guidance for KMC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The STAGE Working Group (WG) on KMC has been created under the chairpersonship Dr. Betty Kirkwood and Dr. Gary Darmstadt, and WHO MCA as the secretariat. The WG has met twice and has started discussions on the Global Position Paper on KMC and the Implementation Guidance for KMC. The deliverables are likely to be completed within an anticipated timeline of 6 months.</td>
</tr>
<tr>
<td>The Global Position Paper and the Implementation Guidance for KMC will be presented at the May STAGE meeting.</td>
</tr>
</tbody>
</table>
Knowledge translation: private sector engagement

To identify the key provisions and strategies for private sector engagement (PSE) specifically to achieve equity, with better outcomes for women, children and adolescents as part of high-quality universal health coverage. STAGE requested a short report on the approach taken to advance MNCAHN within the broader WHO PSE strategy.

A working group was established and will develop a joint working paper to build the basis of collaboration and identifying the role of different partners, including WHO/MCA. The first meeting was held in mid-October. In preparation, MCA has updated its guidance for programmes interested to strengthen the governance of private sector to deliver health results. A short report will be available to STAGE at the April 2022 meeting.

The working group on Engaging private sector to deliver MNCH services, as part of the WHO PSE connector was launched in December 2021. WHO co-leads the secretariat of this working group. Three working streams are developing a joint agenda on PSE country support, Knowledge development and Partnerships.

As part of its engagement and development of the technical agenda, WHO held a technical workshop in February 2022 during which it orientated 10 country teams composed of MoH leadership and partners on the PSE country policy dialogue and MNCH. Three countries have lined up to engage in the PSE process during 2022. Three different papers for publication on peer reviewed journals are currently being written as part of the contribution to the knowledge management workstream, while two webinars on the theme will take place by June 2022.
<table>
<thead>
<tr>
<th>WHO is to establish “well-child” and adolescent services by increasing the number of scheduled contacts between caregivers, children and adolescents with health services, including in schools, and finding new platforms for the delivery of interventions for health and well-being with guidance and tools for programme implementation.</th>
<th>The child health redesign document “Investing in our future: A comprehensive agenda for the health and well-being of children and adolescents” is to be published. A technical consultation to review, discuss and generate consensus on the proposed scheduling contacts, package of interventions, and the draft program guidance document to support well child and adolescent health and wellbeing programming is planned for 6-8 December 2021.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCA has finalized a research protocol, and secured funding, for the Y-check research project that will explore in a multicountry RCT the effectiveness and feasibility of health check-ups in adolescents in the United Republic of Tanzania, Ghana and Zimbabwe.</td>
<td>Published in November 2021 <a href="https://www.who.int/publications/i/item/9789240037793">https://www.who.int/publications/i/item/9789240037793</a> The meeting was held, a report is available but not published (attached). We decided that our next effort will be to develop operational guidance for well care visits for children and adolescents. The meeting looked at paragraphs 2 – 4. Participants welcomed the vision of the comprehensive agenda for child and adolescent health and wellbeing. Building blocks for realizing this vision are available, and the NCF and AA_HA! provide roadmaps. Guidance for children 3 – 9 years is missing, and this gap needs to be filled. To operationalize the vision, comprehensive assessments of children at key transition points in their life course are essential. Assessments should not only be at individual level but also consider family, community, and societal factors. It is essential to give attention to caregivers as well as children and adolescents. Enabling environments of policies, supportive services and empowered communities are needed to support parents and other primary caregivers who are at the forefront of care for young children, and to support adolescents in their evolving autonomy and self-realization. A universal progressive model needs to be built in which all caregivers, children and adolescents receive some support, and those with additional needs receive extra support. Within such a model, priority or high impact areas and outcomes can be defined to improve health and wellbeing at the population level. WHO and UNICEF will use the outcomes of the meeting to further develop operational guidance for well child care visits to support children’s and adolescents’ health and wellbeing. Y Check information to be presented at the STAGE meeting in May.</td>
</tr>
</tbody>
</table>
WHO, with UNESCO, is to lead a global coalition of national governments, United Nations (UN) agencies and donors to improve school health and nutrition and make every school a ‘Health Promoting School’ with focus on creating a framework of accountability so that health and wellbeing considerations become measures of performance of the national education systems.

Jointly with UNESCO, options for global engagement at political and technical level are considered, e.g.:
- Global Education Meetings (GEM) that are happening twice a year
- Engage with the Education Commission who organizes the GEM forum and includes donors countries with a focus on education sector
- Engage with the International Parliamentary Network for Education (IPNeD) that helps mobilize the political leadership necessary to accelerate quality education for all, by working with individual parliamentarians along with groups of parliamentarians at the national, regional and global levels.
- Regular joint statements by heads of agencies, e.g. UNESCO and WHO urge countries to make every school a health-promoting school, e.g. https://www.who.int/news/item/22-06-2021-unesco-and-who-urge-countries-to-make-every-school-a-health-promoting-school

Working with UNESCO, UNFPA, UNICEF, and UNWomen, SRH contributed to a global status report on comprehensive sexuality education in schools: The journey towards comprehensive sexuality education: global status report; highlights - UNESCO Digital Library

We are currently preparing a joint statement by the heads of WHO, UNESCO and UNICEF on “School reopening for ALL”.

We are engaging with UNESCO, UNICEF and other agencies in the preparation of the Transforming Education Summit (TES) to be held in New York this coming September 2022. More specifically, WHO will contribute to the Action Track 1: Inclusive, equitable, safe and healthy schools.

WHO continues to be a member of the, and engages regularly with, the UNESCO led community of practice on school health and nutrition. Work is under way to develop a web platform to support the monitoring of the status of school health in countries.

Jointly with UNICEF, UNESCO and other partners we are co-authoring an analysis paper in BMJ titled “Realizing the potential of school health to improve adolescent nutrition” to advocate for a whole-school approaches to school health.

WHO is a member of the TAG for the global status report on school health and nutrition; we have contributed to the report conceptualization, evidence gathering, review and content development for selected sections (e.g. on students health status and on school health services).
<table>
<thead>
<tr>
<th><strong>WHO</strong> is to include maternal health and wellbeing as part of the life-course approach in the maternal health review and further develop the networks of care as an innovative model of integrated service delivery.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A mapping of maternal health and wellbeing will be conducted based on WHO maternal health recommendations and the well-being domains in the child and adolescent framework by the end of 2021 and hold a technical consultation in late 2021 or early 2022. WHO will hold a technical consultation on networks of care concept in late 2021 or early 2022 to further explore this concept as an innovative model of integrated service delivery.</td>
</tr>
<tr>
<td>WHO/MCA is convening a inter-departmental steering group to guide the work on maternal well-being. As part of this work, we will: 1) develop a WHO definition of maternal well-being and a set of indicators; 2) develop packages of interventions to support maternal well-being linking with the child and adolescent well-being framework; and 3) develop and test implementation of intervention packages to strengthen maternal well-being. We plan to convene a technical consultation in Fall 2022.</td>
</tr>
<tr>
<td>WHO/MCA has continued to support networks of care for maternal and newborn health. A commentary has been submitted for publication, and another publication on the role of networks to improve quality of care is ongoing with the World Bank.</td>
</tr>
<tr>
<td>WHO is planning a series of technical consultations in 2022 and 2023, with the aim to launch a Call to Action and implementation guidance at the AlignMNH IMNHC in May 2023.</td>
</tr>
<tr>
<td>A stakeholder consultation to engage with a few governments and partners to present the agenda and have a policy dialogue on the implications for current programming and next steps is planned for 1st quarter of 2022. This will ensure that the programme guidance and proposed evidence-based packages of interventions are ready.</td>
</tr>
<tr>
<td>We are not discussing a stakeholder consultation yet.</td>
</tr>
<tr>
<td>We have realized that a two pager describing what is being done under the umbrella of the redesign will be useful - for internal and external communications.</td>
</tr>
<tr>
<td>We are organizing ourselves on specific tasks and coordination to take the overall vision forward.</td>
</tr>
</tbody>
</table>

**WHO and UNICEF** are to present the agenda to several governments and partners and discuss its implications for policy and programming.