

**Report of the eighth meeting of the Strategic  
and Technical Advisory Group of Experts for  
Maternal, Newborn, Child and Adolescent  
Health and Nutrition  
14 – 16 November 2023**



**World Health  
Organization**



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# Abbreviations and acronyms

<b>ADG</b>	Assistant Director-General
<b>ATACH</b>	Alliance for Transformative Action on Climate and Health
<b>EmONC</b>	emergency obstetric and newborn care
<b>ENAP</b>	Every Newborn Action Plan
<b>EPMM</b>	ending preventable maternal mortality
<b>GFF</b>	Global Funding Facility (of the World Bank)
<b>ICM</b>	International Confederation of Midwives
<b>ILO</b>	International Labour Organization
<b>IMCI</b>	integrated management of childhood illness
<b>KMC</b>	kangaroo mother care
<b>LMIC</b>	low- and middle-income country
<b>MCA</b>	Maternal, Newborn, Child and Adolescent Health and Ageing (WHO department)
<b>MNCH</b>	maternal, newborn and child health
<b>MNCAH</b>	maternal, newborn, child and adolescent health
<b>MNCAHN</b>	maternal, newborn, child and adolescent health and nutrition
<b>MNH</b>	maternal and newborn health
<b>NFS</b>	Nutrition and Food Safety (WHO department)
<b>PMNCH</b>	Partnership for Maternal, Newborn and Child Health
<b>PPH</b>	postpartum haemorrhage
<b>RMNCAH</b>	Reproductive, Maternal, Newborn, Child and Adolescent Health
<b>SBA</b>	skilled birth attendee
<b>SRH</b>	Sexual Reproductive Health and Research (WHO department)
<b>SSNC</b>	small and sick newborn care
<b>STAGE</b>	Strategic and Technical Advisory Group of Experts
<b>UN</b>	United Nations
<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organization
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>WHO</b>	World Health Organization

## Executive summary

The in-person meeting of the Strategic and Technical Advisory Group of Experts (STAGE) for maternal, newborn, child and adolescent health and nutrition (MNCAHN) was held in Geneva on 14–16 November 2023. Most (24) of the STAGE members attended in person while five attended the meeting online. They were joined by WHO staff at headquarters and online from regional offices, and 50 observers from partner organizations.

The meeting agenda included three new topics (maternal well-being, birth defects and complementary feeding) and detailed updates on various topics from the previous meetings (maternal newborn stillbirth transition framework, maternal and newborn health (MNH) commodities, midwifery models of care, caregiver practices as part of child and adolescent health well-being, and kangaroo mother care (KMC)). The WHO Secretariat had organized meetings either with existing working groups or with small subgroups with the co-chairs of the two workstreams and select STAGE members. These groups provided inputs to the WHO technical teams for the preparation of background information and for the presentations to STAGE.

STAGE Chair Professor Caroline Homer welcomed the STAGE members and invited Dr Bruce Aylward, Assistant Director-General (ADG), WHO, to provide his opening remarks. Dr Aylward acknowledged the efforts and value add that STAGE contributes and reiterated the need for this group to focus on the unfinished agenda of maternal mortality, which has remained stagnant over the past years. He was particularly pleased about the agenda, which included discussions on MNH transition framework and midwifery models of care, both of which he thought would be very useful towards addressing the issue of maternal mortality. He assured STAGE of his Division's and WHO's support.

Dr Anshu Banerjee, Director, Maternal, Newborn, Child and Adolescent Health and Ageing (MCA), then provided feedback on WHO activities in response to the STAGE recommendations from the meetings convened in May 2023 and November 2022. Dr Banerjee informed the group about the formation of new working groups for various topics which were recommended by STAGE. Updates included the comprehensive framework for anaemia and next steps to operationalize it in countries; child and adolescent health well-being and plans to operationalize the new framework in countries; the prioritization process for the MNH commodities; and the progress made on the implementation guidance for transitioning to midwifery models of care. In addition, he provided a progress update on the MNH transition model, work undertaken around climate change and its impact on MNCAHN, and continued efforts to further integrate health into school programs.

The technical sessions followed as per the agenda and, in all sessions, WHO technical teams provided detailed presentations followed by discussions initially by STAGE members and then by WHO regional offices, followed by partners and other observers. The guidance or recommendations were further refined during the closed sessions with STAGE members and WHO technical teams, and through continued online correspondence with the members.

This meeting also included a partners forum, during which Dr Jeff Smith from the Bill and Melinda Gates Foundation led the conversation on how STAGE recommendations were translated and used by various partners and donors to move the MNCAHN agenda forward; he requested that partners provide specific inputs on topics which they thought would be important for STAGE to consider and deliberate.

At the closing session, Dr Laurence Grummer-Strawn on behalf of Dr Francesco Branca, Director, Nutrition and Food Safety (NFS), Dr Özge Tunçalp on behalf of Dr Pascale Allotey, Director, Sexual Reproductive Health and Research (SRH), and Dr Anshu Banerjee, Director, MCA, thanked STAGE for their guidance and support that ensured truly interdisciplinary conversations across all domains and thanked STAGE for their insights on linking many of the topics presented at the meeting to the MNH transition framework. Professor Homer thanked everyone, especially all the STAGE members and partners, for their continued support. The main recommendations of STAGE are summarized below. The full recommendations are given in the relevant sections of this report.

## STAGE recommendations

### Maternal well-being

STAGE suggested several added elements be included in the maternal well-being framework. STAGE noted that it is important to consider maternal well-being within a broader life-course framing of women's health and well-being. This may or may not include pregnancy and motherhood, which was the focus of the review and framework presented to STAGE. Thus, links need to be made to the WHO/MCA broader agenda on well-being across the life course to address this perspective. STAGE also suggested the framework explicitly integrate nutrition, food safety and nutritional security within the existing domains, as well as references to sexual and reproductive health, menstrual health and pre-conceptional care. In the environment domain, the impact of toxic exposure and climate change should also be included. Beyond maternal autonomy, the framework should also consider maternal agency. It is also important to strengthen economic aspects, especially links to universal health coverage, health insurance including social protection, legal protection for maternity leave, financial security, and the safety and security of the women's/ adolescent girls' family and community environment.

### Guidance

WHO to consider all aspects of maternal well-being, in addition to health, when developing normative and implementation guidance.

WHO to operationalize this framework across the life course, ensuring linkages with the Maternal and Newborn Health Transition Framework and with the WHO Framework on Well-being.

### Midwifery models of care

STAGE highlighted the importance of providing greater detail on the scope of midwifery practice in relation to other skilled health professionals (doctors and nurses) and other members of the health workforce including community health workers – all important members of a maternity care team. The forthcoming implementation guidance on midwifery models of care needs to acknowledge the diversity of models that could be implemented in different settings and to showcase, through examples, how countries have developed models to meet specific contexts. National ownership will be crucial to make the transition to a midwifery model of care a reality.

### Recommendations

1. WHO to present (at the next STAGE meeting) the finalized global position paper on midwifery models of care and a draft of the implementation guidance, integrating case studies and country examples that show the diversity of models implemented in different settings, informed by the Maternal Newborn Stillbirth Transition Framework and in consultation with the WHO Health Workforce Department.
2. WHO and partners to utilize the global position paper to operationalize WHO Strategic Directions for Nursing and Midwifery 2021–2025 (WHA 74.15) to advocate for and promote midwifery models of care.
3. WHO, through its collaboration with the International Labour Organization (ILO), to help inform task descriptions for midwifery professionals and midwifery associate professionals in the anticipated revision of the International Standard Classification of Occupations by the ILO<sup>1</sup>.
4. WHO to support identification of knowledge gaps and research priorities on midwifery models of care, including implementation research.

<sup>1</sup> The International Standard Classification of Occupations version 08 (ISCO-08) states: "The distinctions between nursing and midwifery professionals and associate professionals should be made on the basis of the nature of the work performed in relation to the tasks specified in [the given] definition. The qualifications held by individuals or that predominate in the country are not the main factor in making this distinction, as training arrangements for nurses and midwives vary widely between countries and have varied over time within countries".

## Child and adolescent health and wellbeing: caregiver skills and practices

STAGE welcomes WHO's work to develop and implement evidence-based approaches to support parents and other caregivers in their caregiving practices for children and adolescents and build enabling environments as part of the child and adolescent health and wellbeing initiative approach.

STAGE recognizes the timeliness of WHO's initiatives to support caregiver agency and capacity to provide responsive, nurturing care to children and adolescents, to build family resilience, reduce inequities, and enable societies worldwide to build human capital.

### Recommendations

1. WHO to develop guidance to unify and clarify terminology in relation to the different age groups and age groupings that are pertinent to the nurturing care agenda and illustrate evidence-based actions that governments and partners can take to support caregivers of children and adolescents.
2. WHO to document examples of good implementation practices, facilitate knowledge exchange and define implementation research priorities for the caregiving support agenda, with attention to multisectoral collaboration involving health care and other sectors (including but not limited to education, social welfare, community development and child protection).

## Maternal Newborn Stillbirth Transition Framework

STAGE highlighted that it is important to look at maternal deaths, newborn deaths and stillbirth together – taking a unified approach to reducing mortality and morbidity. The purpose of the framework is to support countries to identify prioritized strategic actions that can be taken to move to the next phase, based on context and specific bottlenecks, and develop benchmarks and measures to track and report progress. The transition framework will incorporate and align with recommendations from the position paper on transitioning to midwifery models of care

implementation strategies for quality-assured WHO-recommended commodities, and access to and availability of emergency obstetric care.

### Guidance

1. STAGE endorses the continuing development, use, dissemination and socialization of the Maternal Newborn Stillbirth Transition Framework to prioritize strategic actions to accelerate progress to achieve the Every Newborn Action Plan and Ending Preventable Maternal Mortality (ENAP-EPMM) and SDG targets within a universal health coverage/primary health care approach.
2. WHO to report back at the next STAGE meeting (May 2024).

## Maternal and newborn health (MNH) commodities

STAGE members supported the provision of quality-assured commodities as part of life-saving MNCH intervention packages within a functioning health system with ongoing support for strengthening and maintaining capacity of health workers. Members suggested that WHO should provide a summary document and a country toolkit, although they suggested that the country toolkit could potentially be divided into two parts: a shorter implementation guide and a longer resource guide/library containing additional details. The importance of advocacy was highlighted given that countries are facing budgetary constraints and must choose between the procurement of high volumes of lower quality commodities and lower volumes of quality-assured commodities. The potential role that STAGE could and should play in informing donor decisions around investments in maternal and child health was highlighted.

## Recommendations

1. WHO to develop and finalize a comprehensive summary of WHO-recommended MNH commodities to facilitate implementation across different contexts, as part of the Maternal Newborn Stillbirth Transition Framework.
2. WHO to develop an implementation and monitoring strategy, a compendium of resources and tools to address critical bottlenecks, and advocacy messages for a variety of stakeholders at both country and global levels, building on existing implementation guides.

## Birth defects

With improving child survival across all regions, the proportion of child mortality and morbidity attributable to birth defects is increasing. Birth defects also affect quality of life due to the disability and stigma that survivors living with serious birth defects face over their lifetimes.

Newborn screening can identify newborn with birth defects that can be managed but

doing so requires investment into preparing health systems. Birth defects are thus becoming an increasingly important and urgent agenda towards which renewed focus from WHO is merited.

The terminology – ‘birth defects’ – may not be the most sensitive term; it needs to change but there is no consensus on an alternative term. The term ‘birth defects’ is used in these deliberations in continuity with the WHA resolution.

## Recommendations

1. WHO to move the birth defects agenda forward, given the increasing proportion of child mortality and morbidity attributable to birth defects as child survival improves in low- and middle-income countries (LMICs).
2. WHO to develop an implementation guidance framework for countries seeking to start or expand a universal newborn screening programme, including specific needs and considerations for diagnosis, management and long-term care, to guide countries depending on where a country is situated along the MNH transition framework.

## KMC

The STAGE KMC Working Group has developed and WHO has published a global position paper (Kangaroo mother care: a transformative innovation in health care, <https://www.who.int/publications/item/9789240072657>) and an implementation strategy (Kangaroo mother care – Implementation strategy for scale-up adaptable to different country contexts, <https://www.who.int/publications/item/9789240071636>) in support of the scale-up of KMC for preterm or low birthweight infants globally. To further support scale-up of KMC in health facilities and in communities, the KMC Working Group is finalizing a Practice Guide for Healthcare Providers and Programme Managers, which will be published early in 2024.

## Guidance

1. WHO in conjunction with partners on the ground to coordinate the regional and country-level adoption and adaptation of the principles and practices of KMC implementation for all preterm or low birthweight infants as a foundation for small and sick newborn care (SSNC) as recommended by WHO.
2. WHO to seek support from global partners to support country-level implementation and scale-up of KMC.
3. STAGE recommends reporting by all countries on the ENAP indicator for KMC coverage in health facilities.

## **Complementary feeding**

Inadequate complementary feeding has significant health consequences, including impaired growth, significant morbidity and mortality, delayed motor, cognitive and socioemotional development, impaired brain development, language, vision and hearing, obesity, and reduced work capacity and earnings later in life. Attention to complementary feeding has been inadequate. Social protection programmes can be a powerful approach to improve maternal and child health and nutrition. Health care providers often lack the skills and knowledge to provide appropriate advice to families on optimal complementary feeding. Counselling of families will continue to be an important approach for shaping the foods that are offered to young children. Group counselling can be cheaper, and possibly more effective, than one-on-one counselling.

## **Recommendations**

1. WHO and its partners to scale up advocacy efforts to drive financial resources and significant policy changes to improve complementary feeding.
2. WHO is encouraged to develop solutions with the social protection sector to improve access to healthy and affordable foods appropriate for infants and young children.
3. WHO to develop a comprehensive framework on nutrition education for health care providers.
4. WHO should develop guidance on effective methods of communication on appropriate complementary feeding through group counselling and new modes of communication, including through social media, targeted messaging and virtual clubs.



# Background

The eighth meeting of Strategic and Technical Advisory Group of Experts (STAGE) (second in-person meeting) with a three-day agenda (Annex 1) was convened in Geneva on 14 to 16 November 2023 by the WHO departments of Maternal, Newborn, Child and Adolescent Health and Ageing (MCA), Nutrition and Food Safety (NFS), and Sexual and Reproductive Health and Research (SRH). The meeting was attended by 24 of the STAGE members in person while five members joined online; two members were unable to attend. They were joined by WHO staff from headquarters and from the regions and 50 observers from partner organizations, four of them in person while others joined online (Annex 2).

The preparatory work for the STAGE meeting as per the norm was done either through the STAGE working groups or through smaller subgroups of STAGE members with topic expertise. The four working groups for maternal and newborn health (MNH) transition, MNH commodities and innovations, midwifery models of care, KMC, and child and adolescent wellbeing had one or more meetings to discuss the progress and next steps for these areas of work. For discussion on birth defects and complementary feeding, subgroups were organized across the two workstreams (evidence and guidelines for impact, and health systems and implementation) that included the co-chairs of the respective workstreams and a few STAGE members who were co-opted based on their topic expertise. At the working group and subgroup meetings, the WHO technical teams presented their concept notes and identified specific questions for STAGE. These groups provided detailed comments to WHO technical leads to enable them to clarify their presentations to STAGE.

WHO technical leads prepared the background documents, and these were provided to STAGE members 10 days prior to the meeting. During the open sessions, WHO technical leads made presentations that included the specific questions for guidance from STAGE. The floor was then opened for discussion with STAGE members, representatives of WHO regional offices, United Nations (UN) partners and participants. The discussions focused on next steps or on guidance for these various topics. These were then further revised and refined during discussions at the two closed sessions of STAGE members on day two and day three.

All 29 STAGE members attending the meeting had provided their declaration of interest, which was reviewed by the WHO Secretariat. Eleven members had identified conflicts, mainly related to grants received by their institutions for doing research in their area of expertise. None of the reported conflicts were perceived to have any impact on the members' ability to join the meeting or to provide objective and impartial contribution to any of the sessions.

## Opening session

Professor Caroline Homer, STAGE Chair, welcomed the STAGE members and partners who were attending in person or online and expressed her appreciation of STAGE members, many of whom had attended meetings in the past month in preparation for STAGE. She thanked the WHO technical teams who had worked hard to provide the information at these sessions and the WHO Secretariat for organizing the sessions. She then provided a brief on the planned agenda for the three days, including the partners forum on day two of the meeting, and she welcomed Dr Bruce Aylward, Assistant Director-General, WHO, to the opening session followed by a brief introduction by STAGE members.

Dr Aylward first thanked the STAGE members for their time and inputs and the WHO regional colleagues who were online, and he reiterated the crucial role regional colleagues play in translating the guidance at the country level. He specifically acknowledged the 18 new members of STAGE and thanked them for their time. He expressed his appreciation of the work done so far (he was briefed in August) especially on anaemia, KMC, initiating discussion on midwifery, and adolescent health. Another important area is climate change and its impact on MCNAHN which was discussed last year.

He then highlighted the need to focus on maternal mortality, while also looking at newborn, child and adolescent health. He was pleased that the current agenda includes maternal newborn health transition, midwifery models of care, and maternal and newborn health innovations, all of which would help focus on maternal mortality. He expressed his appreciation for Professor Homer's leadership and thanked STAGE members for helping move the maternal mortality agenda forward; he informed the group that he looked forward to a quick debrief on the last day of the meeting.

Professor Homer then invited the Director of MCA, Dr Anshu Banerjee, to provide an update on the recommendations made by STAGE at its previous meetings. Dr Anshu Banerjee provided a brief summary of the progress made by WHO on the recommendations from STAGE during the May meeting and provided a short update on the actions following the previous recommendations by STAGE.

## Update from May 2023 recommendations

### Comprehensive framework for anaemia

- There was a recommendation to develop operational guidance to support countries, particularly in translation of global recommendations. The NFS department has been working with the Anaemia Action Alliance and with the STAGE working group on the operational guidance that is being developed.
- In response to the recommendation on strengthening communications and advocacy on the burden and consequences of anaemia, the Anaemia Action Alliance working group on investment is helping with estimating global costs to address anaemia. This is being done together with the World Bank's update on its investment framework for nutrition.
- On the discussion at the last meeting about advocating for global targets on anaemia, Dr Banerjee informed meeting participants that there is an official WHA target for anaemia in women of reproductive age that is ending in 2025. Plans are in place to extend that to 2030, while looking at the post-2030 agenda, and to identify targets for children and other population groups at high risk.
- And finally, there was the recommendation to reach out to other partners and look at how we can engage with other multisectoral efforts, such as the collective impact forum. This is under discussion and the team hopes to take it forward in the coming months.

### Maternal newborn health transition framework

- As per a recommendation from STAGE, a working group was set up which met in October.
- The cut-offs for the transition stages have been published and another publication on the obstetrics transition is in press. The recommendation to look at programmatic elements and to link that to the cut-offs will be presented later in the meeting.
- There was also a recommendation to ensure that work on emergency obstetric and newborn care (EmONC) is linked to the transition framework from a continuum of care perspective. The EmONC revisioning working group is finalizing

the framework and handbook, and that will be presented to the STAGE working group to ensure that it is integrated seamlessly.

### **Midwifery models of care**

- The STAGE working group was to develop implementation guidance. It was decided to split that into two parts: the part one to be a position paper on guiding principles and the definitions that will be discussed on day one, and part two to focus on developing the implementation guidance.

### **Maternal and newborn health commodities**

- The STAGE working group was asked to focus on prioritization based on standard criteria, and also to ensure that there is a link with the transition framework. The commodities have been mapped and an online survey was conducted for prioritization of the maternal health commodities and for the newborn commodities. They were organized by levels of care. The implementation guidance is being developed now. More detailed discussion on that would also be presented at this meeting.

### **Child and adolescent health well-being**

- The working group was formed, and they met in October.
- STAGE had discussed the need for a position paper on primary health care in relation to the High-Level Meeting on Universal Health Coverage. With significant contributions from all STAGE members, the [Lancet commentary](#) was published in September 2023 prior to the opening of the UN General Assembly.
- The WHO team has also received clearance for the document on scheduled contacts to support children and adolescents from a well-child perspective, and this will be published soon. And as part of that agenda, Uganda, Malawi and Oman have expressed interest in testing the well-child approach in 2024.

- In 2024, the WHO team will also develop the guidance document on how to implement the well-child approach.

### **Update from November 2022 recommendations**

#### **School health and well-being**

The main recommendations were for WHO and partners to focus on enhancing accountability of educational systems within the Making Every School a Health Promoting School initiative. There had also been a request to ensure that students and parents co-create school health. Another recommendation was that school health should be strengthened through more investment in the creation of leadership cadres for health promotion in education. In response to these:

- A global platform to monitor school health was launched in August 2023, and the link with Making Every School a Health Promoting School was featured within the update of the AA-HA! guidance, which was launched during the Global Forum for Adolescents on 11 October 2023.
- Research is underway and data-to-action workshops were held in Morocco, Jamaica and Ghana at which school health data was analysed. Adolescents, their parents and schoolteachers were involved to help identify adolescent health needs and how to turn those into practice. Action plans with timelines have been developed.
- In the AA-HA! update there is clear guidance on how school health should be part of comprehensive adolescent health programs.

## Climate change and impact on MNCAHN

Recommendations included strengthening in-house and external collaborations; coordinating research on these topics; and establishing a STAGE working group on this topic. Response and actions included:

- The ADG has ensured that climate change is going to be one of the leading themes in the next Global Programme of Work for WHO.
- WHO has set up an alliance and working group for climate, action and nutrition (ICAN). It will introduce a resolution at the World Health Assembly next year on the topic of climate and health.
- WHO, together with the UN Children's Fund (UNICEF) and UN Population Fund (UNFPA) launched a statement/call to action for protecting maternal, newborn and child health from the impacts of climate change.
- In terms of research, WHO has completed a global mapping of heat, health action plans and indicators to assess heat exposure.
- The MCA team developed four papers on the impact of climate change on maternal, newborn health, child and adolescent health and on ageing and older people. These will be published in the first quarter of next year.
- The Climate and Nutrition Working Group is producing a baseline report and an evidence paper.
- The STAGE working group will be formed next year.

- WHO is reviewing and updating the Integrated Management of Newborn and Childhood Illness (IMNCI) approach and the hospital pocketbook around risk stratification, and these are expected in the second quarter of 2024.
- The conceptual framework to measure the impact of adolescent health well-being check-ups will be finalized later this quarter. An investment case across the life course was launched during the Global Forum for Adolescents.
- At a Congress earlier this year, 93 out of 100 countries announced commitments to develop an action plan to improve their legislation, monitoring and better investment to address the use of breast milk substitutes.

STAGE members were appreciative of the work being done as a response to STAGE recommendations. The discussion that followed included queries on the intersectionality of adolescent well-being work with sexual and reproductive health, and how it fits within the life course and not as a separate entity. Members also highlighted the need to situate school health discussions as part of child and adolescent well-being. The WHO team clarified that the school health and adolescent health work is done in collaboration with the SRH department along with other departments in WHO and other UN agencies. Guidance on well-being is also being updated to include the new evidence and thinking.

## Update on previous STAGE recommendations

- A manuscript on the 10 core components of SSNC is expected to be published in the first quarter of 2024.
- The KMC practice guide is being revised, and that is expected to be published soon as well.
- Manuscripts have been developed for the risk stratification analyses. These include the programmatic implications of this approach.

# Recurrent topics

## Maternal newborn stillbirth programmatic transition framework

### Background

Allisyn Moran, MCA/WHO, provided a brief presentation on the MNH transition framework focusing on the changes and progress made since the last meeting. She appreciated support from the STAGE working group, Exemplars steering group, and UNICEF and UNFPA, and the World Bank Global Financing Facility (GFF).

The MNH framework integrates maternal, newborn and stillbirth, acknowledging that cut-offs are arbitrary, the progress is not always linear (could go backwards too) and phases may vary at national and subnational level in the same country. She emphasized the need to have maternal, newborn and stillbirth together for a unified approach for reducing mortality and morbidity.

The cut-offs were developed based on analysis of more than 150 countries, and on how countries moved from 2000 to 2020 to the later stage of transition. The analysis and the characteristics of the phases are available in the background paper shared with STAGE.

Every newborn action plan and ending preventable maternal mortality (ENAP EPMM) targets (90-90-80-80) for coverage, quality, availability and access were taken into consideration in framing the concept. The components of programmatic choices are grouped into four broad categories: (1) Social determinants/community enablers, (2) Health system determinants/policy levers, (3) Political determinants/multisectoral enablers, and (4) MNH interventions and coverage. Health system levers include health workforce and commodities, etc. All phases of transition include routine care; the main differences are around managing complications. The team is in the process of linking the framework to other related works, such as EmONC revisioning, midwifery models of care, etc. Case studies are to be conducted in different settings and possibly the framework will be piloted in several ENAP/ EPMM countries (30–40 countries have either developed or are in the process of

developing MNH Acceleration Plans under the joint ENAP EPMM initiative). WHO leadership sees the potential to use it as the global framework for broader programmatic approach.

### Questions to STAGE

1. What is the overall feedback on the approach?
2. What additional tools might be helpful for operationalization of this framework?

### Discussion

STAGE members agreed that this is a complex but useful framework for countries to advance MNH, and it will help in determining the issues and addressing them in an objective way. They also thought this would be useful for programme planning by managers at various levels and help in prioritizing interventions and resource allocation. However, resources are critical to take a country to the next phase; while donor funding is important and donors could use the tool to support country planning and implementation, domestic funding and leadership is crucial. Discussion and buy-in from ministries of finance along with support from the World Bank would be critical too. In addition, there is a need for understanding how it works in a particular country context and what catalytic support will be needed, for which case studies would be useful and could include some examples of country strategies (e.g. janani suraksha yojana in India). STAGE members highlighted the importance of using this framework as an opportunity to stress the importance of addressing stillbirth, while a few members thought this framework could be applied in the area of non-communicable diseases as well.

STAGE members reiterated that countries would need guidance to operationalize the framework (i.e. for choosing strategies to move to the next phase), with clear messages describing the purpose and steps towards the next phase. Benchmarking would help guide countries to take the framework forward in their own context. They noted that there are different audiences for this transition framework:

- policy-makers – high level summary
- programme planners – assessment tool, menu of options, maybe as an online tool
- donors, including banks – high level summary and priority strategic actions.

Members also highlighted the need to further simplify specific interventions for each phase, to frame them around health system indicators and to conduct a trend analysis.

The members also suggested the framework should consider additional factors during the defining phases: referral network, financing, fertility (contraceptive) commodities, workforce, well-being indicators, refugees, migrants or informal settings. Some suggested that a digital version of the tool could be considered. The group highlighted the need for piloting this in a few countries as soon as possible.

Partners and other observers added the framework should not be used to categorize countries into different “boxes” or phases, but as a benchmarking tool to help countries prioritize and decide on their next steps. Some also emphasized the need to further simplify it as much as possible for anyone to understand.

Dr Moran clarified that the [WHO programme review tool \(MNCAH\)](#) is available to check the trends for the indicators and could be used to assess the national and subnational issues.

Professor Homer thanked all the STAGE members and the STAGE working group for moving this agenda forward. Based on the discussions in the open and closed sessions, recommendations are:

1. STAGE endorses the continuing development, use, dissemination and socialization of the Maternal Newborn Stillbirth Transition Framework to prioritize strategic actions to accelerate progress to achieve Every Newborn Action Plan-Ending Preventable Maternal Mortality (ENAP-EPMM) and SDG targets within a universal health coverage/primary health care approach.
2. WHO to report back at the next STAGE meeting (May 2024).

## Scaling up WHO-recommended maternal and newborn health commodities

### Background

Dr Allisyn Moran, MCA/WHO, gave an update on the progress made and summarized the outputs from the STAGE working group as well the WHO’s technical convening on WHO-recommended MNH commodities held in Geneva, Switzerland, on 30 October to 1 November 2023. Dr Moran briefly described the context for the work while highlighting the links to the ENAP and EPMM initiative, given that medical commodities and devices are one of its 10 milestones.

WHO completed a review of the WHO guidelines to map the commodities essential to reducing maternal and newborn mortality. Commodities were extracted from the WHO recommendations and classified into the following categories: medicines, medical devices and diagnostic tools. The 29 maternal commodities were organised around the major causes of death, based on the recommendation from the STAGE working group. This resulted in 12 commodities for postpartum haemorrhage (PPH), seven commodities relating to pre-eclampsia and eclampsia, and 10 commodities for infections leading to sepsis. The 32 newborn commodities were organised around the major causes of death together with the ENAP levels of care. It was noted that a newborn may be more likely

to be impacted by several conditions so organising by the causes of death is more challenging. In addition, 10 key newborn commodities related to the content of care at the district level based on a recent UNICEF WHO consultation,<sup>2</sup> but not included in the WHO guidelines, were also considered.

The list of prioritized maternal commodities was then shared with a wider stakeholder group to select criteria to provide inputs on implementation strategies using an online survey platform.<sup>3</sup> The 130 respondents (out of 254) included representation from each of the six WHO regions and a variety of organisation types, including health authorities and hospitals, academics, consultants, funders and intergovernmental organisations. The key findings from the survey were as follows:

- Devices and diagnostics were deemed equally important in terms of effectiveness.
- The majority of commodities were available at country level, except for carbetocin, uterine balloon tamponade (UBT), non-pneumatic anti-shock garment (NASG), and uterine artery Doppler (UAD).
- There were common barriers, but also differences among the barriers for different medicines, devices and diagnostics. The most mentioned barriers were costs, uncoordinated supply chains and limited health workers with adequate training.
- It may not be feasible to have a shorter list, as all WHO recommended commodities are effective and the prioritisation may need to be context specific.

The commodities could be divided into three categories:

- essential – life-saving commodities recommended by WHO
- enabling – commodities needed to use/apply the essential commodities (e.g. batteries, catheters, blood pressure measurement devices)

- consumables – commodities for general purposes (e.g. gloves, gauzes, alcohol, needles).

Survey participants emphasised that the quality of medicines is becoming an implementation barrier for the uptake of WHO recommendations at country level, and there are similar challenges with maintaining devices and equipment. Regulators have an important role in terms of providing marketing authorization and undertaking quality control activities. The participants noted that supply chain challenges remain (especially for commodities that require cold chain), and innovative approaches for procurement and financing are essential (e.g. local manufacturing). The participants recommended that MNH commodities should be purchased in bulk and in line with the needs of the health setting, and they emphasized that commodities can only be effectively implemented in a functioning health system, with trained and enabled health workers.

The proposed next steps for the development of the final list of WHO-recommended MNH commodities were presented, including further consultation on the essential list with existing expert groups about the levels of care/cause of death and engagement with countries through existing communities of practice. The final summary list of quality-assured, WHO-recommended MNH commodities will be published and updated as new commodities are integrated into WHO recommendations.

A proposed implementation strategy was presented, including three interrelated parts, namely a global roadmap/strategy, a country toolkit (including a short guide and a repository of materials) and a set of advocacy materials for diverse audiences. The toolkit would build on existing publications, materials and work underway, such as the WHO Roadmap for access to medicines, vaccines and other health products; WHO's PPH innovation pathway; and the forthcoming implementation guide for SSNC in level 2 facilities. It would also include a self-assessment tool that will allow countries to determine their own priorities, based on phases of transition.

<sup>2</sup> <https://jogh.org/2023/jogh-13-03023>

<sup>3</sup> Newborn health commodities were not included in the online survey. The reasons for this were: (i) newborn commodities could already be mapped onto functions required to be performed by level of care,<sup>1</sup> which results in an inherent prioritisation of commodities; (ii) all commodities related to essential newborn care should be universally available at all levels of care; and (iii) commodities linked to small and sick newborn care (SSNC) should be available at level 2 facilities where such babies are cared for. Commodities related to SSNC are necessary to manage the three major contributors to neonatal mortality i.e. prematurity, perinatal asphyxia and sepsis. There is significant overlap between the conditions and therefore the commodities to manage these three conditions (e.g. premature infants are at increased risk of sepsis, as are babies who have suffered perinatal asphyxia), therefore a prioritisation via an online survey was not deemed appropriate.

Dr Moran requested STAGE inputs for the following:

## Questions to STAGE

1. What is STAGE's feedback on the proposed approach for the list of quality-assured MNH commodities, including the potential for three groups, namely essential, enabling and consumables?
2. What is STAGE's feedback on the proposed approach for the implementation strategy, linking explicitly with the MNH programmatic transition framework, to support ENAP-EPMM acceleration plans?
3. What is STAGE's feedback on the development of a monitoring strategy, including benchmarks, to track the progress of quality-assured MNH commodities across different domains, as outlined in the implementation strategy?
4. What are suggestions around how to highlight/emphasize the importance of MNH commodities as part of broader health systems strengthening (including health workers) to achieve the ENAP-EPMM targets and SDGs?

## Discussion

During the discussion, STAGE members provided feedback on the approach to develop the list of WHO-recommended commodities. While generally supportive of the work and its potential contribution to the SDGs, STAGE members emphasised that commodities can only be effective if they are quality assured and part of broader health systems strengthening approaches, including building the capacity of health workers. While STAGE members appreciated the plan to provide practical guidance to countries regarding the scale-up of commodities, STAGE members felt that it was important to also refer to non-commodity essential actions, such as the early initiation of breastfeeding and skin-to-skin contact. Similarly, the monitoring activities should be integrated to include the whole set of interventions and not be solely focused on the provision and use of commodities.

Regarding the list of MNH commodities, several STAGE members suggested that the use of the term “essential” may create confusion with the WHO Essential Medicines List. In addition, STAGE members felt that the enabling and the

consumables categories could be combined into a single category. Furthermore, it is important to name the specific antibiotics, where appropriate. Consideration should be given to the inclusion of commodities for the safe transport of mothers and babies. The maintenance of equipment and the need for countries to budget for consumables were raised as important considerations. It was emphasised that the list will need to be updated as WHO recommendations evolve. The maternal health commodities included in the first mapping had only considered the major causes of death, but there has been feedback to go beyond these areas to include others, such as family planning and abortion care. Finally, it was agreed that additional commodity-specific analysis from the survey may be helpful.

Regarding the implementation strategy, STAGE members were supportive of the approach to provide a summary document and a country toolkit, although suggested that the country toolkit could potentially be divided into two parts, a shorter implementation guide (20 pages) and a longer resource guide/library containing additional details. Furthermore, it will be essential to provide guidance on the need for differentiated approaches to address diverse country contexts. It was recognised that there is a need for technical assistance beyond the publication of a guide, particularly for the procurement of quality-assured commodities. The importance of advocacy was highlighted, given that countries are facing budgetary constraints and must choose between the procurement of high volumes of lower quality and lower volumes of quality-assured commodities. It was noted that, in some cases, available formulations may drive local treatment protocols and these challenges need to be addressed, such as through engagement with procurers and manufacturers. Finally, the potential role that STAGE could and should play in informing donor discussions around investments in maternal and child health were highlighted.

Based on the discussion in the open and closed sessions, the recommendations are as follows:

## Recommendations

1. WHO to develop and finalize a comprehensive summary of WHO-recommended MNH commodities to facilitate implementation across different contexts, as part of the Maternal Newborn Stillbirth Transition Framework.
2. WHO to develop an implementation and monitoring strategy, a compendium of resources and tools to address critical bottlenecks, and advocacy messages for a variety of stakeholders at both country and global levels, building on existing implementation guides.

## Midwifery models of care

### Background

Ms Justine Le Lez, MCA/WHO, provided a recap on STAGE recommendations and the impetus for developing the implementation guidance for midwifery models of care while highlighting evidence that showed that scaling up midwifery could provide 90% of global needs for adoption, sexual reproductive maternal health. She then provided some details from the scoping review that was done to understand the current models of midwifery care, with 90% of the papers coming from high income countries, and 72% of these coming from urban areas. Other than New Zealand, no country has scaled up the continuity of the midwifery care model to a national level.

She also highlighted that currently two definitions of midwife are used: WHO Member States use the definition from the ILO<sup>4</sup> while the maternal health community in general use the definition from the International Confederation of Midwives (ICM). The STAGE working group thus decided to first focus on having a consensus on the definition of midwifery models of care, focusing on what it is and why countries should transition to the model of care. Thus, the decision was to split the document into two parts. The first document will be a global position paper on midwifery models

of care focusing on the definition and the guiding principles. This document will target ministries of health and policy-makers, and it will be a helpful tool for professional associations or for partners to advocate for midwifery models of care. The second document, the implementation guidance, will target the program managers, implementers, health workers and women's groups.

Sally Pairman, co-chair of the STAGE working group on midwifery, provided further details on the process of developing the global position paper, which included a writing group with the WHO Secretariat and continuous consultation with the working group, other experts including women's groups, and UN partners and regional advisers. This document is expected to be finalized in January 2024 and published soon after.

The proposed definition is:

*Midwifery models of care (MMoC) are models of care for women and babies which cover the continuum of care, from pre-pregnancy through to the postnatal period and beyond, in which the primary care providers are educated, licensed, regulated midwives, enabled to legally practice autonomously across the full scope of midwifery practice, and integrated into a well-functioning health system in the context of effective, functional, equal and respectful multidisciplinary teams, supported by referral processes and sufficient resources.*

The guiding principles include person-centred care, continuous care, across the pregnancy and childbirth continuum, coordinated by midwives who are integrated into the health system and working collaboratively with other health professional colleagues as the woman needs, providing high-quality, evidence-based and respectful care, and this is providing equitable services for women as part of universal health coverage.

She then described the second part of this work, which is developing the implementation guidance, taking a 7-step approach which will be aligned to the WHO/UNFPA/ICM framework for midwifery education, the WHO standards for improving the quality of maternal and newborn health in health

<sup>4</sup> The International Standard Classification of Occupations version 08 (ISCO-08) states: "The distinctions between nursing and midwifery professionals and associate professionals should be made on the basis of the nature of the work performed in relation to the tasks specified in [the given] definition. The qualifications held by individuals or that predominate in the country are not the main factor in making this distinction, as training arrangements for nurses and midwives vary widely between countries and have varied over time within countries".

facilities, and the WHO global strategic directions for nursing and midwifery. It will include a number of case studies from various countries, including humanitarian settings. In addition, there are evidence gaps that need to be addressed relating to core outcomes data, the impact of continuity of midwifery care in LMICs, economic evaluation and implementation research. This document is expected to be ready to be presented at the next STAGE meeting in May.

## Questions to STAGE

1. Global position paper: How to optimize its uptake for adoption and implementation?
2. Evidence gaps have been identified throughout this work: How can these gaps be addressed?
3. How can this work be better integrated within the nursing and midwifery landscape?

## Discussion

STAGE members agreed with the importance of such a document and its value in ensuring care for the mother–newborn dyad. Moving from a skilled birth attendee (SBA) to midwifery models of care will ensure continuity of care starting from pre-conception to pregnancy, childbirth, and postpartum or longer. Currently, midwives are responsible for care until six weeks after birth.

Some STAGE members cautioned against replacing SBAs in countries, or in emergency situations, where they are the only trained providers. In some cases, it would be useful to highlight the need for additional training for existing cadres while supporting the strengthening of the midwifery workforce.

STAGE members highlighted the importance of integrating midwives and the midwifery model of care into the health system by bringing together midwives, nurses, doctors, ministry of health stakeholders and high-level decision-makers, so that everyone is part of the decision-making process at the country level. It will be necessary to review the education and training of midwives and other cadres, especially on continuity of care, family planning, sexual health etc. Members suggested the use of “interdisciplinary team” as a terminology and not “multidisciplinary” team,

because they work together on the same goal building different parts. Use of digital technology both for training and practice was also suggested by some members.

Members also highlighted the need to highlight how the midwifery models of care would harmonize and not fragment the health system, and what the characteristics are that would fill up those gaps; these elements should be part of the paper. This work should focus on implementation issues for different country contexts, with short- and long-term monitoring outcomes, including strong economic evaluation components. Some suggested the use of country case studies to understand and demonstrate how this model fits within the context of primary health care.

Discussion was then opened to WHO regional colleagues and other participants who also reiterated the value of the midwifery model of care and highlighted the need for policy-level dialogue, as there are many barriers in many countries to the extent of care midwives can provide. They also highlighted the need for improved training to build up midwifery skills and leadership within various country contexts and cultures. Some partners also highlighted the need for careful positioning of this among countries, as countries are at different stages in terms of midwifery care, so case studies of different country contexts would be important. Others reiterated the need to clearly differentiate this model of care from the existing SBA or auxiliary nurse midwives’ model and focus on how additional training for SBAs may be a way forward in many countries where SBAs are being used.

Ms Sarah Bar-Zeev, Midwifery, Maternal and Newborn Health Specialist, UNFPA, voiced UNFPA’s support for this work and noted it has been included as a key priority in the UNFPA Strategic Plan and in the new UNFPA Midwifery Acceleration Strategy that will be launched later this year. She also mentioned that UNFPA is supporting countries that wish to transition to a midwifery model of care.

Dr Tuipulotu, Chief Nursing Officer, WHO, highlighted the need to continue the development of the current cadre to ensure safe and good quality of care, the need for regulation and to include not only the ministry of health but also the ministries of finance in discussions at country level.

The closed session continued the discussion, reiterating similar issues, and concluded that the the guidance document on transitioning to midwifery models of care will be about operationalizing midwifery care in countries, depending on their context. It will be a practical implementation guidance document that will include case studies. This guidance intends to help countries consider the full scope of moving beyond considering the midwifery workforce as being only SBAs to midwives providing continuity of midwife care to the dyad (mothers and newborn) across the continuum from pre-conception to the postpartum period, including family planning, safe abortion care, and prevention of stillbirths. The guidance will strengthen the importance of collaboration and cooperation across health cadres. This work will be linked with STAGE work on the MNH transition framework, EmONC and primary health care.

STAGE highlighted the importance of clarifying the scope of midwifery practice (perhaps through a diagram) in relation to other members of the health workforce including community health workers. The implementation guide needs to be context specific and should fit with where a country is in relation to scaling up the midwifery model of care.

## Recommendations

1. WHO to present the finalized global position paper on midwifery models of care and a draft of the implementation guidance, integrating case studies and country examples that show the diversity of models implemented in different settings, informed by the Maternal Newborn Stillbirth Transition Framework and in consultation with the WHO Health Workforce department.
2. WHO and partners to utilize the global position paper to operationalize WHO Strategic Directions for Nursing and Midwifery 2021–2025 (WHA 74.15) to advocate for and promote midwifery models of care.
3. WHO, through its collaboration with the International Labour Organization (ILO), to help inform task descriptions for midwifery professionals and midwifery associate professionals in the anticipated revision of the International Standard Classification of Occupations by the ILO.

4. WHO to support identification of knowledge gaps and research priorities on midwifery models of care, including implementation research.

## Kangaroo mother care

Dr Gary Darmstadt, STAGE member and co-chair of the STAGE working group on KMC, provided a brief update on the efforts to develop/refine the Practice Guide for Healthcare Providers and Programme Managers, which will be published early in 2024. The [KMC global position paper](#) and [KMC implementation strategy for scale-up](#) were launched in May 2023. He also presented the prioritised research questions – the top 12 and 24 lower tier research questions – to inform the WHO recommendations for care of preterm or low birthweight infants. He then described the process of developing the practice guide, which included a subgroup taken from working group members. The guiding principles for the guide were that it would describe what health care providers need to know to effectively introduce and sustain KMC for all eligible newborn, irrespective of the setting in which the health care workers work, and it can be used to develop national and local guidelines and protocols from which training material can be developed. The contents include sections on:

1. How KMC is defined, and the motivation, purpose, audience and use of the Guide are outlined.
2. What it is, who is it for, and why is it important.
3. Practising KMC at all health system levels, emphasizing that KMC is not a vertical programme. It presents the key health system requirements and actions for practising KMC at tertiary, secondary and primary level health facilities and in the community while always keeping the mother and baby together and ensuring respectful care.
4. KMC practice in facilities, who, when, how. Provides practical guidance for health care providers on how to support mothers and families in practising KMC in health facilities.

5. How to support mothers and families in starting KMC at home. Covers the initiation and practice of KMC in the community for home births and newborn who left the health facility after birth too soon for KMC to be established. Of particular interest to providers of community-based care, including KMC through community clinics, facility outpatient or outreach services, home supported by community health care workers or through women's or peer groups.
6. Practising KMC for babies transferred between facilities, or between home-facility-home.
7. KMC toolkit: tools and aids to support health care providers.

He then highlighted the plans for country-level policy and programmatic uptake in 2023–2024. These include leveraging the ENAP-EPMM platform, including regional consultation meetings; French translations for the KMC global position paper and KMC implementation strategy, which are complete, and for the preterm/low birthweight guidelines, which are underway; engagement with professional societies, civil society organizations and parent groups; and development and dissemination of policy briefs, implementation guidance, communication and advocacy materials for selected interventions in the WHO preterm/low birthweight guidelines in collaboration with other UN and implementation partners.

Based on the brief discussion among STAGE members, the following guidance was formulated.

## Guidance

1. WHO in conjunction with partners on the ground to coordinate the regional and country-level adoption and adaptation of the principles and practices of KMC implementation for all preterm or low birthweight infants as a foundation for small and sick newborn care (SSNC) as recommended by WHO.
2. WHO to seek support from global partners to support country-level implementation and scale-up of KMC.
3. STAGE recommends reporting by all countries on the ENAP indicator for KMC coverage in health facilities.

# New topics

## Maternal well-being

### Background

Ms Justine Le Lez, MCA/WHO, first acknowledged the contributions of and collaboration with the Health Promotion department, SRH, NFS, Mental Health and Substance Abuse for this work. In her presentation, she alluded to the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), where the terms “survive, thrive and transform” capture the pursuit to advance beyond mortality reduction. In the context of maternal health, although ending avoidable deaths will remain a top priority in the years to come, the quest to achieve a more comprehensive state of health and well-being has emerged as a concrete goal.

WHO defines well-being as “a positive state experienced by individuals and societies. Similar to health, it is a resource for daily life and is determined by social, economic and environmental conditions.” Although WHO's definition of maternal morbidity includes well-being, maternal well-being as a concept is still vague and needs to be developed. WHO has now started to develop a standard definition and conceptual framework of maternal well-being. This effort will be aligned with WHO's framework for well-being from the Health Promotion department, with MCA's work on the framework for well-being throughout the life course, and with MCA's work on child and adolescent health and well-being.

Ms Le Lez then outlined the process used by the MCA department to develop the definition and a draft framework, which included a comprehensive scoping review of the literature (32 studies) on the concept of maternal well-being (conception to 12 months after birth) including previous definitions, domains, indicators and knowledge gaps, to identify how maternal well-being has been previously conceptualized in the literature. To initiate a more formal discussion on maternal well-being, WHO/ MCA convened a technical consultation with a multidisciplinary group of experts, where the main results of the scoping review on maternal well-being were presented to the participants.

The group discussed the findings and produced a draft definition and identified key domains of maternal well-being.

The draft definition is:

*Maternal well-being is a positive state experienced between conception until one year after the end of pregnancy across six domains, and influenced by the world the woman lives in. During this dynamic and adaptive period of transition, the woman and her family have the support, confidence and resources to thrive and realize their full potential and rights.*



Draft framework with key domains that encompasses demographics, equity, environment and policies too.

She then explained the next steps which will include further consultations with Women's groups, midwives and an online consultation. The draft definition and framework were presented at the International Federation of Gynecology and Obstetrics (FIGO Conference for inputs. The revised definition and framework based on all these inputs will be published.

Ms Le Lez ended her presentation with the following questions for STAGE:

### Questions to STAGE

1. Please share your reflections on the framework, particularly the domains and subdomains.
2. How does this framework integrate with a life course approach and WHO work, including health promotion and child and adolescent well-being?
3. Who would you suggest we target for additional consultation and feedback?

### Discussion

STAGE members acknowledged the framework on maternal well-being as being comprehensive; however, they suggested that some areas needed to be strengthened and added to the framework. These included highlighting the life course approach by strengthening links with women's well-being, mothers' well-being and families' well-being and by highlighting the role of partners in maternal well-being and other children within the family, as well as spiritual influences. This will ensure consideration of the preconception period and every pregnancy outcome. Many members reiterated the need to explicitly include nutrition, food safety and nutrition security. Some also suggested highlighting breastfeeding protection and rights. There was a suggestion to include sexual and reproductive health and menstrual health, while considering maternal autonomy and agency, especially with respect to adolescent girls along with women.

Members suggested that specific links to toxic exposure and climate change in the environment domain must be highlighted. Similarly, as part of policy, focusing on economic aspects may also be important, especially links to universal health coverage, health insurance including social protection, legal protection for maternity leave, and financial security.

STAGE members then highlighted the need for WHO to develop an implementation strategy for maternal well-being for countries, with tools and approaches, to operationalize the framework into concrete policy actions from Member States, considering women's perspective on what they consider as priorities.

It was recommended by STAGE and partners to include social workers and informal care groups in the consultation process. WHO should ensure the geographical distribution will address different perspectives of values and cultures.

WHO regional colleagues and partners reiterated the need to specifically focus on nutrition, sexual health, role of partners and financial security while also highlighting the need for clear operational guidance on how to translate this framework to policies in countries.

Based on the discussion in the open and closed sessions and further online consultations with STAGE members, the following guidance from STAGE was finalized.

### Guidance

1. WHO to consider all aspects of maternal well-being, in addition to health, when developing normative and implementation guidance.
2. WHO to operationalize this framework across the life course, ensuring linkages with the Maternal and Newborn Health Transition Framework and with the WHO Framework on Well-being.

## Birth defects

### Background

Dr Ayesha De Costa, MCA/WHO, provided a summary of the work done and plans that are in place for birth defects work in WHO. She started her presentation providing the context and background: In 2010, the [Sixty-third World Health Assembly](#), recognized the importance of preventing and managing birth defects. WHO was advised to support Member States in developing national plans for implementation of effective interventions to prevent and manage birth defects within their national maternal, newborn and child health plan, strengthening health systems and primary care.

The responses from WHO so far have focused on primary prevention (food fortification, vaccines) and secondary prevention (pregnancy interventions like prevention of mother to child syphilis transmission). Tertiary prevention strategies now need to come into focus. The current focus of the MCA department in WHO is on providing estimates

of the prevalence of birth defects (ongoing) and supporting countries with surveillance (ongoing). WHO has also published on terminology, has created a 'burden of birth defects technical working group' and is convening a consortium of analysts to update the [Born Healthy Toolkit](#). It now plans to develop guidelines and guidance to help countries develop newborn screening and management programs. Newborn screening is also mentioned in the WHO postpartum care guidelines and in the universal health coverage compendium for the first time.

An increasing proportion of LMICs are successfully reducing infant and child mortality from infectious causes by increased vaccination coverage, improved water and sanitation, and better access to health care. These improvements have meant that [birth defects](#) make up an increasingly larger share of infant and child mortality. Overall, 8% of deaths in children under 5 years result from birth defects. It is estimated that about 94% of severe birth defects occur in LMICs. While routine newborn screening and early management pathways are well defined in many high-income settings, in LMICs this is an area that needs to be prioritized.

Given that there are a very large number of different birth defects, efforts in this area must be prioritized. The current thinking, based on prioritisation efforts made with regional advisers, a global survey of paediatricians, and a review of registries, is to focus on developing technical guidelines on newborn screening, diagnosis and management of birth defects, focusing first on five to six key birth defects and primarily focused in LMICs. The prioritization was based on several principles that included a relative high burden of the birth defect, the ability to accurately diagnose the birth defect in country (or if not presently, capacity can be feasibly built up), treatment is feasible (or can be built up reasonably) in the context of health systems, the birth defect makes a significant impact on the life of the infant/child, and the health system can reasonably bear the cost (detailed cost-effective studies are not always available). This would be accompanied by implementation guidance. The focus of the newborn screening efforts will be

around the well-being of the baby and not around a particular screening modality.

Dr De Costa then requested STAGE guidance on the following.

### Questions to STAGE

1. In the context a paucity of resources dedicated to this agenda, does STAGE support the need for increased attention and investment from governments and donors in the area of detection and management of birth defects in newborn and children within the current MNH health agenda?
2. Does STAGE support the need for guidelines on newborn screening and management of an initial set of (initially five to six) birth defects? Does STAGE support the focus of these guidelines being on LMIC settings?
3. What suggestions/advice would STAGE have for the process by which the selection of five to six conditions for the first iteration of the WHO guidelines for screening and management will be made?
4. Does STAGE support the need for the guidelines to include implementation guidance for ministries of health in countries to initiate screening and management programs integrated into existing MNH programs?
5. Does STAGE support universal newborn screening for birth defects with a newborn-centred approach to screening rather a screening technology-driven approach?

<sup>5</sup> WHO Maternal and child health epidemiology estimates group (MCEE) 2019

<sup>6</sup> Christianson AL, Howson CP, Modell B. Global report on birth defects: the hidden toll of dying and disabled children. White Plains, NY: March of Dimes Birth Defects Foundation; 2006.

## Discussion

STAGE members recognized and endorsed that this is clearly an important agenda that needs attention now. All agreed that it is important to share some of the information in the slides more widely to raise the priority. They suggested it may be useful to create an investment case to help the prioritization, while considering a hierarchy of choices based on evidence. Members thought the term ‘birth defects’ may not be the most sensitive term but produced no consensus agreement on an alternative term.

Some members suggested that WHO should consider developing implementation guidance first, before specific guidelines, and should link this guidance to the MNH transition framework. Many opined that the guidelines and implementation guidance should focus on tertiary prevention, but should also include a section on prevention, both primary and secondary. Mortality or burden clearly should not be the only criterion for a decision on a condition to be included in a program. Morbidity is equally or perhaps more important, and a suggestion was to use proxy data for morbidity estimates, such as disability registries in the social sector, education sector etc.

Capacity and capability in country are critical factors. Impact on family/society are important (including stigma). Members suggested that it would be important for countries to consider their infant mortality rate and situation along the transition framework. It was important for estimates to capture not just mortality and birth prevalence but to also estimate morbidity. It would be helpful to look for any increase in absolute numbers of mortality from birth defects, as it would allow for ministries of health to plan services. Cost-effectiveness would be an important consideration, and members opined that both direct costs (immediate treatment) and indirect costs (longer term) should be considered.

Many of the STAGE members suggested that it is important to emphasize simple processes like visual body scans. The risk with transcranial magnetic stimulation is real and is a poor use of scarce health resources. They also mentioned that it is important to consider levels of care: screening could occur at primary level, but management may only occur at tertiary level, depending on the condition. However,

a few members were concerned about the ethics of screening when no treatment or support is possible. Members also highlighted that the use of the word ‘treatment’ may imply cure, whereas it may mean mitigation to improve quality of life. Other issues included a context-specific focus like in the Eastern Mediterranean Region, to focus on metabolic disorders because of consanguinity.

Many members believed it may not be best to focus on four to five conditions; rather, WHO could consider a programmatic framework from primary to tertiary prevention around the transition framework and reflect conditions that can be managed from a transition perspective. However, guidelines could focus on one to three conditions and increase incrementally. It may be useful to let countries have experience with one to two conditions and then build on that. Coronary heart disease may be a first condition, given its burden and importance.

The WHO team clarified that, since Birth Defects Day 2022 and after public comments on the use of the term ‘birth defects’, discussions have taken place with the Communications department and with other stakeholders who have also had similar feedback over many years. Consultations held by key donors working in this space and with parent groups have also been undertaken. However, no consensus term has emerged. The term ‘birth defects’ has been used in these deliberations continuously since the World Health Assembly resolution in 2010.

Based on these discussions and those in the closed sessions and during the online consultation, the following has been finalized as recommendations from STAGE.

## Recommendations

1. WHO to move the birth defects agenda forward, given the increasing proportion of child mortality and morbidity attributable to birth defects as child survival improves in LMICs.
2. WHO to develop an implementation guidance framework for countries seeking to start or expand a universal newborn screening programme, including specific needs and considerations for diagnosis, management and long-term care, to guide countries depending on where a country is situated along the MNH transition framework.

## Complementary feeding of children aged 6–23 months

### Background

Dr Larry Grummer-Strawn, NFS/WHO, provided a brief presentation highlighting the issues around optimal infant and young child feeding. Although crucial for children's growth and development, the quality of complementary feeding for young children is often overlooked, leading to poor outcomes such as growth issues, increased morbidity and delayed development. In addition, poor diet quality in young children leads to obesity, non-communicable diseases, reduced work capacity, and impaired reproductive capacity later in life.

The Fed to Fail Report identifies challenges, revealing that a significant percentage of children lack dietary diversity and essential nutrients. Key findings indicate that for children aged 6–23 months, only 59% consume enough vegetables and/or fruit, 45% consume egg, fish and/or meat, with low rates of minimum meal frequency (52%) and dietary diversity (29%). Additionally, one in three children aged under 5 years faces severe food poverty, particularly in South Asia and sub-Saharan Africa.

Global concerns extend to the daily consumption of ultra-processed foods by young children, contributing to health risks such as obesity and non-communicable diseases. WHO offers guidance documents to improve young children's diets, including updates on feeding indicators, counselling training, and regulations against unhealthy food promotion. The WHO/UNICEF manual on infant and young child feeding indicators was updated in 2021 to provide more detailed information and to address consumption of unhealthy foods and beverages. WHO updated the training curriculum on infant and young child feeding counselling in 2021. Guidance on the inappropriate promotion of foods for infants and young children presents recommendations for regulations that would limit unhealthy or unsafe foods and ensure that messaging about food products is supportive of breastfeeding. WHO has

also developed nutrient profile models to identify food products that should be avoided by children. UNICEF has recently published on the state of children's diets and documented a high prevalence of "child food poverty". The UNICEF framework for complementary feeding describes approaches to building better policies and programmes to improve diets in this age group.

In October, WHO launched a new [Guideline on complementary feeding](#), emphasizing the importance of diverse diets and cautioning against unhealthy foods and beverages. It reiterates the importance of a diverse diet to allow children to meet their nutrient requirements, particularly emphasizing the importance of animal-source foods along with fruits and vegetables. It cautions against any consumption of sugar-sweetened beverages and foods high in fat, sugar and sodium, as these displace healthier foods and lead to long-term health problems and poor diets. The guidelines also highlight the importance of responsive feeding, which is built into the WHO nurturing care framework. It also recognizes that for some food-insecure populations, specialized food products will be needed to help young children grow and develop normally. However, it does not address preterm and low-birthweight newborn, acute malnutrition, serious illnesses, disabilities or emergencies. The guideline is supported by 13 systematic reviews and dietary modelling. It provides seven recommendations on: (1) Continued breastfeeding, (2) Milks for children fed milks other than breast milk, (3) Age of introduction of complementary foods, (4) Dietary diversity, (5) Unhealthy foods and beverages, (6) Nutrient supplements and fortified food products, and (7) Responsive feeding.

Towards the end of the presentation, Dr Grummer-Strawn emphasized the need to move beyond health sectors to address complementary feeding issues. He highlighted that WHO and UNICEF are developing implementation guidance, promoting multisectoral actions in health, food systems, social protection, water and sanitation, and education. WHO and UNICEF are also forming a new Global Complementary Feeding Collective to bring together UN agencies, civil society, academics and government ministries in shaping the landscape of complementary feeding. The overall aim is to

galvanize support to scale up interventions for improving complementary feeding and diets of young children, thus contributing to delivering nutrition results and achieve actions prioritized in the Nutrition for Growth Summit. The main priorities that were identified were to strengthen data and knowledge management, identify and build consensus on priority actions related to complementary feeding, address challenges related to positioning of complementary feeding, and address challenges related to programming.

Dr Grummer-Strawn presented key questions to the STAGE for discussion and responses are captured below.

### Key questions for STAGE:

1. How can counselling on infant and young child feeding be better integrated into routine well-child services given the large number of interventions clinicians are expected to cover?
2. What role should primary health care centres and community-based programmes play in the distribution of targeted foods and nutritional supplements?
3. How can multisectoral collaboration be strengthened to engage other sectors in improving child diets?

### Discussion

STAGE identified challenges within the commercial determinants of health and highlighted that while the interventions are restricted to counselling, cheap and unhealthy snacks are prevalent in almost every country. These are easily available and accessible to families, and this finds its ways to toddlers and young children who consume them throughout the day, hindering the intake of nutritious meals. Addressing this issue involves dealing with the ready availability, affordability and potential harm of such foods. Regulation and taxation of unhealthy foods may be some of the necessary mechanisms, which needs to be complemented with educating households and parents about the unhealthy nature of these snacks and encouraging them to make healthy food choices. Members also raised concerns about health care providers promoting healthy practices while contradictory commercial determinants persist, such as fast-food establishments within hospitals. Some suggested

testing the feasibility of extending guidelines to address commercial determinants, like restricting unhealthy food promotions within health care facilities.

However, STAGE members cautioned against a one-size-fits-all approach. Country context and available resources are important factors: there might be certain settings where counselling and information sessions can be integrated in group and community settings; in others, integration could be leveraged through technology.

A few members also discussed the variety of professionals involved in counselling across different jurisdictions, including family physicians, nurses, midwives and community health workers. For example, in Canada it is the family physicians who would provide counselling to new parents. But in other situations, it could be nurses, midwives, community health workers or teachers. It might be worthwhile to generate a list of who does counselling in different jurisdictions. Members reiterated the need for clear standards and guidance for countries and country contexts. They highlighted the importance of curriculum development for counselling on complementary feeding for health care workers and the need to define essential counselling components for everyone and targeted interventions for specific at-risk groups. Some members also underscored the importance of integrating counselling with other life course screenings and health programmes, like the Integrated Management of Childhood Illness (IMCI) framework. Health care professionals, however, for the most part get no nutritional education when it comes to the curriculum, so this needs attention.

Given the time constraints during well-child visits that mothers and caregivers experience, especially at low-income settings, some members advocated shifting the focus of integration from health centres to communities, where more impactful interactions can occur. STAGE members provided a few country examples of integration:

- Indonesia's Posyandu system is an integrated approach covering nutrition, vaccination, growth monitoring, family planning, etc.
- Finland's well-baby clinic approach with pre-visit information packages, quizzes and online follow-ups highlights the importance of human contact alongside digital resources.

- Australia's paediatricians have clearly defined guidance on their role of not promoting certain unhealthy food and formulas.
- Ghana has tested the feasibility of using different trained personnel in counselling – nutritionists, nurses, agriculture extension officers and other trained volunteers – with varying but appreciable success.

These country examples could serve as learning opportunities for integration and the need to explore digital tools, guidelines and apps as opportunities for integration, while emphasizing the need for personal interaction within these technological options.

While counselling is an important intervention, it is equally important to enable mothers and households to access and afford healthy options. In rural settings, agriculture-based interventions enable them to access nutrient-rich foods they may otherwise find challenging. Interventions to encourage people to grow their own food, and discussions around edible landscaping, fostering urban agriculture, vertical gardens, and gardening, may be considered.

STAGE members stressed the importance of cross-ministry and multisectoral policies and regulations, highlighting the Health in All Policies approach as a platform for nutrition initiatives. They called for the integration of nutrition messages in various platforms such as antenatal care, postnatal care and immunization services. There are examples from Bangladesh, Finland and Saudi Arabia where cross-sectorial ministries have been formed at a high level of government. Members also highlighted the importance of NGO involvement in shaping policies and initiatives related to child nutrition. They advocated for the inclusion of the faith sector, particularly in sub-Saharan Africa given its significant role in providing services, in collaborations to address nutrition challenges. These multisectoral approaches should not only be restricted to the national level but also should be encouraged at subnational and district levels.

There was also discussion on more general topics related to cultural aspects of child feeding practices leading to undernutrition and eating disorders; the need to introduce peanuts and eggs early on to reduce future food allergies; the role of fathers in

addressing child nutrition; considering maternal well-being within this concept and addressing the barriers and facilitators to maternal caregiving practices, especially in populations at high risk for malnutrition; and the role of animal milk.

WHO colleagues from the regional offices supported and reiterated many of the comments made by STAGE members. For example, the role of family dietary habits and cultural context, the importance of legal and regulatory mechanisms, the need for multisectoral collaboration, the role and ability of primary health centres to support nutritional interventions and not be just a distribution centre for food supplements; and the need to look at ways to increase demand for healthy foods.

Dr Grummer-Strawn agreed with many of the comments and highlighted that creating demand for healthy foods is important; however, it is important to understand what drives demand – it is taste, convenience and price. Taxation may be a good intervention; however, the industry is fighting any regulation or legislation that affect demand for foods like sugar-sweetened beverages and other unhealthy snacks. He clarified that many of the comments and questions addressed here are going to be fed into the implementation guidance which will address “how do you do this?”, “what are the challenges?”

WHO has done a fair amount on how to address the marketing of commercial complementary foods. However, a lot of the food we are concerned about is not necessarily complementary food, it is just food for the general populations. WHO is doing more on marketing of unhealthy foods to children. However, many of the marketing schemes are not directed to children. It is generally directed to the population and that makes it hard to address the marketing aspects.

Maternal wellbeing is important; however, it has been unclear in WHO's communication whether we talk about the mother, her wellbeing, the family situation etc. WHO is trying to do more in maternal nutrition, but current thinking has been largely focused on antenatal nutrition issues.

The multisectoral theme is an important way forward: coming together to understand what is needed but allowing sectors to work on the issues independently. WHO would like to go forward with the concept of plan jointly, act individually, and evaluate jointly.

Dr Grummer-Strawn was supportive of the idea of wanting to build from the school feeding into the day-care setting. There is currently no guidance on day-care feeding practices. There are day-care programmes that have standards but no specific guidance on feeding in day cares.

Food allergies were considered by the guideline development groups, but more in the context of when should a food group be introduced. The conclusion was that the evidence does not indicate any need for starting earlier than at 6 months.

WHO is working on clarifying the communication around milk and formulas. The question was really around which milks are appropriate to children, do they need to have follow-up formula, do they need to have infant formula in addition to breastfeeding? WHO will continue to work on its future messaging around this.

Based on the discussion in open and closed sessions and further communication online, the following recommendations have been finalized.

### **Recommendations**

1. WHO and its partners to scale up advocacy efforts to drive financial resources and significant policy changes to improve complementary feeding.
2. WHO is encouraged to develop solutions with the social protection sector to improve access to healthy and affordable foods appropriate for infants and young children.
3. WHO to develop a comprehensive framework on nutrition education for health care providers.
4. WHO should develop guidance on effective methods of communication on appropriate complementary feeding through group counselling and new modes of communications, including through social media, targeted messaging and virtual clubs.

## Partners forum

The partners forum was organized to enable partners to provide their insights about how the STAGE recommendations are used and translated at country level. In addition, this was an opportunity for them to provide inputs into topics that will be discussed at STAGE. This session was led by Dr Jeff Smith from the Bill and Melinda Gates Foundation. He started the discussion by highlighting that although the STAGE recommendations are made to the DG, WHO, they are also addressed to the donor community and partners and he invited partners to provide their perspectives.

The United States Agency for International Development (USAID) started off the conversation with Dr Nancy Bolan first expressing her appreciation for STAGE's work and their recommendations, and she alluded to various funding mechanisms used by USAID to support MNCAHN activities both at global level and in countries. These include evidence reviews and normative guidance; implementation grants to WHO; and the grants to UNICEF, UNFPA and other organizations. Externally funded projects include MOMENTUM, a suite of projects that aims to accelerate reductions in maternal, newborn, and child mortality and morbidity in high-burden countries by increasing host country commitment and capacity; MOMENTUM Integrated Health Resilience focuses on conflict and humanitarian settings. Additionally, they support projects on MNH commodities, on the indicators side, and measurement issues.

Focusing on STAGE recommended work that is supported by USAID, she mentioned child health work related to well-being, risk stratification and management of pneumonia and diarrhoea, paediatric quality of care indicators; maternal and newborn health work including respectful maternal care, midwifery models of care work, MNH commodities; SSNC including the KMC work. She said USAID is keen on learning more on the MNH transition framework and the congenital birth defects work from this meeting.

Dr Patricia Jodrey and other colleagues from USAID added that STAGE recommendations and endorsement elevates the topic from the perspective of research to an actionable level

where donors can then support the countries to implement them, and catalyse with core funding and with mission inputs. It allows donors to take an issue to a ministry of health, or to a local mission, or to other partners, and can present the topic as one that has been prioritized by WHO through the STAGE process and recognized by the partners.

Ms Keiko Osaki, Japan International Cooperation Agency (JICA), reiterated its appreciation for STAGE as it allows bilateral organizations such as JICA to learn about priority topics. It also provides the opportunity to reflect its policies and strategies to address MNCH within its focus on strengthening quality, continuum of care for maternal, newborn and child health and aligning with the ENAP, EPMM targets. JICA likes to set the same direction and the same agenda at the country level, and to engage with other partners with similar focus.

Dr John Borrazzo, Save the Children, provided his reflections on STAGE given his experience at USAID and at GFF. In his view, one of the big contributions of STAGE is in supporting implementation by its ability to be a neutral arbiter of issues. Countries suffer potentially from too much information and too many different partners engaging with them. STAGE, through its recommendations, enables countries and partners to focus on the most critical issues. In addition, STAGE's role in advising WHO is important for countries, as they rely on WHO for guidance and guidelines, and it also helps partner coordination on these issues at the country level. Given the reality that countries are pulled in so many different directions with various issues, it is important to be much more systematic about strengthening and helping countries support coordination across all implementing partners. Thus, it is also important for STAGE to focus on fewer rather than many things and to try to really highlight the things that are most critical.

Dr Smith supported the need for better coordination at country level and the need to find ways to ensure that these conversations are happening within the country-level technical working groups for MNH, such that the acceleration plans are being implemented using the collective resources of all the partners at country level.

Dr Himansu Basu from Rotary International added that STAGE strengthens and increases the impact of work done in MNCAHN and extends its reach. He advised partners to use lessons learned from the polio eradication efforts to address maternal and child mortality.

Colleagues from Merck for Mothers reiterated their commitment to help reduce maternal mortality across the globe through their financial commitment and by bringing Merck's own unique capacity to the table. In relation to STAGE's contribution to their work, they believe STAGE guidance does help guide their investments. While they were appreciative of STAGE's role in influencing implementation at country level, they felt STAGE has a lot of influence in ensuring coordination at the global level.

Dr Smith reiterated the need for a coordination mechanism at the global level for MNH. The ENAP and EPMM targets, especially the 90 90 80 80 targets developed by WHO, together with UNICEF and UNFPA, have been important in moving the agenda forward. He felt, however, that there is need to further influence investments made by Gates foundation, GFF and World Bank that respond to MNH needs and help achieve these targets. He provided the example of KMC which was supported by STAGE, and the Gates foundation is funding the implementation research for KMC.

Dr Smith then requested STAGE members to share their expectations from donors and partners and how partners can be better engaged in this conversation about taking STAGE recommendations forward.

Professor Caroline Homer started the discussion by saying that, as STAGE Chair, she would like partners to consider STAGE recommendations when developing their strategies and work plans for countries. Secondly, she would like partners to bring their perspectives on implementation to STAGE. And finally, most important are the resources that partners bring in that enable translation of the recommendations to actions, so coordinated efforts to make this happen are essential. She suggested that partners could perhaps first develop an investment portfolio for MNCAHN. This meeting creates a priority and justification within a broad and neutral set-up. Other members supported this by suggesting bringing the survive and thrive part of WHO's work to the forefront, and the impact on

human capital, which may influence World Bank's policies and investment plans.

Dr Smith provided the recent development of the PPH roadmap as an example where the Gates foundation spearheaded the process with WHO and partners for prioritization of research, guideline, and implementation questions. This ensured that the majority of the world's effort for the next few years in PPH would be addressing the things that the global community had decided were the most important questions to be answered. STAGE also has a similar opportunity, although he was unclear if STAGE is prioritizing issues, as it appears that STAGE is taking on a lot of different things and not necessarily ranking them, which makes it a little bit harder for the donor community. However, there is a great opportunity to work with a group of experts across the domains of MNCAHN.

Various members reiterated and supported Professor Homer's observations and highlighted the value of a committee like this that brings different perspectives to the table, and it is that synthesis that really makes this efficient. Several members raised the issue of transparency in funding decisions and how agendas and priorities are formed within their organizations. One member highlighted that it is often said that basically 86% of research does not contribute to anything, which may be a bit simplistic; however, one of the major criticisms is that the research agenda is driven far too much by donors, and that donors are not responding to needs of the countries. One proposal may be some type of joint process by which Member States together with communities can identify the top research priorities and donors would respond to that.

Another member suggested that partners being at country and regional level can also play a catalytic role in bringing sectors other than health to the conversations. Many of the interventions get stagnant without the support from other sectors in the country level processes. The midwifery models of care could be a good example where partner support at country level could make a huge difference given the political complexities.

STAGE members echoed the need for some way of donors reporting back on how a recommendation from STAGE is making an impact in countries. While Dr Smith raised the issue of ranking topics, it was unclear to many members if that is the mandate of STAGE.

The session ended by Dr Smith suggesting the need for a much stronger conversation between the donor community and the guidelines- or agenda-setting community, and he hoped STAGE will play an important role in helping to have a two-way conversation about setting priorities. He requested partners to send into the STAGE secretariat their list of topics that they would like STAGE to consider. Some partners responded to that, and some topics suggested were the following.

#### USAID:

1. Explore quality implementation of high-impact interventions that could advance EPMM/ENAP/Child survival action (CSA) – supporting country alignment and investment resulting in MNC mortality reduction. These may refer to water and sanitation, nutrition, essential commodities, and human resources, or bundles such as SSNC and PPH.
2. Increase attention to fragile and conflict-affected settings and increase attention on/inclusion of francophone participants/settings.
3. Caesarean section – trends and uptake and best approaches to increasing access as needed, without overuse.
4. Integrate the child health commodities, according to the level of care, with the MNH commodities work.
5. It will be important to see an alignment between Maternal Well-being and Infant/Child Well-being (i.e. not just with the newborn).
6. Examine how climate issues affect all mothers, newborn and children, and not just one specific group.

Foreign Commonwealth and Development Office (FCDO), UK:

Adolescent pregnancy – risks for girls – covering health, education, ability to enter the workforce, stigma etc. with a view to producing guidance/key actions.

FCDO would be interested in jointly running an event on this in 2024 – it would be great to incorporate any STAGE findings if appropriate/useful.



# Closing session and next steps

## Closing remarks

Professor Caroline Homer thanked all STAGE members and all partners, stating that the work shown is a culmination of years of effort. She acknowledged the excellent documents, clear presentations and lively discussion, then called on the directors of the three departments to share their closing remarks.

Dr Özge Tunçalp provided the closing remarks on behalf of Dr Pascale Allotey, Director, SRH, who was on leave. She thanked everyone especially the STAGE members and partners on behalf of Dr Allotey and the SRH department for bringing such wealth of experience, knowledge, wisdom and enthusiasm to support WHO's work and mission. She referred to WHO Chief Scientist Jeremy Farrar's words, "WHO is a scientific voice and now a moral voice for the world. There are challenges, but who has rarely been, if ever, in the last 40 years, more relevant, more respected, and more important than WHO?" Towards this mission, WHO produces the normative products that enable countries to implement the work. WHO now has more intentional and more rigorously developed target product profiles and roadmaps, like for PPH. STAGE has continually highlighted the need for more equitable and meaningful collaborations and co-production across regions, countries and different stakeholders. These are challenging times where health has become even more political and evidence more divisive. And with all this changing global ecosystem from wars to climate change to digital transformation, it is important to be able to take a step back, look at the big picture and the vision, and plan and act strategically, even though our instinct is to just respond. This is precisely the reason why groups like STAGE are important because this is a chance for WHO to be able to convene and bring together diverse expertise and minds to take time for this kind of strategic thinking. She then reflected on the conversation about partners and the STAGE recommendations and about how to make sure that STAGE as an advisory body is positioned to reach its full potential to support WHO's mission.

It is important to review the process periodically to ensure these goals are met. She then mentioned that an introspection process is currently underway at SRH/ HRP (Human Reproduction Programme) where they have several advisory bodies, and after years of running these meetings and getting these recommendations, the department took a step back and did interviews with the advisory group. These have helped both the members and the department to ensure that these advisory bodies give the kind of recommendations that would really impact the lives of women, newborn, children and adolescents. She thanked STAGE for supporting WHO in this journey.

Dr Larry Grummer-Strawn, representing Dr Francesco Branca, Director NFS, conveyed Dr Branca's apologies, as he was travelling this week and unable to attend. He thanked the STAGE members who he felt this time really came together intentionally to be very interdisciplinary, as there was integration of the topics and the interactions were across all the domains. For example, it was good to see the integration with nutrition during the discussion on maternal well-being. Even during the parenting and the nurturing care framework, members highlighted the nutrition component and how it connects very closely with complementary feeding. Maternal health and nutrition are areas that WHO needs to focus on further and strengthen the links between them, as most of the focus has been around nutrition in the antenatal care period. NFS has started to have conversations about nutrition more holistically for women, rather than recommending a particular intervention. So, the push from STAGE is very welcome. Similarly, the midwifery models of care, which is so central to breastfeeding at the start of life and ensuring that MNH commodities work is linked to nutrition, are other examples of how STAGE has helped WHO move forward with the integration of nutrition to MNCAH. He also thanked STAGE for ensuring the commodities discussion is not only about products but about the services that are around those products, like skin to skin, care and cord clamping etc. STAGE has also highlighted the need for integration across multiple sectors, in addition

to integration within the health sector. He thanked STAGE members for all their valuable inputs and for helping WHO to think through the complexities of integration in these issues.

Dr Anshu Banerjee, Director MCA, thanked Professor Homer and the STAGE secretariat for making sure all the work comes together and is presented to STAGE to make the meeting successful. Secondly, he thanked Ms Katia Gaudin-Billaudaz, Senior Assistant to Director, MCA, and other administrative support staff for helping with all the travel, food and IT arrangements.

He echoed Dr Grummer-Strawn's comments and appreciated the links that STAGE highlighted between the topics that were presented as individual agenda items. He thanked the members for making the importance of linking many of these topics clear to WHO. So, besides the recommendations on individual pieces, it is the overarching concept that he valued the most. He then also highlighted the STAGE commentary on MNCAHN and primary care that resulted from the last meeting and the suggestion for another commentary on the humanitarian issues now.

He added that perhaps STAGE could consider a piece on the integration as mentioned by Dr Grummer-Strawn – how to integrate nutrition with MNCAH and more importantly within a multisectoral approach. Also, how to get the recommendations from each STAGE meeting as an external publication, so that it reaches the wider community. He then reminded the group about the ADG Bruce Aylward's focus on reducing maternal mortality as one of the primary agendas for WHO in the next programme of work. The work on the MNH transition framework and the linking of different pieces – maternal well-being, MNH commodities, midwifery, birth defects and complementary feeding around that would be a really good way to take this forward. So, in the next meeting he suggested it may be useful for STAGE to think more strategically as to how to bring different pieces of work together in order to drive the global agenda.

Finally, he thanked all the STAGE members, those who woke up early, who stayed online at midnight and beyond, everyone who travelled to Geneva to participate in the meeting, and specifically Professor Homer at all times for her excellent chairing. He also thanked the partners for joining

the meeting and for their contributions, especially during the partners forum at this meeting. He reiterated and reminded everyone of the value partners bring, as WHO is very much at the policy level and it is the partners who implement policies at the ground level.

Professor Homer then closed the meeting, thanking everyone, with special mention to the new STAGE members who joined in person and to the WHO technical teams and the secretariat. She expressed her thanks to Dr Banerjee for his incredible work and leadership that has made STAGE a reality. She was certain that STAGE is in a strong place now, and it can and will make a useful contribution to the global MNCAHN agenda. She announced the 2024 STAGE meeting dates: 13–15 May as an online meeting and 12–14 November in Geneva.

# Annexes

## Annex 1. STAGE meeting agenda

### Meeting of the Strategic and Technical Advisory Group of Experts (STAGE) on Maternal, Newborn, Child, and Adolescent Health and Nutrition (MNCAHN)

14–16 November 2023

Agenda (Hybrid Meeting, WHO Geneva Salle T)



#### Day 1: 14 November 2023 (all time in CET)

Time	Session	Duration	Purpose (Chair/Lead)
9:15	<b>Opening remarks</b> Bruce Aylward, ADG, WHO (5 min) Caroline Homer, Chair STAGE (5 min)  <b>Update and follow-up of STAGE recommendations</b> Anshu Banerjee, Director MCA (10 min)	30 min	<b>Welcome and Update</b> (Chair STAGE)
9:45	<b>Maternal well-being</b> Justine Le Lez, MCA/WHO (15 min)	1 hr 15 min	<b>Information and Discussion</b> (Chair STAGE)
11:00	<b>Coffee break</b>	30 min	
11:30	<b>Update on child and adolescent well-being: parenting skills</b> Bernadette Daelmans, MCA/WHO	1 hr 15 min	<b>Information and Discussion</b> (Chair STAGE)
12:45	<b>Lunch break</b>	1 hr 30 min	
14:30	<b>Maternal health transition</b> Allisyn Moran, MCA/WHO (15 min)	1 hr 30 min	<b>Discussion and Decision-making</b> (Chair STAGE)
16:15	<b>Update on midwifery models of care: implementation guidance</b> Justine Le Lez, MCA/WHO and Sally Pairman, International Confederation of Midwives (15 min)	1 hr 15 min	<b>Discussion and Decision-making</b> (Chair STAGE)
18:00	<b>STAGE Reception</b>		



## Day 2: 15 November 2023 (all time in CET)

Time	Session	Duration	Purpose (Chair/Lead)
09:15	<b>STAGE Closed session</b>	1 hr 15 min	<b>Decision-making</b> (Chair STAGE)
	<b>Bio break</b>	<b>15 min</b>	
10:45	<b>Implementation of new MNH commodities: update</b> Allisyn Moran, MCA/WHO (15 min)	1 hr 30 min	<b>Discussion and Decision-making</b> (Chair STAGE)
12:15	<b>Lunch</b>	<b>1 hr 30 min</b>	<b>Photo session</b>
13:45	<b>Kangaroo mother care update</b> Betty Kirkwood and Gary Darmstadt, STAGE members	45 min	<b>Information and Discussion</b> (Chair STAGE)
14:30	<b>Birth defects</b> Ayesha De Costa, MCA/WHO (15 min)	1 hr 45 min	<b>Discussion and Decision-making</b> (Chair STAGE)
16:15	<b>Coffee break</b>	<b>30 min</b>	
16:45	<b>Partners forum: taking STAGE recommendations forward</b>	1 hr 15 min	<b>Discussion</b> (Chair STAGE)



## Day 3: 16 November 2023

Time	Session	Duration	Purpose (Chair/Lead)
09:15	<b>Complementary feeding, implementation issues</b> Larry Grummer-Strawn, NFS/WHO (15 min)	1 hr 45 min	<b>Discussion and Decision-making</b> (Chair STAGE)
11:00	<b>Coffee break</b>	30 min	
11:30	<b>STAGE Closed session</b> Refining recommendations and next steps: STAGE members	1 hr 30 min	<b>Decision-making</b> (Chair STAGE)
1:00	<b>Lunch</b>	1 hr 30 min	
14:30	<b>Closing session</b> <b>Summary of recommendations</b> (Parenting skills, MNH transition, Birth defects, Midwifery, MNH commodities, and Complementary feeding. <b>5 min each</b> )  <b>Closing remarks (20 min)</b> Pascale Allotey, Director, SRH/WHO Francesco Branca, Director, NFS/WHO Anshu Banerjee, Director MCA/WHO Caroline Homer, STAGE chair	1 hr 15 min	Caroline Homer, Chair STAGE
15:45	<b>Coffee break and end of meeting</b>		

**MCA:** Maternal, Newborn, Child and Adolescent Health and Ageing

**SRH:** Sexual and Reproductive Health and Research

**NFS:** Nutrition and Food Safety

## Annex 2. List of participants

### STAGE Members

Professor Caroline Homer, Co-Program Director, Maternal and Child Health and Working Group Head; NHMRC Principal Research Fellow, Burnet Institute, Melbourne, Australia, **Chair STAGE**

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## Annex 3. WHO progress report on STAGE recommendations from STAGE meetings in May 2023 and November 2022

### Update of the May 2023 STAGE recommendations

STAGE Recommendations / Guidance (May 2023)	Progress Made (November 2023)
STAGE position paper to be developed on primary health care approach and MNCAHN.	The position paper has been developed and a commentary based on that was published in the Lancet on 17 Sep 2023 <a href="https://www.thelancet.com/action/showPdf?pii=S0140-6736%2823%2901909-8">https://www.thelancet.com/action/showPdf?pii=S0140-6736%2823%2901909-8</a>

### Child and adolescent health well-being: operationalization of child and adolescent health and well-being programmes

<b>Establish a STAGE working group that will focus on</b> developing implementation tools, promoting dissemination, country adoption of successful evidence-based implementation, and continuous improvement strategies.	A working group has been formed and the first meeting of the group was held in October 2023. Key issues raised will be presented and further discussed in the session in November.
The working group with external experts and partners will also develop a position paper to advocate for and advance the realization of the health and well-being agenda.	The working group has not yet decided on when to activate this recommendation, and this will be discussed more during the November STAGE meeting.

### Comprehensive anaemia framework

Develop <b>companion tools</b> to support country implementation of the framework, including implementation guidance, a monitoring framework, and the economic argument for investing in strategies to reduce anaemia through existing structures and programmes.	Plan to start with the operational guidance, which will be developed jointly with partners of the Anaemia Action Alliance with oversight by the WHO interdepartmental working group on anaemia and with advice from STAGE. We are in discussions with partners on the process for development.
WHO to engage with <b>community-led, multisectoral efforts</b> (such as the collective impact forum) and provide backbone support to facilitate implementation and strengthen collaboration.	We have not yet engaged with the Collective Impact Forum, but plan to do so. We have prioritized engagement with a country (Senegal) through the Exemplars in Global Health projects, which involves multiple sectors, and community engagement was emphasized as an important competent. As the Forum provides tools and resources to help collaboratives get started, we will get a better understanding of the tools they provide that will assist in this country support.

Explore **extension of the WHA Global target for anaemia in women 15–49 years** from 2025 to 2030. STAGE Anaemia Working Group to critically examine available data from countries and existing work on anaemia to **explore targets for children and other critical population groups for the post-2030 agenda**.

The WHO NFS department is working on an official extension of the existing 2025 WHA targets to the year 2030. Analyses are underway to evaluate whether the previously proposed 2030 targets should be revised based on more recent evidence. New targets will not be added at this time, although the addition of process targets supporting achievement of the 2030 targets is being considered. A new set of targets will need to be developed for the post 2030 agenda; this will be an opportunity to consider targets for children and other population groups at risk.

### Midwifery models of care

STAGE midwifery working group to develop implementation guidance document which will focus on operationalizing midwifery care in countries, depending on their context. This work to be linked with STAGE work on the maternal and newborn transition framework and on emergency obstetric and newborn care (EmONC).

The working group is developing two different documents: one policy brief on the definition and guiding principles of midwifery models of care, presenting the evidence, and one implementation guidance document with a monitoring and evaluation framework and an agenda for evaluation of implementation of midwifery models of care in different country health systems, as per STAGE initial recommendation.

### MNH commodities

The STAGE working group to focus on prioritization process based on standard criteria and ensure that it links to the MNH Programmatic Transition Framework.

WHO has mapped all WHO recommended MNH commodities (medicines, diagnostics and devices), and developed background materials on the effectiveness and feasibility of each of these commodities organized by major causes of maternal and newborn death. An online survey was conducted to prioritize maternal commodities based on standard criteria, and the newborn commodities have been prioritized according to levels of care. These prioritized commodities will be further refined at a technical convening end October/early November in Geneva, and the final prioritized list will be presented to STAGE in November 2023. In addition, an outline of the implementation guidance will be developed and discussed at the technical convening end October/early November, and will be written in 2024, ensuring links with the MNH Programmatic Transition Framework.

### MNH programmatic transition framework

Create a STAGE working group to further develop and finalize the transition framework.	The working group has been formed and its first meeting was in October 2023 to discuss the presentation to STAGE.
Need to finalize the cut-offs for the transition stages and to refine the programmatic elements for each stage.	An update to be provided at the November 2023 meeting. The paper was published which outlines the cut-offs, and another publication is in press on the obstetric transition. Once the publication is available, we will begin discussions on the cut-offs with the MNH community. A draft document on the programmatic elements has been developed and feedback incorporated from UNICEF, UNFPA and World Bank/GFF as well as regional colleagues. The document will be discussed at the STAGE meeting in November 2023.
EmONC to be contextualized in the continuum of care and to be part of the STAGE working group on the MNH programmatic transition framework, with a focus on management of maternal and newborn complications.	An update to be provided at the November 2023 meeting. The EmONC Revisioning group is working on drafting the framework and handbook and, once finalized, it will be discussed with the STAGE working group to incorporate relevant elements into the MNH Programmatic Transition Framework. The EmONC Revisioning group plans to have draft documents available for review in early November.

## November 2022 STAGE recommendations

STAGE Recommendations / Guidance (November 2022)	Progress Made (May 2023)	Update (November 2023)
<b>Comprehensive framework for integrated action on the prevention, diagnosis and management of anaemia</b>		
Developing operational guidance to support countries in translating and integrating global recommendations at national and local community levels.	<p><b>A further update will be provided during the May meeting</b></p> <p>As we near completion of the comprehensive framework, the working group meeting in late April discussed next steps such as the development of operational guidance, a monitoring framework and an investment/costing framework. There is an opportunity to work with the programmatic working group of the Anaemia Action Alliance on the development of the operational guidance.</p>	Update provided in the earlier section.
Strengthening communications and advocacy on the burden and consequences (health-related and economic) of anaemia (at individual, family, and community level), as well as the investment required to prevent and treat anaemia.	<p>See above comment on the next steps and possible development of an investment/costing framework. There is an opportunity to work with the investment working group of the Anaemia Action Alliance on the investment/costing framework as well.</p> <p>WHO is also updating its health topic page on anaemia and developing an anaemia fact sheet.</p>	<p>The investment working group of the Anaemia Action Alliance has proposed an activity to estimate global costs to address anaemia, in collaboration with the World Bank's update of the Investment Framework for Nutrition and including activities beyond nutrition and the health sector. Funding for the activity has not yet been secured.</p> <p>WHO's web pages have been updated. <a href="#">Anaemia as a health topic</a>, <a href="#">Anaemia fact sheet</a>.</p>
Collaborating with the WHO working group on devices and drugs to stimulate innovation in diagnosis of anaemia and its causes (using non-invasive techniques) and treatment (e.g. delivery of iron, blood substitutes).	We have not yet connected with this group.	We have connected with this group and are providing input.

Advocating for global targets on anaemia that are realistic and achievable and that cover all relevant age groups/populations at risk across the life course (for example adolescent girls).	The WHO Department of Nutrition and Food Safety is working on an official extension of the existing 2025 World Health Assembly targets to the year 2030. Analyses are underway to evaluate whether the previously proposed 2030 targets should be revised based on more recent evidence. New targets will not be added at this time, although the addition of possible process targets supporting achievement of the 2030 targets is being considered. A new set of targets will be developed for the post 2030 agenda. We are aware of work being undertaken by the Lancet Commission on Haematology that could inform these new targets	Update as provided in the earlier section.
Ensuring linkages with other initiatives within WHO—for example, school health and youth screening programmes, MNH innovations, and with other developmental efforts addressing social determinants of health; and strengthening engagement with the other relevant sectors.	We have obtained feedback on the comprehensive framework from the Adolescent and Young Adult Health unit, MCA department. We reached out to team members in Social Determinants of Health, and invited the directors of Integrated Health Services, TB and HIV to nominate a focal point for anaemia but were not able to connect with the teams.	CLOSED

### School health and well-being

WHO and partners focus on enhancing accountability of educational systems in Making Every School a Health Promoting School, under the leadership of education authorities.	WHO and UNESCO have developed a provisional list of indicators to monitor school health, and a web platform to collect data and calculate indicator values. On 20 April 2023, a meeting of the UN interagency group on school health was organized, and meeting participants endorsed the proposal to develop a consensus list of indicators for school health and highlighted that it should be informed by ongoing efforts (e.g. by the school meals coalition).	<p>The global platform to monitor school health, endorsed by WHO, UNESCO, UNICEF and the World Food Programme (WFP, went live at end August 2023. Here is the web page that describes it <a href="https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/adolescent-and-young-adult-health/school-health/global-platform-to-monitor-school-health">https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/adolescent-and-young-adult-health/school-health/global-platform-to-monitor-school-health</a></p> <p>School health, and new guidance from the Making Every School a Health Promoting School package, is prominently featured in the second edition of the <a href="#">AA-HA! guidance</a> that was launched on 11 October 2023 and endorsed by seven UN agencies and PMNCH.</p>
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WHO and partners to ensure that school health is co-created with students, parents, and teachers, is context specific, is inclusive of the whole school community and beneficial to out of school children.	Adolescent and Young Adult Health unit, MCA, is leading an adolescent health data project in Ghana, Morocco, Jamaica and India in over 100 schools to generate health information through school surveys that will be used directly and locally, involving students and school staff, to change structures and policies and plan school health actions to improve health. Messages that school health is co-created with students, parents, and teachers, is context specific, is inclusive of the whole school community and beneficial to out of school children are an integral part of WHO guidance on school health.	The research project described earlier continues. In the reporting period, data-to-action workshops have taken place in Fes, Morocco; Kingston, Jamaica; and Sekondi-Takoradi, Ghana. The workshops brought together health and education officials, local authorities, school administrators, parents, teachers and students from the intervention schools that jointly analysed school health data from baseline assessments, identified adolescent health needs based on the collected data (needs assessment), identified gaps in policies/programmes/practices, and developed a draft action plan with timelines.
School health should also be strengthened through more investments for: creation of leadership cadres for health promotion in the education system, integration with adolescent health programmes, dissemination of lessons learned and for strengthening research.	A global report <i>Ready to learn and thrive: School health and nutrition around the world</i> was released by UNESCO in collaboration with WHO and other partners in January 2023 targeting policy-makers and planners in ministries of education, health and finance, and development partners, to advance a common agenda and greater collaboration on school health and nutrition. A series of policy briefs was developed with the aim of informing policy-makers about the value of investing in school health for issue-specific agendas such as mental health, sexual reproductive health, substance use prevention, etc..	The second edition of the AA-HA! guidance describes school health as part of comprehensive adolescent health programmes.

### Promoting child and adolescent health and wellbeing

STAGE requests the Director-General to support the health and well-being work spearheaded in the MCA department, make resources available towards its advancement.	An update and information on operational guidance will be presented at the May 2023 meeting.	The document on scheduled contacts to support children and adolescents in the first two decades has been completed and is being prepared for publication. A companion document with guidance on how to plan for establishing these contacts is in progress.
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Call upon Member States and partners to lead the transformation in health systems including the human resources that is essential for healthy growth, development, and well-being of children and adolescents.	Work across teams is in progress to develop the guidance on well-child/well-adolescent visits.	The Department has not yet engaged in a country support activity to socialize the wellbeing agenda and learn with national policy-makers and stakeholders about how to operationalize it. Uganda, Malawi and Oman have expressed interest. The proposal to work on scheduled contacts as a first step towards system strengthening for the well-being agenda will be applied in 2024 in selected countries that have expressed a keen interest.
<b>Risk stratification analyses to identify infants and children at high risk of mortality</b>		
Evaluate programmatic approaches to identify infants and children at high risk of mortality and impaired childhood development.	The work has focused on completing the primary analyses. There were some unexpected delays, now resolved, and the main analyses are almost complete. Manuscripts are in development to frame the concept of risk-differentiated care. These will include the main findings and include discussion on programmatic implications and opportunities. Formal evaluation of programmatic approaches will require dedicated funding and the Department is seeking funding opportunities.	The primary analyses are complete, and manuscripts have been drafted. These are under review with the members of the working group and will shortly be submitted to journals for consideration. Programmatic implications of the findings are included in the Discussion sections.
Develop and evaluate – through clinical and implementation research – interventions to mitigate these risks and improve deployment of health system resources, including skilled personnel.	A research consultation is planned in Q3/Q4 to develop intervention strategies to reduce mortality in high-risk infants and children. The focus is prevention of mortality among infants and children in the early post-discharge period.	This has been deferred until Q1 2024 because the primary analyses needed to be complete and also funds identified. The week of 18 March 2024 is under consideration.
Review and update WHO tools e.g. IMCI/Hospital pocketbook to include differentiated care approaches based on available evidence.	A review of specific elements of IMCI/Hospital pocketbook is underway to consider revisions that will reflect risk-differentiated clinical care approaches.	A guideline process to update some areas of IMCI/Hospital pocketbook recommendations will be completed in Q2 2024. At this time, the new recommendations and considerations from the consultation will be incorporated into updated versions of IMCI and the pocketbook.

### Maternal and newborn health innovations

WHO to define innovations for MNH and conduct a horizon scanning/ mapping of innovations.	Detailed feedback on the framework is being reported at the May meeting.	Detailed update provided at the November 2023 meeting, as part of the MNH commodities.
Convene and prioritize innovations among stakeholders with a focus on the end-to-end process from development to implementation at scale, including involving end-users.		List of prioritized innovations to be presented at the November 2023 STAGE meeting.
Develop TPPs (target product profiles) and normative products for MNH.		The TPP for ultrasound is almost finalized and will be launched before the end of 2023.
Include scale up and sustainability of innovations within the implementation strategy for scaling up commodities across different country contexts as part of strengthening health systems and improving quality of care.		We have not had an opportunity to move forward on this recommendation due to lack of staff and funding.

### Small and sick newborn care

WHO to continue the acceleration of the scale up of SSNC in level 2 facilities including the integration of maternal and newborn care, zero separation, and human resourcing.	(1) Manuscript in Press with Journal of Global Health that summarises and advocates for SSNC. (2) Norms project underway. This provides the foundation for the SSNC scale-up. It will establish benchmarks for essential components of level-2 care of SSNs in LMICs: including number of beds per population of live births, time to travel to level-2 facilities, human resources, and space and design required in SSNC units.	(1) Manuscript published. <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10120390/pdf/jogh-13-03023.pdf">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10120390/pdf/jogh-13-03023.pdf</a> (2) Norms project ongoing. Will be completed second quarter 2024.
WHO to provide presentation at a later STAGE meeting on progress toward defining and standardizing signal functions indicators for monitoring SSNC.	To be finalized. Discussions underway for a EmONC presentation at this meeting to include some of the indicators.	To be incorporated under the timeline for the maternal EmONC work.

### The impact of climate change on MNCAHN

WHO to strengthen in-house collaboration to embed MNCAHN into climate change policy and actions, and vice versa, and to define and consolidate internal roles, responsibilities, and actions.	Discussions are underway across various departments in WHO (MCA, SRH, NFS and Climate Change and Health Unit (CCH)). All departments are also invited by CCH to collaborate as per the ATACH, particularly the Working Group on Climate Resilient Health Systems, to support Member States, including those that have signed the COP26 Health Programme commitments on building climate resilient health systems, to progress and drive the climate resilient health systems agenda forward and to promote accountability.	Climate change is a leading theme in WHO's next General Programme of Work.  Partner collaboration to call attention to MNCAH and the impact of climate change in COP.  An ATACH Working Group on Climate Change and Nutrition (I-CAN WG) has been established.  During an in-house WHO forum on climate change and health (29 September 2023), I-CAN was presented to staff.
WHO to call upon Member States, UN agencies and partners to work together to ensure a coordinated response to the climate change and health crisis, with specific attention on actions to safeguard MNCAHN, on sharing lessons learned from country experiences and on strengthened capacity of national MNCAHN actors.	A first agreement has been the WHO-UNFPA- UNICEF-WMO publication on indicators to monitor the impact of extreme heat on MNCH, led by WHO/MCA and WHO/CCH. A meeting with external experts (climate scientist, MNCH, and monitoring experts) and UN partners to scope the indicator prioritization was held in April 2023. Next steps were identified including gaps in the literature and research and next steps needed to identify priority indicators.  WHO/MCA with UNFPA have co-led the organization of a satellite session at the International Maternal Newborn Health Conference to discuss climate change and MNCH, particularly extreme heat.  A WHO call to action on climate change and MNCH is underway to be signed by UN partners and other implementing partners. A policy brief is also being developed as part of the Initiative on Climate Action and Nutrition (I-CAN).	The work on the selection of indicators to monitor the impact of heat on MNCH and the UN agency publication is ongoing, and additional work that will inform this effort is currently underway: (1) A global mapping of heat health action plans and of indicators currently used in countries to assess heat exposure on the population. (2) A consensus process to identify criteria to consider when selecting heat indexes for pregnant and postpartum women, newborn and children.  WHO developed a WHO-UNICEF-UNFPA statement/call to action on climate change and MNCH in the lead-up to COP28 (launch on 21 November 2023); in parallel, PMNCH will launch an advocacy brief on the effects of climate change on women, children and adolescent health.  A virtual three-hour workshop was organized in May 2023, including permanent missions in Rome and Geneva as well as other non-State actors, to discuss I-CAN and provide strategic direction on I-CAN.

<p>WHO to strengthen and coordinate research, including strengthening research capacity and synthesis of evidence and implementation experience to address climate risks for MNCAHN.</p> <p>WHO to lead on bringing together studies and documentation.</p> <p>WHO to identify research gaps in the evidence base.</p> <p>WHO to identify, document and share case studies.</p>	<p>WHO/MCA has taken the lead on evidence synthesis including a review of impacts of different climate events on MNCAH and nutrition as well as a scoping review of grey and published literature to develop an inventory of interventions undertaken in different settings to address the impact of extreme heat and/or outdoor air pollution. Publication of scoping reviews on the impacts in a peer-reviewed journal is expected this year.</p> <p>WHO to identify research priorities for climate change and SRH and MNCAH.</p>	<p>Four papers on the impact of climate events for MNCH, on older people and across the life course are being finalized for publication in peer-reviewed journals.</p> <p>The paper comprising an inventory of actions to protect MNCH from air pollution and heat is currently in the final write-up stage, and publication is expected by the end of 2023.</p> <p>An I-CAN baseline report and an I-CAN evidence paper have been published.<sup>7</sup></p>
<p>WHO to scale-up communication and advocacy to raise awareness among policymakers on the impacts of climate change for MNCAHN.</p>	<p>See call to action above.</p>	<p>As stated above.</p> <p>Through I-CAN, interest has been raised among policy-makers through various channels (including World Health Assembly, the Climate Forecast System, UN Food Systems Summit +2, the UN General Assembly, COP28).</p> <p>A resolution on climate and health is currently being drafted by Member States to be discussed at the WHO Executive Board in January 2024.</p>
<p>WHO to establish a working group of interdisciplinary experts who can provide inputs on an action plan for integrating MNCAHN into climate change efforts.</p>	<p>To be organized.</p>	<p>Planned for early 2024.</p>

<sup>7</sup> I-CAN 2023 – Accelerating action and opening opportunities: a closer integration of climate and nutrition  
I-CAN 2023 – Climate action and nutrition: pathways to impact





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