South-East Asia Regional TAG meeting to accelerate reduction in newborn and child mortality towards achieving SDG 2030 targets

Virtual meeting 16–19 November 2021
South-East Asia Regional TAG
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South-East Asia Regional Office of WHO

Virtual
16-19 November 2021
Report of Regional TAG meeting to accelerate reduction in newborn and child mortality towards achieving SDG 2030 targets

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Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

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Executive Summary

The seventh meeting of the Regional Technical Advisory Group (TAG) meeting was held virtually from 16-19 Nov 2021. The aim was to review the situation and impact of the pandemic on the regional progress and recommend actions to accelerate the reduction in newborn and child mortality towards achieving SDG 2030 targets in the Region.

The objectives of the meeting were to 1) review the potential impact of COVID-19 pandemic on SRMNCAH outcomes in the region, with a focus on newborn and child mortality; 2) review the regional progress in reduction of newborn and child mortality and identify key actions; and 3) provide recommendations for accelerating newborn and child mortality reduction for making progress towards achieving the related SDG targets.

On the first day of the meeting, SEAR-TAG members reviewed the preparations and programme of the meeting and revisited the previous recommendations. On the second to fourth days of the meeting, national programme managers for newborn and child health from countries, focal persons from WHO country offices and headquarters, representatives from UN H6 agencies at regional and country office level, and other partners joined the regional meeting. They contributed to the deliberations by sharing their work and experiences in the countries.

WHO-SEAR has achieved higher reductions in newborn and child mortality and stillbirths compared to the global reductions between 2000-2019. Yet, SEAR is likely to miss SDG 2030 NMR target unless it takes accelerated action. Prematurity is the leading cause of neonatal mortality in the Region. The distribution of causes of deaths will shift as the mortality levels decrease, and birth defects are likely to emerge as a concern. There are wide disparities in mortality rates across and within countries. The Region has done a lot in this space, but outstanding health systems issues and persisting and emerging priorities, e.g., nutrition and development and birth defects need more attention.

There is new evidence and guidance related to newborn health which can help accelerate the reductions in newborn mortality if implemented at scale and with good quality in the Member States. These include evidence for safe and effective use of antenatal corticosteroids for early preterm birth (16% reduction in neonatal mortality), community-initiated KMC (30% lower risk of newborn mortality), and immediate KMC in hospitals (25% reduction in newborn mortality). Implementation of the PSBI guidelines, i.e., treatment of fast breathing in 7-59 days old infants with oral antibiotics at first-level health facilities; and outpatient treatment of clinically severe infection, in situations when referral is not possible, can improve newborn survival. Findings of new research on the use of pulse-oximeter for management of pneumonia in children in the field, low dose zinc for diarrhea management, WHO’s small and sick newborn and pediatric standards for good quality care, and operational guidelines for pediatric mortality reviews and audits were shared. All of these could significantly contribute to the reduction in under-five mortality. TAG discussed the importance of implementing new guidance for improving coverage and quality of newborn and child healthcare in the Region.
Other global updates included the nurturing care framework for early childhood development (ECD) and related implementation guidance including the strategic actions. WHO HQ discussed the importance of advocacy and shared an advocacy toolkit for successful implementation. The discussion also included the importance of the emerging agenda of child and adolescent health and wellbeing, which highlighted the need to place children and adolescents at the center of health programming using a life course, and “whole of government” approach for addressing the multiple but linked needs of children from birth to 19 years age. TAG emphasized the importance of focusing on the first two decades of life and life course approach in achieving optimal outcomes.

Countries that have achieved or are on track to achieve the SDGs for newborn and child mortality reduction and those likely to miss the targets by 2030, made presentations on the status and progress of newborn and child health. The presentations highlighted challenges and solutions adopted by the countries to improve newborn and child health and reduce mortality. These led to important insights and discussions on the Region- and country-specific actions required to accelerate the reduction in newborn and child mortality and strengthen health systems to improve overall health and wellbeing. TAG highlighted the need for countries to learn from each other and adapt the successful strategies.

WHO Secretariat summarized the regional work on understanding the indirect effects of the COVID-19 pandemic on the delivery of essential RMNCAH services from the two rounds mapping essential services during the pandemic. WHO HQ and RO joint mitigation project work to support country efforts to prevent additional mortality, morbidity, malnutrition, mental and physical ill health for pregnant women, mothers, children, and adolescents by maintaining levels of service delivery as close as possible to those before the pandemic in five SEAR countries was also shared. Information on what worked for maintaining essential services during the COVID-19 pandemic, based on MRT, Pulse Survey, and study of best practices was also shared. The need for Technical Advisory Mechanisms (like the TAG for immunization) in the SEAR countries like the SEAR-TAG to support policy and service delivery level actions specific to the country was emphasized.

TAG members reviewed all the technical updates presented during the meeting and identified the gaps and priority themes for work, with special considerations to the COVID-19 pandemic. The TAG noted the impact of the COVID-19 pandemic on the essential health services with a potential risk of additional maternal, newborn, and child mortality and stillbirths with deep concern and advised that the RMNCAH must continue to remain at the heart of Universal Health Coverage during pandemic recovery and thereafter. They discussed the need to reduce disparities to achieve equitable coverage of essential interventions, improve the quality of care for achieving effective coverage and ensure financial protection for essential and expanded RMNCAH services.

The SEAR-TAG advised continued actions on previous recommendations and provided additional technically rigorous yet practical actions for further improving the newborn and child survival and wellbeing in the Region.
Recommendations

During the seventh meeting of the South-East Asia Regional Technical Advisory Group (SEAR-TAG) for women’s and children’s health TAG Members reviewed the progress in the reduction of newborn and child mortality deliberated on the ways to further accelerate the progress in RMNCAH programmes.

The members commended the progress in the Region in increasing the coverage of evidence-based interventions and continued decline in mortality, which could be further accelerated if the coverage could be quickly expanded with reduction of disparities that are a matter of concern.

The TAG expressed deep concern over the impact of the COVID-19 pandemic with health systems in countries getting overwhelmed and the essential health services getting disrupted. There is a serious risk of additional maternal, newborn, and child mortality and stillbirths with a potential setback to the progress towards achieving SDGs.

The SEAR-TAG advised to continue implementation actions on previous TAG recommendations and proposed the following actions to build on the work under progress.

**Keeping RMNCAH at the center of UHC**

Realizing the disruption of essential services during the COVID-19 pandemic exposing the vulnerability of health of women, children, and adolescents, the SEAR-TAG is concerned that the ongoing agenda of RMNCAH cannot be taken for granted as the Region has to make progress to achieve SDGs to which all Member States have committed.

**RECOMMENDATION:** SEAR-TAG strongly recommends that RMNCAH must remain at the heart of Universal Health Coverage to accelerate progress towards SDGs while recovering from the pandemic and accelerate the progress towards high and equitable coverage-leaving no one behind, improving quality of care for achieving effective coverage, and ensuring financial protection for essential and expanded RMNCAH services.

**Actions:**
- SEAR-TAG recommends that WHO supports countries to accelerate achieving 90% coverage for the evidence-based interventions across the RMNCAH life-course.
- Set equity-based targets for key RMNCAH interventions, improve measurement mechanisms for equity and monitor these at regular intervals at national and sub-national levels.
- Undertake qualitative and quantitative research to understand the causes of persistent low coverage of certain interventions (like postnatal care, breastfeeding, antibiotic treatment for childhood pneumonia, and use of ORS and Zinc for diarrhoea management), develop models for rapid scaling up with quality, and set up national targets of reaching at least 70% in three years.
- Introduce Pneumococcal and Rotavirus vaccines in all SEAR countries in the universal immunization programmes.
- Develop and implement a communication strategy for RMNCAH to promote advocacy, awareness generation, social mobilization, and behaviour change to improve demand and utilization of services.
• Address the social determinants of health across the life-course continuum of RMNCAH through intersectoral actions.
• Building on the regional experience in point of care quality improvement (POCQI) countries to expand continuous quality improvement at all levels of healthcare and implement quality assurance (accreditation) mechanisms as per the national standards.
• Improve the health financing strategies and plans for RMNCAH
• Expand and strengthen the mechanisms for minimizing out-of-pocket expenses for RMNCAH services and prevent catastrophic expenses using locally appropriate financing strategies.
• Promote RMNCAH sub-accounts for tracking the budgeting and spending on different components of RMNCAH and plan the expansion of good quality services.

COVID-19 pandemic mitigation and recovery.
While reinforcing the previous set of guidance from SEAR-TAG on mitigating the risks of the pandemic, it was emphasized that RMNCAH must continue to receive sustained support to achieve full recovery from the disruptions and diversion of resources to activities to address the pandemic that could severely offset progress made in recent years in the journey towards achieving SDG targets.

RECOMMENDATION: SEAR-TAG recommends that WHO along with partners continues to support the countries for adequate and quick recovery of RMNCAH services and building back better using the preparations undertaken to manage the pandemic.

Actions
• Assist countries in closely monitoring recovery from disruptions in essential RMNCAH services
• Take stock of diversion of resources (financial, health workforce, and others) from RMNCAH towards managing the pandemic.
• Help countries to assess lessons learned and prepare an evidence-based recovery plan and a plan to build back better, e.g., sustaining the upgraded pediatric care services for COVID-19 cases beyond the pandemic as well as better preparedness and stronger resiliency.
• Encourage countries to focus on motivating communities to utilize RMNCAH services, as the demand side is significantly affected during the pandemic.

National TAG for women’s and children’s health
An influential technical advisory mechanism in the countries (akin to the national immunization TAGs -NITAGs) would strengthen the adoption and implementation of evidence-based strategies by the programme leadership to accelerate the reduction in maternal, newborn, and child mortality and morbidity and stillbirth prevention. This will also ensure that RMNCAH remains at the center of PHC and UHC strategies in the country and during the recovery from the pandemic. The role of WHO and partners at the country level to support the national TAG will be important, as has been the experience from NITAGs.

RECOMMENDATION: SEAR-TAG recommends that WHO along with Partners supports countries to set up a national TAG for RMNCAH to provide policy and implementation guidance to MoH and to provide financial assistance for its functioning for initial two years.

Actions
• Advocate with MOH to establish National TAG for RMNCAH.
• TAG membership to include national experts including academia, professional associations, and civil society representatives.
• Experience and lessons learned from national immunization TAG may be used to define the SOPs of the RMNCAH TAG.

Health system strengthening for RMNCAH programmes
In the SEAR-TAG meetings, health system constraints in the countries have been noted to be barriers to achieving a high level of coverage of evidence-based interventions, major factors being related to financing, health workforce, service delivery, and health information, and weak accountability mechanisms.

RECOMMENDATION: SEAR-TAG recommends that the WHO works with the Member States to undertake an assessment of RMNCAH related health system and take actions to strengthen it, immediately focusing on the health workforce component.

Actions.
SEAR-TAG has pointed out the following components and actions to be considered:
• Skilled health workforce for RMNCAH
  • Guide and support countries to assess the RMNCAH health workforce situation, requirements in terms of skill mix (clinical, supervision, programme management) and numbers, and current challenges related to the management of the national RMNCAH workforce including forecasting, education, recruitment, deployment, and retention.
  • Support countries to prepare and implement plans for an appropriate skill mix for survive and thrive services with an adequate number in proportion to the workload and population served by them, especially focusing on the areas in the countries that are hard to reach and work.
  • Support countries to strengthen leadership for RMNCAH programmes at national and sub-national levels. Set norms for such techno-managerial cadres in terms of numbers required, education, training, and skills.
  • Continue to work on previous TAG recommendations related to the development of midwifery-led care and neonatal nursing.
• RMNCAH service delivery
  • Strengthen service delivery for RMNCAH continuum in relation to the population served and their health needs in all geographic areas including hard-to-reach areas.
  • Support countries to partner with the private healthcare sector using appropriate PPP models.
  • Along with the strengthening of neonatal care services, pediatric hospital care must be expanded for under-five and older children, including the emerging needs for specialized neonatal and pediatric intensive care and surgical services.
  • Building upon the significant progress in the region on birth defects surveillance, prevention, and management, support the countries for prenatal diagnosis, termination of pregnancy, and corrective surgeries and rehabilitation.
• Quality data systems for RMNCAH:
  • Use the Regional monitoring framework to guide countries to further improve data systems and real-time data analytics for effective monitoring of the RMNCAH programmes and immediately taking actions for improvement in programme outcomes.
  • Prepare a monitoring framework for health system performance specific to RMNCAH to track country-level progress and help the countries to address the health system constraints.
• Strengthen implementation of MPDSR and institute / strengthen implementation of child death reviews and audits as part of the improvement in quality of care.

**Digital-Health applications for RMNCAH**

Countries have augmented and accelerated the use of digital-health technologies during the pandemic for disseminating information, capacity building of health workforce, teleconsultations, data management, etc. TAG members deliberated on optimizing the use of digital health going forward based on the experience during the pandemic.

**RECOMMENDATION:** SEAR-TAG recommends assisting countries to the optimal use of digital/telehealth for RMNCAH beyond the pandemic phase based on an assessment of the experiences.

**Examples of applications:**
- Tele-consultations and telehealthcare options for field-based services including ANC, PNC, nurturing care, adolescent health, etc. These would be useful as new normal in the post-pandemic phase.
- E-Training and e-learning resources for different cadres of health workers to support continuous professional development.
- Creation of informational materials on digital platforms like films, audio-visual materials for community awareness and create demand for services and adoption of health promotion practices.
- Adoption of digital devices for diagnosis, self-care, and monitoring clinical / health conditions like blood pressure apparatus, glucometers, etc.
- Digital health records and data systems to monitor the situation in real-time and take necessary corrective actions to improve programme performance.
Background

Between 2010 and 2019, the neonatal mortality (NMR) in SEAR reduced by 30%, and under-5 mortality rate (U5MR) reduced by 39% as against the global reduction of 21% in NMR and 26% in U5MR. Despite the progress, an estimated 0.7 M newborns and 1.1 M children died in the Region in 2019, constituting 29% and 21% of all newborn and child deaths across the world. Projections to global SDG 2030 targets for NMR and U5MR assuming that the ARR for 2010–2019 (pre-COVID) will hold for 2019–2030 shows that 4 countries (India, Myanmar, Nepal, and Timor-Leste) will not reach the NMR and 2 countries (Nepal and Timor-Leste) will not reach the U5MR targeted in the SDG 2030 goals. At the same time DPR Korea, Maldives, Sri Lanka, and Thailand have already achieved low rates of under-five and newborn mortality.

WHO-SEARO has considered acceleration in ending preventable maternal and child mortality as a high priority and has instituted Regional Flagship with a focus on accelerating reduction in newborn mortality. WHO-SEARO has considered six countries, i.e., Bangladesh, India, Indonesia, Myanmar, Nepal, and Timor-Leste as high priority countries because of a relatively high burden of newborn and child mortality. WHO, along with partners has provided focused support to these countries to analyze the situation and adopt context-specific high-impact approaches to address causes of newborn and child mortality. The Region has made good progress towards achieving the SDG 2030 targets for ending preventable child mortality – reduce the under-five mortality rate to 25 per 1000 live births, or lower and newborn mortality rate to 12 per 1000 live births, or lower - in 2019 the Regional U5MR was 32 per 1000 live births and NMR was 20 per 1000 live births.

To accelerate the reduction in newborn and child mortality the countries need specific strategies by addressing the ongoing challenges related to coverage and quality of services and new and emerging causes of death. The emphasis has been on rapid and equitable expansion of evidence-based interventions, improving the quality of care, and strengthening data systems for effective monitoring of the progress. For accelerating the reduction in child mortality the focus has been on the good quality of care at the time of birth, preterm care, facility-based and home-based care of small and sick babies, and strengthening management of childhood pneumonia and diarrhea.

However, the direct and indirect effects of the present COVID-19 pandemic may stall or even to some extent reverse the progress achieved. While the data suggests that most countries are on a path to recovery, more attention needs to be given to the recovery and getting back on the previous trajectory of mortality reduction.

The seventh SEAR-TAG Meeting aimed to discuss and prepare action plans for implementing high-impact approaches for accelerating newborn and child mortality reduction in the countries. In the run-up to this meeting, an in-depth analysis of the newborn and child mortality, causes and determinants, and the coverage of essential newborn and child health interventions were undertaken and shared with the SEAR-TAG members and countries.
Proceedings of the meeting

Day 1

Opening Session

In her address the Regional Director, Dr. Poonam Khetrapal Singh welcomed the TAG members and all participants. She highlighted Region’s progress in neonatal and child mortality reduction which has been greater than the global reductions, and the need to continue to build on this progress. She noted that four of eleven member states are unlikely to achieve the SDG 2030 target for NMR and two countries may not achieve the U5MR as per the projections based on the annual rate of reduction since 2010. She emphasized that while the Region as a whole, is likely to achieve the SDG 2030 target for U5MR, it may miss the NMR target by a couple of points as per these projections. She emphasized that with dedicated actions for addressing social, economic, and geographical disparities in RMNCAH, strengthening the quality of maternal and newborn care, and a focus to achieve UHC women and children the countries could cover the lost ground due to the pandemic and make adequate progress towards achieving SDG targets before 2030. She thanked the TAG chair for his leadership and all the members for their deliberations and appropriate recommendations and reaffirmed WHO’s support to implement these.

The TAG chair, Dr. Vinod K. Paul greeted and welcomed all participants, and set out four early thoughts for consideration:

1. **Intensification of efforts**: Most countries of the Region can achieve SDGs for newborn and child health with intense and consistent efforts.
   a. Given the uncertainty posed by the COVID-19 pandemic, women and child health must continue to remain a priority for WHO and partners during the pandemic and the post-pandemic recovery phase.
   b. It is important to focus on reducing mortality but issues like nutrition and growth, development, and enabling environment to promote optimal health and well-being for all women and newborns should continue to receive adequate attention.
   c. There is a need to focus on improving the coverage for key interventions in the Region, as the regional average is very low, e.g., institutional deliveries (regional average ~70%), skin to skin contact, and breastfeeding in the first hour after birth (~35% and 45% respectively), use of zinc and ORS for diarrhea (18%) and antibiotic treatment for pneumonia (28%). He emphasized that postnatal care for newborns has been a weak area with the regional average being unacceptably low (40% for the proportion of newborns who have postnatal contact with a health provider within two days after birth and only 10% for the proportion of newborns who receive home visits in the first week of life). He emphasized that postnatal care provision at home is important for optimizing breastfeeding and is important both for survival and wellbeing.
   d. The countries should aspire to do better than the stated SDG targets at not just the national but also at the subnational levels, with due considerations to achieve equity in coverage of evidence-based interventions and outcomes.
2. **Catch up after COVID** - The challenges of the COVID-19 pandemic are persisting and there are concerns around future waves as well. Thus, the support to countries should be continued to address the disruptions due to the pandemic and facilitate post-COVID recovery.

3. **Universal health coverage (UHC)** – Women and children are the first beneficiaries and should be at the center while developing the paradigm of universal health coverage in the countries. Resources for maternal, newborn, and child health including care of small or sick newborns and sexual and reproductive health should be ensured as part of primary/essential health care and should not be diverted to emerging issues under any circumstances.

4. **Creating national TAGs** - There is a need to strengthen techno-managerial leadership at the national and subnational level given the shift in focus from MDG to SDG and the need for a systems-level approach that should be driven by evidence and public health principles. A structure like the Regional TAG is required at national and subnational levels for promoting women’s, newborn, and child health.

Dr. Neena Raina, Senior Adviser, MCA, introduced the SEAR-TAG members. She shared the meeting objectives:

- Review the regional progress in the reduction of newborn and child mortality and identify key actions.
- Review the actions taken on SEAR-TAG recommendations related to newborn and child health.
- Provide recommendations for accelerating newborn and child mortality reduction for making progress towards achieving the related SDG targets.

**Session 1. Regional situation and strategies for improving newborn and child health**

Dr. Rajesh Mehta, Regional Adviser WHO-SEARO presented the regional situation and strategies for improving newborn and child health. The key points of the presentation were:

- WHO SEAR has made greater reductions in newborn and child mortality and stillbirths compared to the global reductions between 2000-2019 - 43% reduction in U5MR, 31% reduction in NMR, and 50% reduction in stillbirths compared to 33%, 26%, and 33% global reduction respectively.
- Mortality rate projections for the year 2030\(^1\) suggest that four countries in the Region are likely to fall short of the NMR target and two countries are likely to fall short of the U5MR 2030 SDG target unless accelerated action is taken. SEAR is likely to miss SDG 2030 NMR target.
- There are wide disparities in mortality rates across the SEAR countries as well as within countries by place of residence (rural-urban), mother’s education and wealth quintiles, etc.
- WHO and MCEE estimates updated in Feb 2019 suggest that neonatal causes, pneumonia, birth defects, and diarrhoea are top causes of under-5 mortality, while prematurity, birth complications, severe infections, and birth defects are top causes of neonatal mortality in the Region. He acknowledged that the distribution of causes of death will shift as the levels of U5MR decrease.

\(^1\) assuming that the pre-pandemic annual rate of reduction (ARR) for 2010-2019 for NMR and U5MR would apply to the period 2019 to 2030
UNICEF/WHO low birth weight (LBW) estimates suggest that LBW prevalence in SEAR is 24%, as of 2019, compared to the global average of around 14.6%.

Nutritional status is an important determinant of mortality and an impact indicator by itself. The status of wasting as the form of acute malnutrition is quite varied among the Member States of the Region, with some countries showing worsening.

The main causes of ability to accelerate reduction in maternal, neonatal, and child mortality in SEAR countries are health system constraints, low and uneven coverage of evidence-based interventions and poor quality of care indicated by standard clinical guidelines not practiced, inadequate skills in emergency care, no TRIAGE system in hospitals, poor discharge and follow-up, inadequate staff, equipment and supplies, non-availability of clean water in the delivery room, weak monitoring systems with no audits of hospital deaths.

Regional actions - Ending preventable maternal, newborn, and child health deaths with a focus on neonatal deaths is a Regional Flagship area and the Regional strategic Guidance was developed to achieve this. He shared the list of high-level actions by WHO-SEARO including a Joint Statement by the UN H6 Regional directors on improving the health of women, children and adolescents released in 2015, and an H6 Regional Working Group and Regional TAG were formed; high-level advocacy was undertaken through the organization of parliamentarians meeting with the release of call to action; capacity building of the countries on KMC, Pneumonia, Nurturing care for early childhood development, and quality improvement through the point of care quality improvement (POCQI) approach and MPDSR; strengthening of national RMNCAH programmes through policy analysis, programme reviews; updating of national plans and guidelines; and development of training tools. SEAR-TAG recommendations have been implemented in the countries. More recently, COVID-19 Mitigation work was undertaken to support the countries in protecting the essential RMNCAH services during the pandemic.

Outstanding issues in the Region are - Health system performance for RMNCAH, UHC for RMNCAH: National commitments and domestic funding, Monitoring and evaluation: Health Information System - Better measurement, Regional Monitoring Framework, coordination within the health sector, and multisectoral actions.

Emerging priorities – Nutritional issues (under-nutrition and micronutrient deficiency and obesity), birth defects, early childhood development, and evidence-based interventions to improve health and nutrition for 5–9-year-old children,

Session 2: Country Presentations
In this session, three countries, India, Indonesia, and Bangladesh presented the challenges and potential solutions for accelerating reduction in newborn and child mortality in their contexts.

India presentation: Many achievements and the challenges in service provision at critical time points for newborn care were highlighted:

• Good quality care at the time of birth is a big challenge including an annual cohort of 26 million births, almost 20,000 delivery points in the government sector, shortage and frequent rotation of staff in facilities, and about 1% of babies reported with visible birth defects.
• Postnatal care has been recognized as a weak area despite two specific programs, i.e., Home Based Newborn Care (HBNC) program till 42 days of age (operational since 2011; approx. 50% of the birth cohort visited in the first 42 days of life in 2020) and its more recent extension to 15
months after birth, known as the Home-Based Young Child Care (HBYC) program. The challenges are training and its comprehension and retainment among frontline workers, esp. with the expansion of the scope of services to include family participation for ECD and nurturing care. Health and Wellness Centers (HWC) at the village level have a new cadre of mid-level providers who may be leveraged but they have a greater focus on non-communicable diseases and advocacy will be required to place RMNCH higher on the agenda.

- Much progress has been made in facility-based newborn care with >910 newborn care units (SNCUs) providing level-2 neonatal care in the country. These SNCUs are nearly all in the districts except 8 aspirational districts. In addition, there are 20,000 newborn care corners (NBCCs, at delivery points for level-1 care), and 2579 newborn stabilization units (care provided is between level-1 and level-2). There is an institutional mentoring support system to provide technical support to the SNCUs through the state resource centers but it was highlighted that this may not be sufficient given the huge population and a large number of districts in many states. The challenges are: 15% (117) districts do not have a level-2 newborn care unit, level one care (NBSU) is not optimally functional in many states leading to overcrowding at level-2, compromising the quality of care given to the newborns, lack of planning for expansion of SNCUs (infrastructure/beds/HR, etc) and the need to expand level three care to all medical colleges; and quality of care is a major challenge because of untrained staff, inadequate use of health information database for performance review and continuous quality improvement. The need to re-envision facility-based care and integrate existing initiatives like comprehensive lactation management centers, KMC and maternal-neonatal care units, District early intervention centers (DEIC), midwifery-led care, etc. was emphasized. The new operational guidelines for facility-based newborn care may address some of these issues. In addition, there is a need for mapping all the available beds (public and private) in a district to allow access to services by all newborns in need of care and ensure a functional referral system. A national review of the progress in India’s Newborn Action Plan (INAP) between 2014 and 2020 has been initiated and a road map for 2030 is being prepared.

- Over the years Pediatric care had not received the same attention as newborn care in India. However, recently, the Government has committed to accredit facilities for newborn and pediatric care and ensure that they meet the quality standards under a new initiative called MusQan. Additionally, Government announced a COVID emergency response and health system preparedness package in July 2021 which led to the creation of 827 pediatric units in the district hospitals, with more than 19,000 oxygen supported beds and more than 10,000 beds for high dependency care and intensive care and 42 pediatric centers of excellence across the country.

- Some cross-cutting developments discussed were- inclusion of new data elements in health management information system (under process), development of an integrated online platform for maternal perinatal child death surveillance and response, ongoing work on stillbirth surveillance and response guidelines for health facilities, and countrywide scale up the Hib, pneumococcal and rotavirus vaccines.

Following India’s presentation, the TAG members provided several suggestions: the need for Child health directors/ managers at the state and central levels, a national technical support unit similar to immunization programme for newborn child health, measures to involve private sector pediatricians in newborn and child health, need to upgrade the skills of doctors and nurses to deliver NCH services at PHCs and HWCs, improvement in coordination with, maternal health and nutrition services, extending the focus
from under-five age to include 5-9 year old, and capitalizing on the opportunity to improve child health services given the substantial capacity building in the system during the COVID-19 pandemic.

**Indonesia Presentation.** Indonesia discussed the key health system constraints and strategies being undertaken to address these, as follows:

- **Human Resources** - The concerns are related to uneven distribution (general practitioners, specialists, midwives, nurses) and high turnover and rotation. The country has undertaken a capacity-building program and placement of health workers through ‘Nusantara Sehat’ in rural areas.
- **Infrastructure** is still limited in some geographic areas, and funding being under-utilized for physical infrastructure.
- **Essential Medicines** - Gentamicin not available at PHC - being fulfilled as essential medicine through programme.
- **Health Services** - Implementation barriers, quality of care, and access limitation during the COVID-19 pandemic. Technical guidance for MCH services during COVID-19 pandemic, utilization of funding for program/service fulfillment and implementation, mentoring of primary and secondary health facilities by the higher-level facilities, collaboration with Universities on death audit and quality improvement (POCQI), finalization of MPDSR guidelines, and utilization of MPDN application.
- **Recording & Reporting** - Manual system is to be replaced by an electronic platform (e-cohorts, MPDN, and Komdat Kesmas) for improved reporting and provide timely feedback on submitted reports.
- **Disparity Issue** - Decentralization makes different standards of care at the district level, utilization of the Minimum Service Standard at the district level is being defined.
- **Financing** - About 82% population have national health insurance (JKN), there are additional funding resources at a subnational level, a Jamperasal program for poor mothers who have no insurance, and continuous subnational advocacy. They also shared the maternal, newborn, and child health care adaptation during the pandemic:
The TAG suggested looking at the disaggregated data by area and by wealth quintile, and improve the measurement of disparities, and considering strategies for reducing disparities. Government’s role in undertaking such analysis and how the capability of universities and partners like WHO can be utilized to catalyze the data availability and data analysis were discussed.

**Nepal Presentation.** The key challenges highlighted by Nepal were:

1. **Human resource**- Unavailability of adequate human resources to provide additional or new services, limited availability of specialized pediatric care at district-level hospitals, and frequent turnover
2. **Persisting inequities**- Disparities in program coverage and service utilization among different quintiles (geography, wealth, education) for antenatal care, institutional deliveries, postnatal care, FP, newborn, and childcare
3. **Challenges in delivering quality care**- Insufficient national routine data on newborn and childcare services (mainly from hospitals)
4. **Limited scope of services**- Limited interventions on the management of birth defects and childhood disability, limited interventions for childcare beyond five years of age
5. **Insufficient research and evidence generation**
In terms of the next steps, Nepal is planning a review of the national newborn action plan (NENAP) and development of a new implementation plan (2022-2026), the introduction of revised and updated IMNCI protocols, expansion of quality of care initiatives at all levels, expansion of community- and hospital-based KMC programs, onsite coaching/mentoring of SNCUs/NICUs, strengthening of referral linkages, engagement with the private sector, strengthening community MPDSR, undertaking research and evidence generation and introduction of the COVID-19 vaccine for children.

The country shared the plans to expand telehealth and new apps and strategies. The country is also proposing an assessment of the telehealth services during the COVID-19 pandemic with support from WHO.

The TAG Members emphasized utilizing the power of digital technology, data, and devices during and after the pandemic to expand the coverage and quality of services, monitoring systems, and training of health workers. It was suggested that countries should consider plans to extend specialist pediatric services to children up to 19 years of age in the future. TAG members also discussed the potential approaches to tackle the long-standing issue of anemia among women and children including micronutrient supplementation and nutritional strategy for adolescents in the pre-conception period guided by the prevalent causes of anemia.

TAG suggested exploring a bundle approach for postnatal care to tackle anemia, lack of contraception, and improve breastfeeding, immunization, and kangaroo mother care with increasing institutional deliveries. The need for improving secondary education for girls as an approach to reduce some of the prevailing health inequities was also discussed.

**Myanmar Presentation.** The country summarized the mortality trends and coverage of major newborn and child health interventions in the country along with the impact of the COVID-19 pandemic on key indicators.

The key challenges and potential solutions highlighted were as follows:

- **Inadequate health workforce** with overloaded basic health services - Vacant positions at township level due to frequent staff turnover, long time for replacement of vacant positions, and new appointment. MW is responsible for many villages/populations and multiple programs. Need of multiplier training on NCH to cover all townships in State/regions and for newly appointed MWs.

- **Inadequate funding for health programmes** - No regular budget for NCHD program, limited budget for training and supervision at different levels, no incentive for CBHWs. The country is considering the expansion of the Maternal and Child Cash Transfer (MCCT) program.

- **Supply Chain Management System** - Availability of storage facility, preparation and plan for forecasting issue and distribution plan for newborn and child health commodities is a challenge.

- **COVID-19 pandemic and ongoing political upheaval in Myanmar** has further worsened the situation.
The country proposed the following strategies to accelerate the reduction in newborn and child mortality:

- **Scaling up of IMNCI at different levels:** IMNCI for BHS (midwives), facility-based IMNCI (doctors & nurses) and Community Case Management (health volunteers), training plan based on training need assessment (consider digitalization), regular and adequate supply of essential medicines (e.g. Chlorhexidine, Amoxicillin, Vitamin K, etc.) and equipment as well as reporting forms, register books, IEC materials, etc.

- **Strengthen and scale up training of health staff on the quality of care for newborn and child health** by the expansion of Point of Care Quality Improvement (POCQI) implementation

- **Focus on Preterm care in facilities and homes,** e.g., Kangaroo mother care

- **Promote institutional delivery and newborn care** through community awareness for birth preparedness and scaling up community-based newborn care (CBNBC)

- **Strengthen emergency referral linkage especially in hard-to-reach areas by referral mapping and promoting advocacy**

- **Expansion of Maternal and Child Cash Transfer (MCCT) program**

- **Strengthen child death surveillance and response (CDSR) and include perinatal deaths**

- **Address the impact of COVID-19 pandemic by assigning MWs only related to the provision of health services in the community,** not to assign MWs not related to health services (e.g., assign duty at entry gates), promote support for community leaders to MWs to strengthen preventive measures and service delivery during COVID-19 and create a suitable communication channel for continuity of health services (e.g. PNC via phone or internet).

TAG commented that given the current situation including the limited availability of funds the proposed solutions appear to be quite ambitious and need a prioritization exercise. The country informed that they plan to prioritize implementation of IMNCI, and the ongoing work with the ministry and the private sector and civil society organizations to serve the hard-to-reach and conflict-affected areas. They emphasized the need for digitalization of the IMNCI, due to the focus on supervision and follow-up and adding quality improvement components during the implementation of IMNCI.

**Timor-Leste Presentation.** Timor-Leste shared that they have been progressing steadily in ensuring universal health coverage within the service delivery of maternal and child health to achieve the SDG targets for newborn and child mortality rates. All the relevant stakeholders are committed to addressing the issues. However, they are facing challenges with improving health information systems from paper-based to digitalized which often delays access to data, and timelines of reporting and completeness remain an issue. In addition, lack of essential resources such as neonatal centers within the regional and referral hospitals and essential equipment within the BEmONC center. Another challenge faced is the lack of awareness of pregnant women on healthy living and the importance of ANC visits, delivery at the health facility center, and post-natal care. To this date, the national policy and strategy for quality of care is still under process. In addition, the population’s traditional and cultural beliefs remains a challenge for healthier behavior adaptation.

The discussion following the presentation focused on human resource issues. The country has limited availability of pediatricians, neonatologists, and obstetricians but there are general practitioners to help
in the health posts and community health centers. They have nurses and midwives, but they are working in the city, but the remote areas still lack health workers and there is a lack of motivation among them.

TAG members observed that human resource constraints are a common issue among countries with high mortality burden, as well as the availability of medicines, collection of data, lack of research in specific areas like nutrition, and anemia. Improvements can be made if we had better background data and better research.

The summary of discussions by the TAG members related to high priority countries:

- The TAG members discussed that the focus of public health programmes, as well as this meeting, is under-5 children, the governments should consider revising the age group to cover the health of older children as well. For example, International Pediatric Association has highlighted that the clinical area of pediatrics extends up to 19 years of age. SEARO acknowledged this as a gap and highlighted the need to understand the repercussions of this recommendation in terms of workforce and training by the country which might be quite challenging in the Region and the need to continue the dialogue on this issue. Most countries in the region treat children up to at least 12 years in the pediatric departments n hospitals.

- TAG also emphasized the need for expanding referral services available to the pediatric population by developing new and strengthening existing pediatric intensive care units to expand the coverage and quality of pediatric care. The government of India has recently launched a plan for pediatric ER strengthening because of COVID forecasts, and they have plans to consider a pediatric intensive care unit in all district hospitals which cater to children up to 12 years of age. Other countries like Bangladesh have also strengthened oxygen delivery programs using the opportunity provided by the COVID-19 pandemic for strengthening District Health Care System for pediatric care.

- TAG members observed that currently the staffing is based on the level of the healthcare facility, irrespective of the workload in terms of patient load. They suggested systematic time-motion and workload studies of care providers, e.g., midwives, doctors, and specialists to convince the Governments for more human resources. In the OneHealth costing tool, there is a consideration on health workforce requirement for case management. SEARO informed that the Region is committed to a Decade of Strengthening Human Resources for Health, 2015 – 2024, and the health systems department is helping countries set up national HR strategies and plans for the health sector. MCA department will continue to work with the health system department to understand and articulate specific needs for RNCAH work.

Concerning mitigating the direct and indirect effects of the COVID-19 pandemic, it was discussed that there is a need to identify and quantify the problem caused by the pandemic at three levels, i.e., delay in accessing care by people (willingness, transport), availability of care (inadequate staff due to absence/reallocation), quality of care (delay the diagnosis or treatment). Increased resources will be required for the recovery of RMNCAH services and for building back better. SEARO also proposed a joint meeting with the health system department around human resources, essential medicines and supplies, and digital health issues, and specifically on how to improve measurement of outcomes.
The TAG chair observed that: Several issues are country-specific, but some relate to more than just one nation and human resources are one such area. He emphasized the need to take a futuristic approach as they want to push the frontier of RMNCAH further under universal health coverage. For example, the countries which are on the trajectory to achieve newborn and child mortality targets should also consider expanding the scope of newborn and child health services to include, pediatric surgery and neonatal and pediatric ICUs to further reduce mortality.

Noting that digital health has not been employed optimally and suggested exploring services that could be safely and effectively delivered to women, children, and adolescents and for training health workers and improving data systems.

Day 2

Session 3. Technical Updates

Technical update 1: New evidence and guidance for newborn care (SSN Standards, AN Corticosteroids, KMC, PSBI)

Dr. Rajiv Bahl from WHO HQ, Geneva, presented the recent evidence from international research coordinated by WHO.

Antenatal corticosteroids for early preterm birth at 28-34 weeks of gestation (ACTION-1 trial recently published in NEJM): The key messages for programs are that for safe scale-up of ACS to improve survival of early preterm babies, 1) Reliable determination of gestational age is required by using sonography-based dating; 2) Obstetric care providers need to be competent to identify imminent preterm birth and rule out risk factors, and 3) Minimum package of care for preterm babies must be available (infection treatment, feeding support, KMC, CPAP, monitoring)

For Kangaroo Mother Care (KMC), he shared the findings from three new research studies:

- **KMC scale-up implementation research** conducted in 8 million population in Ethiopia and India reported achievement of 68% - 88% KMC initiation and 53% - 82% KMC coverage. The critical actions that achieved high coverage were: Government ownership and system changes, improved weighing to identify all LBW babies, availability of KMC unit: a supportive environment for providing KMC, respect, and facilities for mothers stay in the hospital—bed, food, toilet, bath, the conviction of staff that KMC is the standard of care, and continued support at home after discharge.

- **Community-Initiated KMC**: The research has shown feasibility and benefits like 30% (4-49%) higher newborn survival and 25% (7-40%) higher survival to 6 months age

- **Immediate KMC**: In this research feasibility and effectiveness of starting KMC in unstable small babies was studied. New space for Mother-Newborn ICUs was established at the hospitals to minimize separation between mother and the newborn. The results include encouraging findings with a 25% reduction in newborn mortality, an 80% reduction in hypothermia, and a 35% reduction in sepsis.
The implications of new evidence on KMC are that scale up KMC Implementation model can be implemented in all facilities that provide care for LBW babies, KMC should be expanded to cover all LBW babies in the population including during home care.

Dr. Bahl informed the group that based on the new research, the WHO guidelines on KMC are being updated.

For the WHO treatment guidelines for newborns with sepsis (Possible Serious Bacterial Infection) if referral is not feasible were published in 2016, and WHO coordinated implementation research in 2016-19. The findings of implementation research suggest that high coverage may be achieved by:

- Engagement with MOH, policy adoption, and the support of national technical experts
- PSBI management implemented as part of IMNCI programme/strategy
- Health workers are trained, empowered and their confidence built
- Timely identification of sickness and care-seeking ensured by contacts with community health workers
- Essential supplies like antibiotics, syringes needles, etc. were available at all health facilities
- Close monitoring

As next steps, WHO will update WHO guidelines for in-patient and out-patient treatment of PSBI in 2022.

A new trial is underway to determine if babies with low mortality risk signs of sepsis need hospital admission (or could be treated on an OPD basis) and if those with moderate mortality risk signs can be discharged early after initial treatment in hospitals.

The TAG members concurred with the need to strengthen community KMC and acknowledged the need to address context-specific barriers including financial and social-cultural factors. It was discussed that a deeper understanding of the determinants for low utilization of hospital services for referral cases for PSBI is required to close the gaps in treatment.

**Technical update 2. New evidence and guidance: Pneumonia, Diarrhoea in children**

Technical updates on recent guidelines on antibiotic treatment of childhood pneumonia were shared. Information on new research on the use of pulse-oximeter for management of pneumonia in children in the field and a low dose of zinc for diarrhoea management was shared.

**Technical update 3. Pediatric standards for good quality care and paediatric death audit guidelines**

Dr. Wilson Were from WHO HQ, Geneva highlighted that poor-quality care significantly contributes to the high mortality burden particularly in the LMICs- hospitalization leads to 134 million adverse events contributing to > 2.5 million deaths annually. Between 5.7 to 8.4 million deaths occur annually from poor quality of care. In some cases, poor quality contributes > 50% of overall deaths. The cost of lost productivity due to poor-quality care is $1.4 to 1.6 trillion. The challenge in LMICs is lack of basic facilities—nearly 40% of health care facilities lack running water and nearly 20% of healthcare lack sanitation and poor attitude towards care with many patients experiencing abuse, lack of respectful compassionate care, and exclusion from decision-making during care. Many patients do not use government health facilities because of inadequate infrastructure, unavailability of doctors, health workers, drugs, poor quality, inconvenient hours with long wait times, or distrust. UHC is the central theme of global health policy today, and WHO’s vision is, “Every woman, newborn, child and adolescent receive quality health services throughout the continuum of their life course and level of care”
The paediatric quality of care framework is structured around the provision and expérience of care and sets out 8 standards and 40 quality statements with a core set of indicators for all 8 paediatric quality standards. Most of these indicators are process-related (64%) and 20% are outcome/impact indicators. The majority are relevant for both outpatient and inpatient care facilities.

Dr. Were shared the Operational guidelines for pediatric mortality reviews and audits: Key points discussed were:

• Countries need to establish national and subnational systems to support (PDAR) building on the experiences of MPDSR.
• Use a phased approach - start small, build up facility capacity and scale-up
• Document and share best practices and benefits across facilities & districts
• Always keep in mind that the purpose of PDAR is NOT the process, or the figures, or the reports or software, but the improvement in the quality of care for better outcomes.

TAG observed that in general, the healthcare workers in SEAR countries have limited time to for providing quality care due to workload and specific recommendations may be required to address this issue. TAG also noted that:

• The quality issues may be related to technical processes as well as behavior of the service providers.
• The number of pediatric deaths is more than maternal deaths and a standardized reporting and audit of all pediatric deaths could be challenging and time-consuming for the hospital teams. However, noting that Sri Lanka has successfully initiated child death reviews, TAG suggested that countries could start small and focus on the improvement of QoC during the review and not just the reporting.

In this session, country presentations were made by countries with a low burden of mortality i.e., Bhutan, Maldives, Sri Lanka, and Thailand. The countries highlighted the key factors that have led to the success and what additional actions are required to progress further to end preventable newborn and child mortality.

Bhutan presentation. Bhutan has sustained >75% coverage of ANC and PNC services, Institutional delivery 95%, good coverage of ENC and Early breastfeeding, Immunization coverage 95%. The key program strategies and way forward were:

• Improving case management and health-seeking behavior through different tiers of IMNCI strategy
• Sustaining all medicines and current achievements.
• Mainstreaming of child health programs into Local Government Plan.
• Empowering Early Childhood Care and Development
• Initiate and adopt Child-Friendly Health services
• Strengthening supportive supervision.
**Sri Lanka presentation.** Sri Lanka has achieved highly impressive reductions in MMR, NMR 6 Per 1,000 live births, U5MR 8.5 Per 1,000 live births (2015) but NMR and U5MR have plateaued since the last decade. The coverage of recommended interventions: four ANC, Delivery by SHP, Institutional Deliveries is >90%and level 2 care is available in 100% districts.

The contextual factors that have contributed to this success are: high female education and literacy levels, community sensitization of safe mother and child concept, female empowerment, free health services at point-of-care in a government-led system, integration of preventive, curative, and promotive health and continuum of care across the life cycle and service delivery platforms

The Government’s efforts in health systems strengthening were shared:

1. Leadership and Governance: Functional structure and policy environment
2. Proven effective interventions along the continuum of care
3. National guidelines of delivering evidence-based interventions to the target population
4. Morbidity and Mortality Surveillance: evidence used to revise policies
5. Access to Health Services: Service availability within 3 km for all population
6. Actionable Information Systems/ Effective Communication: RHMIS, CRVS
7. Conduct MCH reviews in each district annually
8. Learning platform (e-bridge) for virtual training

Main strategies that would be used by Sri Lanka to further accelerate the reduction and end preventable newborn and child mortality were specified as below:

1. **Sustain**- High coverage of interventions which is a challenge due to COVID-19 and strong monitoring and supervision at national and sub-national levels
2. **Accelerate**- Address district and sector disparities through targeted interventions, ensure skilled human resources for RMNCAH services (recruitment and capacity building), improve coverage of pre-conception care, newborn screening programmes for critical congenital heart disease and congenital hypothyroidism; and
3. **Innovate**- improve quality of care at the time of delivery, and explore intersectoral collaboration and multi-dimensional approaches to address social determinants of health

**Thailand presentation.** It was highlighted that 99% of the population is covered by insurance (except tribal and migrant populations). The country is divided into 13 Service Plan Areas which cover all health facilities. Monitoring and evaluation of mortality occur at health facilities every 3 months. Neonatology is prioritized by the government as NMR is a major cause for U5MR and the main causes are prematurity, birth defects, birth asphyxia, PPHN, and sepsis. The professional societies are very active and continuous medical education and updates for service providers are a norm. QI projects focusing on ANC and prematurity are undertaken routinely. Maternal deaths and stillbirths increased during the COVID-19 pandemic, but COVID-19 vaccinations were initiated promptly, and the use of digital technologies is expanding.

**TAG noted that:**

- Bhutan has achieved good coverage of essential interventions and inquired if there was a focus on remote areas for which the country doesn’t presently have a specific plan.
• Sri Lanka has maintained a good level of service coverage with quality, accountability, and surveillance, Sri Lanka's success is due to health system strengthening, dedicated programme leadership in MOH (FHB). Service providers are distributed uniformly, including in remote areas. Few approaches taken by Sri Lanka are recruitment and training governed by Central Government, deployment by FHB ensuring difficult areas are also covered.
• Thailand has universal health insurance which ensures UHC, Service Plan Areas distribution and reviews have been critical in achieving the targets.

TAG discussed that countries like Sri Lanka and Thailand achieved the targets over the last 30-35 years, and there are important lessons that the high burden countries can adapt and use to achieve acceleration in mortality reduction to reach the SDG targets by 2030. TAG also noted that countries like Bhutan and Sri Lanka where coverage is similar but the mortality indicators for Bhutan are not at par with Sri Lanka, which might be due to variability in the social determinants of health in the two countries. The need for standardization of the UHC package was highlighted.

**Day 3**
**Session 5. Impact of the covid-19 pandemic**

**Presentation 1. The indirect impact of the COVID-19 pandemic on RMNCAH and mitigation actions – the importance of National TAGs**

Dr. Anoma Jayathilaka, Medical Officer: Maternal and Reproductive Health, WHO SEARO summarized the indirect effects of the COVID-19 pandemic on the delivery of essential RMNCAH services, leading to increased maternal and child mortality.

- The objectives of continuing essential health services in SEAR are: to prevent a decrease in the provision of essential RMNCAH services by maintaining coverage of essential RMNCAH services and lifesaving interventions, essential supplies, and medicines; to prevent a decrease in utilization of services by maintaining access to health services through various strategies and delivery platforms, creating demand for services by safe delivery of services and confidence in the community; and to prevent an additional increase in mortality, morbidity, fertility, mental and physical ill-health, in target group & achieve progress towards SDGs.
- WHO Guidance on ‘Continuing essential Sexual Reproductive, Maternal, Neonatal, Child and Adolescent Health services during COVID-19 pandemic’ was shared.
- Dr. Anoma presented the WHO SEAR actions to mitigate the adverse impact by two rounds of mapping on essential SRMCAH and VAW services, and findings from the mapping exercise were shared.
- In addition, WHO HQ and RO joint mitigation project to support country efforts to prevent additional increases in mortality, morbidity, malnutrition, mental and physical ill health for pregnant women, mothers, children, adolescents, and older people, maintaining levels of service delivery as close as possible to those before the pandemic in five SEAR countries was presented.
- From the project, Dr. Anoma presented the role of TWGs in different SEAR countries (India, Myanmar, Nepal, Timor Leste) for the development and issuing of policy briefs and service
delivery guidance to optimize service delivery settings during the pandemic. Strategies adopted and innovative examples through countries’ TWG were shared.

- SEARO plans to support country plans in policy dialogue and governance, capacity building in data for decision making, rapid assessments of digital platforms in RMNCAH, and intercountry learning.

**Presentation 2. Continuing essential services during the COVID-19 Pandemic: What worked and what more is required?**

Mr. Manoj Jhalani shared what worked for maintaining essential services during the COVID-19 pandemic, based on MRT, Pulse Survey, and Study of best practices.

- It was learned that countries with significant and longstanding investments in PHC including supply-side investments in Human Resources for Health, Medicines, and Infrastructure, were more quickly able to respond to the pandemic while maintaining EHS (e.g.; Bhutan, Sri Lanka, Thailand).
- Robust approaches for the engagement of communities and utilization of community health workers, good monitoring/tracking system, optimizing the health workforce and strengthening its capacity, decentralized approach- flexibility and autonomy along with broad guidance and principles, deciding core/ desirable EHS that would be maintained within constrained resources, reorganize service delivery flows- integrating needs of Covid care with that of non-Covid care e.g.; pregnancy care, dedicated Covid and Non-Covid hospitals/ separate premises, wide publicity that the services have not stopped, triaging, Help-desks and signage within the hospitals to guide patients, telemedicine, leveraging Partnerships with private and not for profit sector, and revising the protocols (e.g.; medicines distribution) were the approaches that worked well.
- The way forward to continue essential services during the pandemic are:
  - Enable PHC-oriented transformation of health systems
  - Development of SEAR PHC Strategy to support the Member States to support and guide the Member States
  - Leverage Digital technologies, including telemedicine and telehealth
  - Strengthen HRH as per national health needs
  - Enhance public spending on health, particularly primary health care, and improve strategic purchasing to improve equity and efficiency
  - The resilience of medical products and strengthening of supply chains to improve access to medical products.

After the two presentations, participants from UNICEF shared their reflections on the mitigating efforts for service disruption due to the pandemic, highlighting the benefits and challenges of modeling studies.

**Session 6. Global updates**

**Presentation 1. Nurturing care for ECD: Implementation guidance**

Dr. Bernadette Daelmans, Unit Head, Child Health and Development, Department of MCA, WHO HQ introduced the Nurturing Care Framework launched in 2018 which outlines why efforts must begin in the earliest years, from pregnancy to age 3, how nurturing care protects children from the worst effects of adversity and what support do caregivers need to provide nurturing care.

She shared the five strategic actions of the framework: lead and invest, focus on families and their communities, strengthen services, monitor progress, use data and innovate. There are three principles to
guide the actions of the framework: 1) Remember to continue to invest in health, nutrition, education, child and social protection; 2) Strengthen services so that they reach the whole of the population, especially the most vulnerable families and children; and 3) Add interventions, such as for responsive caregiving or opportunities for early learning, for more holistic support for young children and their caregivers.

Dr. Bernadette shared WHO guidelines on improving early childhood development (ECD) and ECD country profiles and highlighted the importance of advocacy and advocacy toolkit for successful implementation.

Presentation 2. Child and adolescent wellbeing initiative: The approach and implications for implementation in countries

Dr. Wilson Were, Medical Officer, Child Health Services, MCA, WHO HQ discussed the importance of a new agenda of child and adolescent health and wellbeing, and highlighted the trends from survival to survive, thrive and transform, preconception through the first two decades of life, services to ecological approach, health sector to multisectoral actions, and skills building to system strengthening.

He stated that a global public health response needs strategic shifts to put children and adolescents at the center of health programming using a life course and “whole of government” approach and emphasized the importance of focusing on the first two decades of life and life course approach.

To achieve optimal child and adolescent health and wellbeing, six domains have been identified in which actions are required and these domains build on both the nurturing care and the adolescent health and well-being framework.

Other sectors beyond health are critically important in shaping child and adolescent health and wellbeing through a multisectoral approach spanning different platforms. Existing services for RMNCAH can provide platforms to deliver targeted age-specific interventions including physical and mental health needs of parents and other caregivers but require optimizing and building additional capacities to respond to the comprehensive needs of children and adolescents.

Dr. Wilson also shared that for the programmatic guidance, the vision and framework for child and adolescent health and wellbeing will be published soon.

Session 7: Concluding Session

Dr. Rajesh Mehta, WHO SEARO, shared the draft recommendations based on the discussions. The TAG members provided important comments and feedback to refine these. The secretariat will revise the recommendations and circulate them among the TAG members to finalize these.

Dr. Neena Raina, WHO-SEARO closed the meeting with thanks to the TAG Chair and TAG Members for their keen interest in the deliberations and technical advice. She expressed thanks to the government delegates, partners, and academia for their participation and contribution to discussions. She thanked the Regional Director and senior management at WHO-SEARO for their continued support and appreciated the secretariat staff for successfully organizing the meeting.
Annexes

Annex I: Opening address by Dr Poonam Khetrapal Singh, WHO Regional Director for the South East Asia Region

Good afternoon and welcome to this seventh meeting of the South-East Asia Region Technical Advisory Group (SEAR-TAG) on women’s and children’s health.

Since 2014 the Region’s Flagship Priority on ending preventable mortality among women, newborns, and children has accelerated Region-wide progress to achieve the unfinished agenda of the Millennium Development Goals – a mission that is almost accomplished.

Throughout that journey, this SEAR-TAG has provided Member States and partners actionable advice to accelerate progress towards applicable Sustainable Development Goal (SDG) targets. Such targets include:

First, by 2030, reducing the global maternal mortality ratio to less than 70 per 100,000 live births.

Second, by 2030, ensuring universal access to sexual and reproductive healthcare services.

And third, by 2030, ending preventable deaths of newborns and children under 5 years of age.

Underwriting these targets is of course target 3.8, on achieving universal health coverage (UHC) – another of our Flagship Priorities.

In its first two meetings, this SEAR-TAG deliberated on strategies to accelerate progress on the third of these targets – ending preventable deaths of newborns and children under 5 years of age.

In subsequent meetings, the TAG focused on the first and second of these targets, addressing key areas of action throughout the life-course, such as adolescent health, maternal health, stillbirths, and sexual and reproductive health.

In this seventh SEAR-TAG meeting, you will revisit newborn and child mortality, reviewing the Region’s many achievements, while considering how best we can drive additional and accelerated gains.

You have tremendous progress to build on.

Between 2010 and 2019, the Region reduced its neonatal mortality rate by 30%, compared with 21% globally.

The Region reduced its under-5 mortality rate by 39%, compared with 26% globally.

Hundreds of thousands of lives have been saved – lives that you have contributed to saving.

And still, our mission continues.

In 2019 an estimated 1.1 million children in the Region – including 0.7 million newborns – died, accounting for 29% of global newborn deaths and 21% of child deaths. At the current annual rate of reduction, estimates suggest that India, Myanmar, Nepal, and Timor-Leste are unlikely to reach the 2030 neonatal mortality rate target.

Myanmar and Timor-Leste are unlikely to reach the under-5 mortality rate target.

While the Region is likely to meet the 2030 target for under-five mortality, it is unlikely to meet the target for neonatal mortality, missing by just one point.

But I put it to you: With accelerated, high-impact action, that point can be regained.
For example, although coverage in the Region of evidence-based interventions has in aggregate increased, there remains wide variation not only between countries but within them, mostly caused by social and economic disparities. In all countries of the Region, addressing those inequities will provide a massive boost.

Another key accelerator is enhancing the quality of care – an accelerator that this TAG has long emphasized. Together, we must continue to highlight the need to strengthen the implementation of the Point of Care Quality Improvement approach – a task that our Region has excelled in thus far.

The battle against COVID-19 has been long and hard, and very much continues.

Through it all, you have provided outstanding support to countries in their efforts to maintain essential health services, including reproductive, maternal, newborn, child, and adolescent health.

I give my special thanks to partner agencies and professional associations, many of whom are with us today.

While we do not yet know the pandemic’s full impact on newborn and child mortality, we can be certain that an impact there has been.

The latest UN estimates, based on national data for 2020, will be released by year-end and will inform our activities and projections moving forward.

I take this opportunity to commend Member States for their commitment to catch up on pre-pandemic progress and to build back better essential health services to achieve UHC and the health-related SDGs, as highlighted in a landmark resolution unanimously adopted at the Seventy-fourth session of the Regional Committee in September.

I express my sincere thanks to all SEAR-TAG Members, and to Professor V K Paul, TAG Chair, for his able, ongoing, and inspiring leadership.

I am certain that through coming deliberations, this SEAR-TAG will continue to provide an invaluable service to all countries of the Region, and all women and children therein.

I wish you a successful meeting, reiterate WHO’s full support, and look forward to your recommendations.

Thank you.
Annex II: Programme

SEAR-TAG Members Meeting: 16 November 2021

- Accelerating reduction in newborn and child mortality
- Regional Situation and progress in RMNCAH
- SEAR-TAG Recommendations on NCH and country actions
- Observations from TAG Members
- National TAGs: Strengthening advisory role in national RMNCAH programmes
- Interactions
- Synthesis by TAG Chai

Day 1: 17 November 2021

- Address by Regional Director
- Remarks by SEAR-TAG Chair
- Objectives of the meeting & Introduction
- Group photograph

Regional progress in reducing newborn and child mortality and strategies for accelerating mortality reduction in high priority countries

Country presentations: Accelerating reduction in newborn and child mortality: Challenges and potential solutions

- Bangladesh
- India
- Indonesia
- Nepal
- Myanmar
- Timor-Leste

Observations by TAG Members

Day 2: 18 November 2021

- Day-1 Summary
- Remarks by TAG Chair
- New evidence and guidance for newborn care
- (SSN Standards, AN Corticosteroids, KMC, PSBI)
- New evidence and guidance: Pneumonia, Diarrhoea
- in children
- Pediatric standards for good quality care and pediatric death audit guidelines

Low mortality countries: What has worked and what do they need now to end preventable newborn and child mortality

- What are the key factors that have led to the success?
- What more actions are needed to progress further?
  - Bhutan
  - Maldives
  - Sri Lanka
  - Thailand

- Observations from TAG Members
- Synthesis by the TAG Chair
Day 3: 19 November 2021

- Day-2 Summary
- Remarks by TAG Chair
- The indirect impact of the COVID-19 pandemic on RMNCAH and mitigation actions – the importance of National TAGs
- Continuing essential services during the COVID-19 Pandemic: What worked and what more is required?
- Nurturing care for ECD: Implementation guidance
- Child and adolescent wellbeing initiative: The approach and implications for implementation in countries
- Observations from the country delegates and partners
- Recommendations from the TAG
- Closing Remarks by SEAR-TAG Chair
Annex III: List of Participants

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Annex IV: Photographs

Regional TAG meeting to accelerate reduction in newborn and child mortality towards achieving SDG 2030 targets

Virtual

16-19 November 2021