Report of the Third Meeting of the WHO Strategic and Technical Advisory Group of Experts
for Maternal, Newborn, Child and Adolescent Health and Nutrition

27–29 April 2021
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## Abbreviations and acronyms

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<th>Abbreviation</th>
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<tr>
<td>HMIS</td>
<td>health management information systems</td>
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<td>HPS</td>
<td>health-promoting schools</td>
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<td>KMC</td>
<td>kangaroo mother care</td>
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<td>MCA</td>
<td>Mother and Child Health</td>
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<td>MNCAHN</td>
<td>maternal, newborn, child and adolescent health and nutrition</td>
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<td>MNCH</td>
<td>maternal, newborn and child health</td>
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<tr>
<td>PSE</td>
<td>private sector engagement</td>
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<td>SDG</td>
<td>Sustainable Development Goals</td>
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<td>STAGE</td>
<td>Strategic and Technical Advisory Group of Experts</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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Executive summary

The World Health Organization (WHO) convened the third meeting of the Strategic and Technical Advisory Group of Experts (STAGE) on a virtual platform on 27–29 April 2021. The meeting included 28 STAGE members who were joined by staff at WHO headquarters and regional offices and 62 participants from partner organizations as observers.

After the opening remarks by the Deputy Director General, the Director, Maternal, Newborn, Child and Adolescent Health and Ageing (MCA), summarized the actions undertaken along with activities that are ongoing in WHO that address the recommendations of STAGE at its meeting in November 2020.

Professor Caroline Homer, Chair of STAGE, described the way in which the meeting had been planned, which consisted of the formation of four workstreams, three of which were continuations from the working groups in November 2020. The additional workstream, Evidence and guidelines for impact, was created to review means for bridging the gaps between evidence, guidelines and impact. The workstreams and topics were thus:

- Mitigating the impact of COVID-19 on maternal, newborn, child and adolescent health and nutrition (MNCAHN) services,
- Evidence and guidelines for impact: kangaroo mother care,
- Knowledge translation: private sector engagement (PSE) and
- MNCAHN throughout the life-course: redesign of maternal and child health.

Three to four members of STAGE participated in each workstream, which met three or four times during February and March 2021 to discuss draft recommendations. These were presented during the STAGE sessions, which were open to STAGE members, partners and observers.

The recommendations were finalized during the closed session of STAGE members held after each meeting day.

At the closing session, Dr Anshu Banerjee, Director, MCA, and Dr Francesco Branca, Director, Nutrition and Food Safety made remarks, and Professor Homer thanked all members and partners for their participation. She reiterated that STAGE members would finalize the recommendations on the basis of all the inputs received during the meeting. She commented on the planned prioritization process for soliciting input from the global community, from STAGE members and from WHO, which would be considered as topics for future STAGE meetings.

The main recommendations of STAGE are summarized below. The full recommendations are given in the relevant sections.

Mitigating the impact of COVID 19 on MNCAHN service provision and use

- WHO and partners are to support Member States to develop, a timely and coordinated response to health emergencies and crises with better coordination and communication among national and sub-national emergency response structures, health systems, and programmes for the life-course, nutrition, and diseases to ensure that the response addresses both the direct, and the indirect impact of COVID-19 on populations at risk. Coordination is expected to start at WHO between the emergency response structures and other programmes.
• WHO and partners, particularly donors, are to have a sustained commitment to strengthen health management information systems (HMIS) and surveillance in countries to ensure reporting of granular, sensitive data, including on the work of private providers and nongovernmental entities.

• WHO is to continue to work with partners to identify, document and share experiences and lessons from countries that are meeting national policy objectives to reduce SARS-CoV-2 infections while also maintaining essential MNCAHN services. WHO is to continue to work with partners engaged with adolescents to identify any vulnerability that might have been exacerbated by COVID-19. STAGE requests WHO to further strengthen self-care in MNCAHN and ensure its integration into the “Maternal–Child Health Redesign” life-course approach.

• WHO at its three levels (headquarters and regional and country offices) is to support MNCAHN technical working groups in ministries of health in collaborating with partners to optimize research and minimize duplication of work in countries. At global level, WHO to collate and synthesize studies of critical interventions for anticipating needs and maintaining essential MNCAHN services during shocks.

• WHO is to establish a working group composed of experts in digital health and MNCAHN to identify what contribution WHO can make to country programmes to assess how digital health tools can effectively improve MNCAHN outcomes.

Evidence and guidelines for impact: kangaroo mother care

• STAGE should convene working groups on priorities that are likely to have an impact, by addressing difficult problems, interventions for which evidence is available or likely to become available and problems that would benefit from bringing stakeholders together.

• STAGE should create a working group on kangaroo mother care (KMC) to facilitate consensus and acceptance of strategies so that governments and partners can act in a harmonized way to maximize impact. The working group will prepare a global position paper on KMC and guidance for KMC and for integrating KMC with other key newborn care interventions in routine health systems.

Knowledge translation: Private sector engagement

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

MNCAHN throughout the life-course: Redesign of maternal and child health

• STAGE endorsed the document “Investing in our future: A comprehensive agenda for the health and well-being of children and adolescents” and fully supported the agenda described by WHO, UNICEF and partners.

• While strengthening existing child and adolescent health programmes to improve survival, WHO is to establish “well-child” and adolescent services by increasing the number of scheduled contacts between caregivers, children and adolescents with health services, including in schools, and finding new platforms for the delivery of interventions for health and well-being with guidance and tools for programme implementation.

• WHO, with UNESCO, is to lead a global coalition of national governments, United Nations (UN) agencies and donors to improve school health and nutrition and make every school a ‘Health Promoting School’

• WHO is to include maternal health and wellbeing as part of the life-course approach in the maternal health review and further develop the networks of care as an innovative model of integrated service delivery.

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

The WHO departments of Maternal, Newborn, Child and Adolescent Health and Ageing (MCA), Nutrition and Food Safety and Sexual and Reproductive Health convened the STAGE for its third meeting on a virtual platform on 27–29 April 2021. During the 3 days, 28 of the 31 STAGE members were joined by staff at WHO headquarters and regional offices and 62 participants from partners organization as observers.

After the previous meeting, in November 2020, extensive consultations between the WHO secretariat and STAGE led to the formation of four workstreams, three of which were continuations, with fluid STAGE and WHO secretariat membership according to the topics. An additional workstream, on “evidence and guidelines for impact” was created to find ways of bridging gaps between evidence and guidelines and impact. This group discussed the process and endorsed the value of working groups, as recommended in the STAGE operational handbook.

The agenda items (Annex 1) for the meeting were chosen either because of the importance of the topic (e.g. COVID-19) or because they were areas identified by WHO teams as priorities for discussion by STAGE (e.g. redesign of child health) within its terms of reference. A topic is considered either directly by STAGE or through a working group according to the level or depth of information available. Most of the workstreams met during February and March 2021 to discuss detailed evidence or information provided by WHO on the topic. The discussions addressed technical areas; STAGE focal points provided inputs, and then made recommendations to be presented for further discussion with the larger STAGE group. A document on the topic and the draft recommendations were sent to all STAGE members two weeks before the meeting and were presented during the open session for remarks by STAGE members, representatives of WHO regional offices, UN partners and participants. The recommendations were finalized on the basis of comments and discussion during the closed sessions at the end of each day.

All 28 STAGE members who attended the meeting confirmed that they had no new conflict of interest since the previous meeting. Earlier conflicts were assessed by the WHO secretariat, and none was relevant for the current meeting.

Opening session and report

Dr. Zsuzsanna Jakab, Deputy Director-General, WHO, opened the meeting. She described the impact of the various waves of the COVID-19 pandemic on essential services, especially on those for mothers and children, and school closures, which have affected the physical and mental health of children and adolescents. It is to be hoped that lessons learnt from the pandemic will improve the response to future crises and make health and the other systems more resilient. She welcomed the broad expertise of STAGE members and the useful recommendations provided at the previous meeting for improving coordination within and beyond WHO and translation of WHO’s normative products into efficient, effective programmes in countries. WHO will continue to provide updates on progress on those recommendations. She looked forward to STAGE inputs on the redesign of maternal and child health programmes, in the short and long term, as WHO strives to reach the triple billion targets.

Professor Caroline Homer, STAGE Chair, thanked Dr Jakab for her remarks and echoed the welcome to STAGE members and partners in virtual space, thanking especially those who were attending the meeting at unsociable hours, although she noted that the format reduced emissions due to travel. She explained that STAGE had worked differently
for this April 2021 meeting, focusing on issues identified by WHO as requiring strategic guidance: mitigation of the impacts of COVID-19 on MNCAHN service provision and use, guidance on KMC, PSE and redesign of maternal and child health. She invited the Director of MCA, Dr Anshu Banerjee, to describe WHO’s work in following up the recommendations made by STAGE at its previous meeting.

Dr Banerjee noted that full implementation of the STAGE recommendations would take a few years. As WHO has been able to mainstream some of the STAGE recommendations, they are complementary to work already under way. He said that progress would be reported regularly, and a written report will be attached to the STAGE report (Annex 2). He recalled that the recommendations fell into two broad themes: the impact of the COVID-19 pandemic on MNCAHN services and knowledge translation for better implementation of WHO guidelines.

The first recommendation was for a global mechanism for measuring the disruption caused by the COVID-19 pandemic and its socio-economic impact on MNCAHN, so that the lessons learnt can be applied for any future shocks, in coordination with the WHO emergency response. The STAGE recommendations were communicated to the secretariat of the Global Preparedness Monitoring Board, and a number were incorporated into the COVID-19 Strategic Response Preparedness and Response Plan 2021.

The second recommendation addressed real-time measurement of public health with strengthened national HMIS data, which was discussed with the WHO emergency response department and the Global Preparedness Monitoring Board secretariat, which have the same goals. WHO’s mortality database now includes weekly and monthly data on mortality (by cause) from 30 countries and is expected to include more countries. To support countries in analysis and use of HMIS data for examining changes in health service use, WHO has published “Analysing and using routine data to monitor the effects of COVID-19 on essential health services: Practical guide for national and subnational decision-makers” in January 2021.

The third recommendation was for mitigating the effect of COVID-19 on MNCAHN services and learning lessons for the future. A WHO project coordinated by the MCA department consists of collating lessons learnt from 19 countries and also from previous events that disrupted health systems. The results will be discussed with countries and partners. The recommendation included the impact of COVID-19 on the health workforce, and WHO will soon publish “Standardized measurement and reporting of impacts of COVID-19 on health and care workers”.

Several recommendations were made on strategies for knowledge translation to improve use of WHO guidelines and for monitoring gaps. The Quality, Norms and Standards department at WHO was investigating several issues that influence both the uptake and monitoring of use of WHO guidelines in countries. To improve uptake, an MNCAHN operational handbook will be prepared within the frameworks for universal health coverage and primary health care based on human-centred design methods; they will be complementary to existing tools and make use of digital opportunities. The Sexual and Reproductive Health and Research department has launched the WHO SMART guideline on antenatal care to increase the availability and impact of WHO recommendations, and the approach will be extended to intrapartum care, postnatal care and a new health emergencies mobile application. The latter is being developed with many organizations working in humanitarian settings, which are investigating adaptation and integration of clinical pathways for neonatal and child health, including nutrition. MNCAH guidelines are also disseminated in countries through the "quality of care network" for international and national learning, which is to be extended.

In order to monitor use of guidelines, WHO is reviewing evidence of their uptake, and operational research has been undertaken to improve implementation of the guideline on antenatal care.

The fourth recommendation is for institutionalizing a programme of support in training health-care workers. WHO is designing a framework for global competence linked with undergraduate curricula. In collaboration with the WHO Academy, applications are being developed for a midwifery training toolkit
and for distance training in integrated management of neonatal and childhood illness, which will be in modular format for incorporation into national curricula according to country needs. The final recommendations related to regional and national technical advisory groups, and Dr Banerjee noted that such groups have been formed in the South East Asia and African regions.

He said that, although work on some of the recommendations complemented current work, they also encouraged in-house collaboration.

In response to a question on WHO’s work on inequity, Dr Banerjee recalled that this was the focus of World Health Day in 2021. Work is under way to monitor inequity in reproductive and MNCAH service delivery, and the intention is to develop a toolkit to support programme managers in ensuring that all population groups are included.
**Workstream 1: Mitigating the impact of COVID-19 on MNCAHN services**

**Background**

Ms Anayda Portela, MCA, presented the lessons learnt in maintaining the provision of MNCAHN services during the COVID-19 pandemic on the basis of the experience of 19 countries, a systematic scoping review of the literature on measures taken to maintain service provision and use during crises/health service disruptions and case studies on macroeconomic policies during the pandemic.

Although policies and guidance were quickly developed at national level, some countries find it difficult to disseminate them sub-nationally, resulting in lack of harmonization of principles and standardized action. Policies and guidance relating specifically to adolescents was found to be lacking.

Countries identified key indicators from the health information system and used this to identify gaps and actions to be taken. However, this was reported as a challenge, as decisions had to be taken with poor-quality data, insufficient disaggregation and lack of data from some sources (like community-based services and the private sector). Although many partner agencies are keen to undertake relevant studies and surveys, a key lesson for future shocks was that high-quality health information systems are necessary for obtaining real-time data.

The actions reported by countries to be the most important for maintaining MNCAHN services were: digital health interventions for interaction with service users; online training; strengthened infection, prevention and control; measures to motivate and care for health-care providers, including their mental health; and regular use of data for decision-making.

Countries had learnt that the indirect harms of a shock such as COVID-19 could be limited by broadening contributions to decisions beyond traditional incident management teams to include components and partners of health programmes and systems. A whole-of-government approach, intersectoral action and strong subnational links were considered more effective for crisis management, with a specific plan for maintaining essential MNCAH services.

This could result in a balance between crisis-related actions and maintenance of essential services.

Case studies in four countries explored the correlation between targeted macroeconomic policies and continued coverage of maternal, newborn and child health (MNCH) services during COVID-19. Nationally aggregated numerical counts of monthly use of health facilities for a few key indicators in 2020 (January–December) were similar to those reported in 2019, suggesting minimal changes in use patterns. It is speculated that cash transfers, the main economic intervention used in the four countries, may have eased the economic burden on households and thus minimized disruption of health care use; however, other competing or contributing factors were not fully considered.

A scoping review of the literature of measures taken to maintain the provision and use of essential MNCAH health services during past crisis/disruptions is still being analysed. The methods and preliminary findings were presented. In contrast to the information presented from experiences of 19 countries, the published literature addressed mainly activities led by international non-governmental organizations. The problems and the interventions used to maintain services varied from those for abrupt events to longer-term, more complex emergencies and income level. Low-income countries often manage a crisis with few resources, weak systems and international input, whereas, in high-income countries, governments lead crisis responses. The literature on responses to the COVID-19 pandemic refers mainly to adaptations by individual clinics and facilities in high-income countries, with limited evaluation. Telemedicine is also mentioned frequently in this literature, showing the opportunities but also limitations, including access and potential loss of quality as compared with face-to-face contact.
Representatives of the UN Population Fund (UNFPA), the UN Children's Fund (UNICEF) and the World Bank described their experiences in supporting countries to maintain essential MNCAHN services during the COVID-19 pandemic.

Dr Anneka Knutsson, UNFPA, emphasized the importance of WHO’s normative role. She noted the importance of real-time measurement to confirm or adjust estimates of the impacts of COVID-19 on MNCAH, to understand decision-making with scarce data and to support capacity to analyse and use data for decision-making. She also noted the importance of work with adolescents and young people, highlighting UNFPA resources and the role of peer support. She concurred with the emphasis on care for the health workforce, which should include gender-transformative approaches, as 70% of the workforce are women but they are unequally represented among decision-makers.

Dr Luwei Pearson, UNICEF, described how data can be used to predict the magnitude of shocks and to improve response. She highlighted school disruptions and asked the group to consider the lasting effects of these changes.

Dr Muhammad Ali Pate, World Bank and the Global Financing Facility, agreed that a whole-of-government approach is essential for an effective response to the pandemic. He said that threats to essential services include continuing disruptions as second and third waves of COVID-19 hit countries, the fact that vaccination will further strain compromised health systems and that it is estimated that more than 150 million people will fall into extreme poverty by the end of 2021, giving them even fewer resources available to access care. Furthermore, slowed economic growth and high debt will limit governments’ spending on social sectors, risking lower per capita public health expenditure. With these pressures, it will be important to protect spending on essential services and accelerate efficiency reforms and innovation in service delivery and financing. He emphasized the crucial role of the health workforce, planning for their protection (both physical and mental health) with adequate equipment and training and rational deployment of front-line health workers.

Professor Mariam Claeson, on behalf of STAGE focal points presented the draft recommendations, which was followed by a discussion by STAGE members and regional WHO staff and partners. Themes highlighted in the discussion were issues of coordination, data systems, equity in service provision, use of digital tools, the impact of shifts to learn for the future, support to the health workforce and protection of rights.

Partnerships outside the health sector are essential, as the social dynamics and economic implications of COVID-19 require inter-sectoral collaboration and engagement with the whole society. The recommendation emphasizes One WHO; however, One UN indicates better coordination between WHO and other UN agencies. Solidarity among countries appears to be suboptimal, and a Health Council, similar to the UN Security Council, might be a mechanism for better coordination of responses to crises.

The accuracy, completeness and sources of health information data should be considered. Data from the private sector are not usually reported in HMIS and, similarly, there is very little data on COVID-19 and MNCAHN intervention coverage. Coordination with non-State actors to provide or triangulate data could provide a more complete picture. The limitations of completeness, accuracy and timeliness of data were present before COVID-19, however the pandemic has exacerbated or revealed gaps. Short-term investments will not address the underlying issues. Sustained work and investment are required to build data systems for specific contexts that provide synthesized information for decision-making. Researchers are partially contributors for poor data, as they often build parallel data collection systems rather than use existing routine monitoring data. STAGE expressed its support to WHO in efforts to improve routine MNCAHN data. Furthermore, academics and non-State actors, especially those in countries with sub-optimal systems, could support strengthening of national data systems, automation of data analysis and use of data in the long term, although this will require resources. Other aspects include mistrust of data and that entities do not always wish data to be transparent. In some countries, coordination of research by national institutes rather than ministries of health could reduce duplication of effort.
Some major shifts in practice will continue, even if they are not positive, and WHO and partners could influence the “new normal” to ensure that the good is kept and the bad is minimized. For example, there have been increases in remote care using digital technology, shifts to the private sector health service and losses of the health workforce. The impact of these trends on MNCAHN outcomes should be monitored and positive innovations, such as digital learning, extended, for example to pre-service education. In any recovery or future resilience, the protection, inclusion, appreciation and training of health workers are important. Mitigating harm is especially important in communities that are more difficult to reach, including refugees, pastoralists and people living in urban slums and humanitarian contexts. Better coordination and learning among agencies with respect to guidance for these groups as well as for adolescents and young people and people with disabilities is necessary.

Gender and social norms can shift during a shock, and there maybe opportunities revealed through the pandemic for gender transformation. The Ebola virus disease outbreak showed that community trust in the health system is important, as lack of trust has cost many lives; nevertheless, in some contexts, the importance of community engagement has again been overlooked. In some contexts, human rights (in childbirth and newborn care) have been eroded, and it will be important to understand how such changes affect long-term trust in the health system. The COVID Law Lab is a resource in which countries can examine legal instruments that were developed during the pandemic, some of which were positive for health.

**STAGE recommendations**

The meeting took place during a surge in the COVID-19 pandemic. STAGE members made recommendations for current and anticipated direct and indirect effects as countries undergo repeated waves of infections and further erosion of resilience, especially in vulnerable communities. The comments received during the meeting and during the closed session led STAGE to make the following recommendations.

**Recommendation for integration of MNCAHN into emergency response structures**

STAGE strongly reaffirms its recommendation of November 2020 for enhanced coordination between emergency response and MNCAHN programmes in the response to external shocks in the light of lessons learnt from the COVID-19 pandemic and the evolving situation.

STAGE urges WHO and partners to support Member States in developing coordinated responses to emergencies and health crises through better coordination and communication among emergency response structures, health systems and programmes for the life-course, nutrition and specific diseases at national and subnational levels, to ensure a timely, coordinated response that addresses both the direct and the indirect impact of COVID-19 on populations at risk. Integration of MNCAHN would facilitate closer monitoring of the (direct and indirect) impact of COVID-19 on women, newborns, children and adolescents; more effective responses to the needs of these populations; and help protect essential MNCAHN services to minimize the impacts on MNCAHN.

STAGE further recommends that WHO strengthen integration of life-course-, nutrition- and disease- specific programmes in WHO emergency response structures in headquarters and at regional and country offices to expedite uptake of the above recommendation and to enhance its own coordinated support and guidance to countries to ensure a more proactive response to the direct and indirect impacts of COVID-19 on the health and well-being of women, newborns, children and adolescents. Such integration is timely for the pandemic and would be relevant for future, similar shocks.
Recommendation to strengthen use of data for decision-making and health information systems for MNCAHN

STAGE recommends that WHO and partners, particularly donors, make a sustained commitment to strengthening HMIS and national surveillance systems to ensure that they are granular and sensitive to shifts in MNCAHN indicators, health status and the needs of different populations. Specific mechanisms are required to include the work of private providers and nongovernmental entities. Furthermore, systems should be strengthened to capture and integrate gender-disaggregated and other indicators of various forms of inequity. It is important that data are publicly available to enable comparisons and support accountability. WHO has a critical normative role in establishing indicators and definitions and supporting Member States in using MNCAHN data for decision-making. To succeed, Member States will require coherent, non-duplicated support from partners under government leadership.

Recommendation to support countries to optimize learning and invest in future resilience

STAGE recommends that WHO continue to work with partners to identify, document and share experiences and lessons from countries that have been able to reduce SARS-CoV-2 infection while maintaining essential MNCAHN service provision. This could include examples of governance mechanisms that encourage enhanced coordination among emergency response structures, health systems and life-course-, nutrition- and disease-specific programmes and with implementing partners, including those in other sectors, the private sector, professional associations, civil society and academia. Documentation from fragile or conflict-affected countries and those that effectively reach vulnerable groups would be particularly informative. Mechanisms to share information and enable discussion need to be determined.

STAGE recommends that WHO, at its three levels (headquarters and regional and country offices), support MNCAHN technical working groups under the leadership of ministries of health in Member States in working with partners to optimize research and minimize duplication at country level. Many studies are under way, and the many more are planned in each country, region and globally to understand, measure and evaluate the impact of the COVID-19 pandemic on MNCAHN and its services and the measures used to mitigate disruption to those services. Implementing partners are also urged to work with national technical working groups and bodies responsible for research to review and develop a portfolio of research to address priorities, identify gaps, enhance understanding of key mitigation activities, shifts in the delivery of MNCAHN health care, equity and gender-transformation opportunities.

STAGE recommends that WHO lead, in partnership with relevant stakeholders, to facilitate a support a portal for information which could be vetted for quality with a six-monthly update of relevant studies to enhance understanding of effective interventions in order to anticipate needs and maintain essential MNCAHN services during future shocks. This would contribute to a critical review of improved practices beyond the pandemic and help in preparation for future health shocks. The results should also reflect optimal ways for ensuring the identification of high-quality information for decision-makers on actions and understanding the status and trends in essential services during crisis response.

STAGE requests WHO to further strengthen self-care in MNCAHN and ensure its integration into the “Maternal–Child Health Redesign” life-course approach being designed by WHO and partners.
STAGE requests WHO to establish a working group composed of experts in digital health and MNCAHN to identify the unique contribution of WHO to support country programmes in assessing how digital tools can effectively contribute to better MNCAHN outcomes, including interactions and people-centred care, with consideration of populations outside the digital health infrastructure. This recommendation is a response to the rapid proliferation of digital health tools, which could increase self-care and family care practices and bring services closer to women, children, adolescents and families. The work would bring together the many people developing such tools and the many documented lessons learnt, including advantages, limitations and concerns.

STAGE recommends that WHO continue to work with partners engaged with adolescents to identify any vulnerability that was amplified during COVID-19, such as mental health, mistreatment and early marriage, and support countries in ensuring that their essential MNCAHN services include the particular needs of adolescents and innovative ways of reaching this age group when they are isolated during pandemics, such as teleconsultations. This work would draw on good practices that could be scaled up in partnership with other agencies (UNICEF, UNFPA, Global Financing Facility, Partnership for Maternal, Newborn and Child Health and others). The response to this recommendation could inform the Maternal–Child Health Redesign life-course approach being undertaken by WHO and partners.
**Workstream 2. Evidence and guidelines for impact**

A new workstream was formed to explore how evidence is used for guidelines and impact. Using KMC as an example, Professor Betty Kirkwood on behalf of the workstream made a recommendation on STAGE processes to further develop the operational procedures indicated in the STAGE handbook.

**Recommendation**

STAGE should convene working groups on priorities (a) that are likely to have a large impact by addressing difficult problems (b) for which evidence of effective interventions is available or is likely to become available and (c) that would benefit from convening stakeholders to chart a way forward under the leadership of STAGE. Topics for consideration can be proposed by STAGE members, WHO and other stakeholders, including country programme managers, UN agencies and bilateral development or donor agencies. The proposed topics should be assessed by STAGE members according to defined criteria, which will be set in the coming months. All working groups convened by STAGE should have clearly specified time frames and outputs, which could include advice on gaps in evidence and/or guidelines and building consensus on implementation strategies among stakeholders.

**Kangaroo mother care: next steps**

Dr Rajiv Bahl, MCA, presented the background on maximizing the impact of KMC on newborn survival to illustrate movement from evidence to impact. He highlighted the evidence available in 2015, the gaps in knowledge and the findings from three studies to address those gaps.

In 2015, despite the existence of guidelines, global coverage of KMC was estimated to be less than 5%. The first challenge was to increase its coverage. Secondly, the evidence was limited to KMC initiated in hospitals, and it is not clear whether community KMC improves neonatal survival. Thirdly, KMC is usually started 3–10 days after birth, after stabilization, by which time about two thirds of low-birth-weight babies would have died before KMC was initiated. Therefore, studies are required to determine the potential impact of starting KMC as soon as possible after birth. Three studies coordinated by WHO but with wide participation were conducted to respond to those questions.

Implementation research on facility-based KMC was conducted in Ethiopia and India to determine how to overcome barriers to achieve > 80% KMC coverage in districts. The study showed that KMC (defined as 8 h of skin-to-skin contact and exclusive breastfeeding) increased coverage to 53–82%. Areas for improvement were identified as more accurate weighing of newborns, providing a dedicated environment for KMC, respect, care and facilities for mothers and ensuring staff that KMC is the standard of care.

A randomized controlled trial on community-initiated KMC was conducted in India to determine the safety and efficacy of community-initiated KMC on neonatal survival of stable infants weighing > 1500 g born at home. In the intervention group, KMC was initiated at home as soon as possible after birth, while a control group practised routine newborn care. The study showed a 30% (confidence interval, 4 ; 49) lower rate of neonatal mortality in the intervention group.

A randomized controlled trial was conducted in Ghana, India, Malawi, Nigeria and the United Republic of Tanzania to determine the safety and efficacy of KMC initiated as soon as possible after birth for infants weighing 1000–1800 g. The difference between the two arms was the time of KMC initiation, as the control group received KMC after the infant had become stable. The study team established a newborn intensive care unit in which mothers could provide the necessary care for their infants and a mother–newborn intensive care unit in which the mother’s bed and chair were in the newborn intensive care unit, modelled on Scandinavian experience and testing of its applicability in low-resource contexts.
The potential impact of implementation extrapolated from the new evidence was illustrated. The current impact, assuming 5% coverage with a 40% reduction in mortality in stable infants weighing <2000 g, is 10,000 deaths prevented annually. Increasing coverage in facilities to 60% would prevent 150,000 deaths, which would increase to 250,000 lives saved if community-initiated KMC, with 80% coverage in stable infants weighing <2500 g, is added. Addition of the anticipated effect of immediate KMC of a 20% reduction in mortality would result in approximately 400,000 newborns saved per year.

The implications are as follows. KMC could be considered for scale up in facilities that provide newborn care and should be extended to all low-birthweight babies (<2500 g), although this would require a strategy for postnatal wards. Furthermore, a paradigm shift for preterm and low-birthweight babies could be considered of no separation and the presence of mothers in newborn intensive care units. Lastly, community-initiated KMC could cover infants born at home or infants born in a facility and discharged without initiation of KMC.

New WHO guidelines are being drawn up; however, the challenge is to integrate KMC into routine newborn care in facilities and the community. Barriers to how STAGE, partners and the global community can catalyse such integration are that parts of the KMC community consider skin-to-skin contact 24 h a day as the only option, and some health care providers and families believe that incubators are superior to KMC. The current service delivery system and infrastructure should be changed to set up maternal–newborn intensive care units.

Professor Kirkwood presented the draft recommendations on behalf of the group, which were discussed by STAGE members and partners.

Discussion

Professor Homer commented that this evidence-based intervention is yet to be implemented successfully at scale, and she suggested that STAGE members, with their broad expertise, could meet this challenge. Observations, barriers and solutions were offered in the discussion among STAGE members, regional colleagues and partners. The team was congratulated on a well-thought-through research agenda and translation of the agenda into research. While the work had taken years, now, advocacy is necessary for implementation at scale. This, however, has cost implications, especially for a space for mothers in newborn intensive care units and training of health workers; donor agencies should be included in the working group to provide resources for KMC in countries. The proposed 6–12-month working group should have wide stakeholder representation, in addition to donors, national representation and the presence of parents’ groups.

Cultural acceptance and determining how to change behaviour at all levels of the system would be an important next step. It was noted that KMC is often acceptable to mothers, regardless of their religion, urban or rural residence or region. Therefore, women should be empowered and their well-being ensured during KMC, as well as wider acceptance by fathers, families, communities and care providers and associated support. Investment in education and tailored messaging for health-care providers, programme managers, policymakers, professional associations and politicians will be important for implementation and updated decision-making.

It should be emphasized that KMC is an effective intervention for all newborns, regardless of the country’s economic level; it is the standard of care and not a second-best choice for low- and middle-income countries. Stressing that KMC is effective beyond early development, throughout the life-course and the associated benefits of breastfeeding are key elements for increasing acceptance. A tailored approach should be used in each context to lower the barriers to implementing high-quality KMC. It is important to learn from places and people for whom it has worked but also to acknowledge the poor uptake since 2015, and a new impetus is required.

Many discussants stressed the importance of incorporating KMC into routine newborn care and into health systems but also acknowledged opportunity costs and other causes of mortality, which will not be solved by KMC alone. Avoidance of a vertical approach, even in language, was
emphasized as well as maintaining flexibility in local interpretations of KMC for adaptation by countries and facilities. One mechanism for sustaining advocacy and learning beyond the STAGE group would be use of learning networks as platforms for sharing and documenting lessons learnt during implementation.

WHO has the responsibility to make a difference, and commitment by WHO and partners is central. The support and leadership of STAGE would be valuable as the work develops to build momentum for KMC as essential for newborn survival within a wider health system strategy.

**STAGE recommendations**

STAGE should convene a working group on KMC to reach consensus on implementation strategies, so that all governments and partners act in a harmonized way to maximize impact.

KMC was chosen as the first priority topic for the following reasons:

a. high potential impact on newborn survival and development, new evidence suggesting that almost 400,000 newborn deaths could be prevented each year;

b. substantial challenges in achieving high effective coverage; and

c. building consensus among all stakeholders on approaches for implementation is critical for maximal impact.

The working group should be charged with producing the following three outputs within 6–12 months:

- a global position paper on KMC, summarizing the evidence and outlining strategies on implementing KMC as part of ongoing maternal and newborn programmes;
- implementation guidance for different levels of health care and services adaptable by countries; and
- guidance to integrate KMC with other key newborn care interventions within routine health systems at scale, while using a continued learning process to address knowledge gaps.

The members of the working group should comprise WHO (as secretariat), selected STAGE members, other scientists and key stakeholders, such as country programme managers and representatives, UN agencies, the World Bank, the Global Financing Facility; bilateral development agencies in Australia, Canada, Japan, Norway, the USA and other countries; foundations such as the Bill & Melinda Gates Foundation, the Children’s Investment Fund Foundation and the Wellcome Trust; and professional bodies, nongovernmental organizations and women and parent organizations.
Workstream 3. Knowledge translation: private sector engagement

Background

Dr Blerta Maliqi, MCA, presented the rationale for using PSE as an example of knowledge translation. The private sector delivers more and more services in low- and middle-income countries. In some WHO regions, such as the Eastern Mediterranean, over 70% of first contacts with health care are in the private sector. WHO’s role is to enable Member States to ensure that evidence-based guidance and recommendations are used by all health system providers, irrespective of their sector. In order for WHO guidance to reach every user of services and make an impact, national health systems must address service delivery in both the public and the private sector.

PSE is a new priority for WHO, requested by Member States to accelerate achievement of high-quality, equitable universal health coverage. The challenge has become evident during the response to the COVID-19 pandemic. Dr Maliqi said that her presentation was not about how WHO engages with the private sector but focused on WHO’s guidance to Member States on the governance of private sector service delivery.

In 2020, WHO developed a strategy for Member States to use in strengthening governance of their engagement with the private health service sector. The strategy calls for a focus on governance of both private and public health sectors to ensure quality and financial protection for patients, irrespective of where they seek care. The advisory group selected six aspects of governance for the strategy – build understanding, foster relations, enable stakeholders, align structures, nurture trust and deliver the strategy – each with a specific goal and scope of action. One issue raised by countries about engagement with the private sector in improving the quality of MNCAH care was their lack of accountability in use of ministry of health or WHO guidance, limited data- and information-sharing and minimal regulations and governance oversight.

The work of the MCA department is now included in broader WHO work on PSE for universal health coverage. Current work addresses PSE to deliver high-quality maternal and newborn services, which will include a situational analysis in Bangladesh (in collaboration with the US Agency for International Development in a project led by Institute for Healthcare Improvement and Save the Children), Ghana and Nigeria and the role of the private sector during the COVID-19 pandemic (starting in May 2021). WHO should clarify its PSE strategy with regard to the MNCAH agenda. The aim should be to contribute to the development of health systems that can deliver care for all women and children, no matter where or how they access services. The agenda is broader than WHO MNCH, and partners such as the Global Financing Facility and the US Agency for International Development MOMENTUM Private Healthcare Delivery are already addressing various aspects of PSE for MNCH. STAGE should advise WHO on the inclusion and improvement of MNCAH outcomes in its PSE agenda.

Discussion

Participants commented on the role of accrediting agencies or national therapeutic regulators; clarification of how WHO and governments will engage with the private sector; use of economic and funding models, especially insurance models, in private health care; the reasons for disengagement of the private sector in some countries, including incentives for providers of continuing medical education and for better quality of care, which could be influenced by professional bodies; definition and indicators of the quality of MNCH services; the role of the MCA department (e.g. guiding ministries of health in engaging with the private sector). Areas of concern or that require attention included policies to ensure better data-sharing by the private sector, engagement of the private sector at a high policy level and areas of mistrust that should be resolved. Many participants called for better regulation, especially of the quality and equity of care provided by the private sector. They noted, however, that the distinction between public and private providers could be blurred in countries in which providers could work in both sectors. WHO could learn from experiences and best practices of PSE during the COVID-19 pandemic in both MNCAH and direct surveillance and management of COVID-19 patients.
Participants commented that a broader group of experts and stakeholders should be engaged in the discussions, including for instance experts in health economics and financing, health insurance, professional organizations and associations, national governments, civil society and patient groups. They agreed that PSE is important for WHO, and the department would benefit from further exploration of the issue. STAGE members requested clarification of collaboration in WHO’s broader work on PSE and the possible contribution of a STAGE working group.

**STAGE recommendations**

The draft recommendation was presented by Mike English on behalf of the STAGE focal points. The comments received during the meeting and during the closed session led STAGE to make the following recommendations.

STAGE suggests that WHO identify the specific provisions or strategies for PSE that are necessary for or will help to achieve equity in improved MNCAHN outcomes for all women, children and adolescents as part of high-quality universal health coverage.

STAGE suggests that it receive feedback on the approach taken to advance MNCAHN as part of the broader WHO PSE strategy in the form of a short report on: the priorities for achieving MNCAHN goals, the scope of work on MNCHAN, progress in any work conducted and how MNCHAN is represented in WHO PSE-related working groups.
Workstream 4: Maternal, newborn, child and adolescent health and nutrition throughout the life-course: redesign of maternal and child health

Background

Dr Wilson Were, MCA, described the extensive work accomplished with various WHO departments, UN partners and experts, which builds on the Global Strategy for Women’s, Children’s and Adolescents’ Health, Ending Preventable Maternal Mortality and the Every Newborn Action Plan. The work reflects the change in focus from ending preventable deaths to “thrive and transform” as part of the reframing of the global agenda for children and adolescents to health and well-being. He described global contributions to the framework over the past 2 years (“Investing in our future: A comprehensive agenda for health and well-being of children and adolescents”), which included reviews of trends in mortality, morbidity and nutrition. He asked STAGE to endorse the framework and recommendations for its implementation.

The goal of the paradigm shift is to ensure that every child and adolescent from 0 to 19 years is healthy and is being raised in a safe environment, is prepared physically, mentally, socially and emotionally and can contribute to the social and economic well-being of society. The aim is to build on gains at each stage of development and to tailor programmes to the needs determined by the unique combinations of risks and protective factors to which children are exposed. Six domains were identified as critical for the health and well-being of children – good health; adequate nutrition; responsive relationships and connectedness; a secure, safe, clean environment; opportunities for learning and education; and personal autonomy and resilience. The interventions in those domains, such as vaccination, will be universal for every child. Services for sick child and those with disabilities will also be emphasized. He showed a matrix of interventions, from preconception to 19 years, which will be presented to countries for selecting and prioritizing programmes. Many of the interventions will include other sectors, such as education, agriculture, water and sanitation, and will account for mortality and morbidity and changing epidemiology in countries and regions. The interventions will require leadership, governance, financial and human resources and means for integrating them in a health system that has so far focused on the management of illness.

The steps to be taken in 2021 will include integration of the well-child and adolescent care programme into national programmes; individual packages adapted to countries and co-design of programmatic guidance and tools with several countries. STAGE guidance will be crucial in directing these steps.

Dr Valentina Baltag, MCA, said that although the idea of “health-promoting schools” (HPS) was introduced in 1995 by WHO, the United Nations Educational, Scientific and Cultural Organization (UNESCO) and UNICEF, few countries have implemented the approach to scale, with little attention to support systems and a focus on single outcomes, such as nutrition, de-worming or mental health. Health was generally considered to be external to the core business of education, and schools were used as platforms to deliver rather than to strengthen their capacity as institutions to improve health and well-being. Teachers’ training is an important component of the programme, although performance measures are often not addressed. In view of the length of time children spend in schools (8000–10 000 hours, up to 14–15 years of age), building resilience and connectedness and nurturing relationships are important.

The COVID-19 pandemic highlighted the fact that school is much more than an institution for ensuring literacy and numeracy, as the mental and physical health of children, including nutrition services, are all being disrupted.

Global standards and indicators and implementation guidance for HPS have been developed by expert groups. The eight global standards are intended to function as a system, governed by national policy and resources, to promote strategic shifts and greater accountability. The implementation guidance is to be published with the WHO guideline on school health services. Guidance from STAGE is sought on how WHO can improve its reach to the education sector and ministries of education to ensure that promoting health is part of education;
how WHO and partners can better support countries in building such systems; how leadership can be encouraged in teacher education; how the education system can contribute to the health and well-being of children; and the options for increasing resources.

Dr Allisyn Moran, MCA, summarized a review on maternal and perinatal health (in collaboration with UNFPA and UNICEF) based on a framework for “obstetric transition” (among levels of baseline maternal mortality), and an overview of work on networks of care. The review was the basis for guidance and recommendations on different models of care for optimal outcomes in countries at different stages of the obstetric transition, which are expected to be implemented in up to 20 countries in 2021. Studies of six countries are being analysed. Networks of care comprise care from primary to tertiary level and community care. The review explains how the networks function, links between front-line workers and higher-level facilities and how to strengthen the links while ensuring sufficient skilled staff with adequate supplies and equipment.

Although the focus remains on reducing mortality, the team would like to extend it to include the health and well-being of mothers, thus linking it with child and adolescent well-being. Guidance from STAGE is sought on packaging services at different levels of care in different contexts for child and adolescent well-being, use of networks of care to optimize and build resilient health systems (being tested in Cameroon and Nepal) and how interventions should be designed for the well-being of mothers and newborns.

Reflection from UN partners

UN partners commented that the plans for redesigning maternal and child health are well aligned with their priorities and strategic objectives.

Dr Aboubacar Kampo, UNICEF, recalled that their focus is on primary health care, in a zero-dose community approach in which the emphasis is not only on health but also on education, nutrition, water and sanitation. They try to reach the communities most severely deprived of all such services. Attention is being extended to children’s and adolescents’ mental health, psychosocial well-being, noncommunicable diseases, injury prevention and chronic care, with a focus on communities to improve access to financing, increase quality, strengthen data systems and introduce use of digital solutions. They will continue to work with WHO to ensure that child health and well-being are part of primary health care, including through multisectoral community platforms.

Dr Anneka Knutsson, UNFPA, addressed the well-being and rights of young people, including access to sexual and reproductive health services. UNFPA provides opportunities to young people both within and outside schools. She commented that the review on maternal health was opportune for maternal and perinatal programmes, including lessons learnt during the pandemic. The review will be used to strengthen support to countries, especially for midwifery, and to highlight the importance of improving the quality of routine and emergency obstetric care.

Dr Christopher Castle, UNESCO, said that the HPS initiative was a good example of the link between education and health and looked forward to working with WHO on the new standards. UNESCO will ensure that the standards are promoted and taken up by countries and will continue to lead research and advocacy. UNESCO and WHO are working with a few countries (Botswana, Egypt, Ethiopia, Kenya and Paraguay) that have already adopted the scheme. Globally, UNESCO will make the case for integration to the education sector, arguing that achieving health and nutrition goals will also lead to positive education outcomes. The focus is on safe, inclusive, health-promoting learning environments, especially for noncommunicable diseases. He looked forward to the recommendation of STAGE.

Following the presentations and reflections from UN partners, the draft recommendations were presented by George Patton, on behalf of the STAGE focal points. STAGE members, regional colleagues and partners presented their views, mainly on HPS, with some comments on child health redesign and the maternal health reviews.
Discussion

Child health redesign

STAGE members endorsed the strategy, which is based on universal principles and is relevant to low-, middle- and high-income countries, with sufficient focus on vulnerable communities. While progression from “survive” to “thrive” is important, a balance must be maintained to ensure that mortality in countries where the rate is high is addressed equitably.

The universal principles should be adapted to national needs and priorities. Some suggestions for adaptation were to encourage countries to ensure that plans for maternal, child and adolescent health are based on or incorporate the principles and strategies in a way that is relevant to their context; to develop a generic curriculum for maternal, child and adolescent health programmes to be used in nursing and health-care worker training; to develop a universal curriculum on the Sustainable Development Goals (SDGs) for use in schools in different detail at different ages; and to connect organizations for people-centred care. People, or at least families, should have ownership of their data, with child records from conception to meet the SDGs.

Participants also stressed that the child health redesign framework and implementation guides should include gender considerations and that gender be reflected throughout the strategy. An intersectional approach could be used to ensure that it reaches children living in poverty, with a disability or other inequities.

Regional colleagues expressed support for the framework and called for greater focus on and consultation with regions and countries in its implementation. In the European Region, a greater focus on clinical care is necessary, and they are preparing a pocketbook for primary care of children and adolescents. The approach should be comprehensive, with more competent providers, health information systems, health financing and pre-service training. Work on HPS had begun in the European Region several years previously, with networks of “school for health”, which could provide lessons for other regions. In the African Region, maternal and child mortality rates remain high and thus survival is still the primary issue; countries require practical tools and guidance to tackle these rates first. A representative of the Region of the Americas said that political arguments are necessary to translate the framework into national policy effectively and efficiently. In the Eastern Mediterranean Region, the emergency and humanitarian context is important and should be considered in implementation plans. Continued advocacy and accountability for women and children’s health are required in this Region and elsewhere.

Health-promoting schools

STAGE members commented that the HPS concept should be linked to the COVID-19 pandemic, to change the strategy from a binary decision on keeping schools open or closed to keeping schools safe, with guidance on testing, ventilation, social distancing so that children can remain in school. Health and education departments usually give separate guidance about school closure and rarely jointly. Joint working groups (or a mechanism for intersectoral work) between ministries of health, education and social protection should be created. If a school closes, there should be provision to continue the services.

The reasons that HPS was not adopted when it was introduced 25 years ago should be found to ensure that the same mistakes are not repeated in teacher training and in integration of health. Dr Baltag said that a thorough review had been made of barriers and enablers in countries. In 1995, an underlying assumption was that health and well-being are not the responsibility of the education sector, and this attitude must change for HPS to be successful.

The issue of non-state and private school systems was raised, including those considered to be informal or complementary, which are often not regulated by ministries of education yet account for large numbers of learners in some contexts. The interconnectedness of school health and maternal health for mothers who leave school because of pregnancy, parenting and/or marriage was noted. For topics in HPS that comprise reproductive rights and choices, gender and even vaccines, WHO, UNFPA and UNICEF should work together and with religious organizations, which are major providers of or have a considerable direct influence on schools.
Other sectors, such as agriculture and environment, should also be included; in some countries, gardening programmes have been introduced in schools. Introducing the global vision at local level may be difficult in view of existing fragmentation of vertical programme. Country dialogue is essential for changing school, maternal and child health programmes. As systems may not be ready to adopt all the proposed changes, incremental gains might be sought.

Although schools should not be overburdened, changing social behaviour is as important as literacy and numeracy; gender and a focus on poverty, disability, gender and other inequities should also be introduced. Research has identified skills-based health education, comprehensive sexuality education and safe, inclusive learning environments as priorities for preventing noncommunicable diseases.

Concern was raised that the definition of “health” is too narrow and that teachers would require experience or medical expertise to teach health as now defined. It was suggested that the definition of health include jobs, social security, personal security, housing, human capital and governance. In all countries, there are more teachers than health workers, and it might be useful to redefine health more broadly and foster collaboration between the two sectors to advance health and nutrition throughout the life-cycle and achieve the SDG agenda.

Teachers who are responsible for including health and well-being in the curriculum often have limited knowledge and experience in teaching health promotion. Queries were raised about accreditation standards for HPS and whether teachers’ unions or professional organizations have provided input to the model.

Maternal health review

Maternal health should be provided with evidence-based practices adapted to countries’ context and needs. Systems should be flexible and adaptable. Countries need practical tools for use in their context and setting. Care in childbirth emergencies should be included, with rapid response and resuscitation (stabilization) available at community level. This approach could align evidence-based packages for countries, strengthen midwifery, improve access to and the quality of emergency obstetric and newborn care. Reference was made to the report on the state of world midwifery and the importance of this workforce in taking forward the concept of maternal well-being.

STAGE recommendations

STAGE members used the discussion to finalize their recommendation.

STAGE endorses the document “Investing in our future: A comprehensive agenda for the health and well-being of children and adolescents”, and fully supports the agenda of WHO, UNICEF and partners to promote the good health and well-being of women, children and adolescents. The agenda builds on state-of-the-art evidence and responds to the “survive, thrive and transform” objective of the Global Strategy for Women’s, Children’s and Adolescents’ Health for attainment of the SDGs. It is an appropriate response and a major strategic shift to address the growing demographic and epidemiological transition and to invest in the human capital of current and future generations to build stable, prosperous societies.

STAGE recommends that, while strengthening existing child and adolescent health programmes to address survival, there are compelling reasons to establish well-child and adolescent services beyond the antenatal and postnatal period to vaccination and school entry check-ups. This will require more scheduled contacts between caregivers, children and adolescents with services, including in schools, and new platforms for delivery of health and well-being interventions. The purpose of these services is to monitor health, growth, development and well-being, provide anticipatory guidance on developmental transitions and age-specific needs and ensure timely interventions to address apparent difficulties or additional needs. This will require investment to ensure available, accessible, adequate health and other providers to improve service coverage and realize the programme goals, particularly in fragile and low-resource settings.
STAGE recommends that WHO and UNICEF extend evidence-based packages of interventions and indicators throughout the life-course to provide contacts with multiple services and platforms, with guidance and tools for implementation of this broad agenda. STAGE would welcome the opportunity to review progress in this regard at its next meeting, in November 2021.

STAGE advises the WHO Director-General that making school health and access to school health and specific nutrition services an Organizational priority. This would be a major step towards achieving the target of “1 billion lives made healthier” by 2023. Schools are an exceptionally large, cost-effective system for promoting student well-being. STAGE recommends that the Director-General, with UNESCO, lead a global coalition of national governments, UN agencies and donors to improve school health and nutrition and make every school an HPS. This will require more investment, creation of leadership cadres for health promotion in the education system, strengthening and disseminating the evidence base and creating a framework for accountability so that health and well-being become measures of the performance of national education systems and core considerations in education.

STAGE recommends that WHO expand the maternal health review to include maternal health and well-being as part of the life-course approach. This should specify the activities to be conducted in each of the six domains of the health and well-being of women, from preconception to those already articulated for child and adolescent health and well-being.

STAGE encourages WHO to develop the concept of networks of care further, as it is an innovative, integrated model for service delivery throughout the life-course, building on the findings of the maternal health review. A functional network of care uses the existing system to strengthen linkages and collaboration for coordinated continuity of high-quality care and service delivery for MNCAHN and well-being, ultimately optimizing linkages for efficient, resilient health systems.

STAGE recommends that WHO and UNICEF engage with several governments and partners to present the agenda and discuss the implications of current programming and next steps on the basis of the multisectoral discussions under way in many countries on nurturing care and adolescent health and well-being.
**Closure and next steps**

Professor Homer thanked all the participants and said that she would present the STAGE recommendations to the Director-General on 30 April. She invited Dr Anshu Banerjee, Director, MCA, and Dr Francesco Branca, Director, Nutrition and Food Safety to make remarks. (Dr Ian Askew sent his apologies.)

Dr Banerjee noted the wide spectrum of topics chosen for the meeting, some of which, like KMC, were ready for implementation and scaling-up and required guidance on implementation with partners, while others, like HPS, are at an earlier stage and their operationalization requires more reflection. STAGE guidance is important at both strategic and operational levels. He noted the comments of regional colleagues on redesigning maternal and child health with regard to consulting countries on areas relevant to them. He said that reducing child mortality should still be stressed in countries with high rates, whereas a move to the “thrive and transform” agenda was important in countries in which child mortality rates are falling. Country ownership is essential, and he referred to comments from STAGE members about designing appropriate national plans with countries. The COVID-19 pandemic, and especially the second wave in many countries, underscores the need to learn lessons from 2020 to build back better. He looked forward to continued guidance from STAGE to WHO in translating its guidance into implementable country programmes. While all the STAGE recommendations will not be implemented within 1 or 2 years, the journey would be taken together among the three levels of WHO.

Professor Homer thanked the STAGE members, partners, WHO technical leads and the STAGE secretariat (who have been working both online and offline since November 2020). She said that the next step should be to prioritize a few key issues, guided by the multidisciplinary expertise of STAGE and inputs from the broader group of partners and stakeholders. She said she would form a group for that purpose, with the WHO secretariat. She would continue work to break down silos of implementation policy and programming by involving countries and regions in STAGE discussions. She wished everyone well in these difficult times, especially those in countries hit badly by second and third waves of COVID-19 and closed the meeting.

Dr Branca thanked the group for their comments. He was pleased that STAGE had endorsed the framework “investing in our future”, the call for new platforms to improve nutrition. He noted that fortification of food at home has been used widely as an alternative to supplementation. New ways should be found to address adolescent obesity, through alternative channels such as social media, and his team is preparing guidelines on the management of obesity in children and adolescents. A delivery platform that is suitable for adolescents is the key, as what they want and care about and their views of health differ from those of health practitioners. HPS is important, as, over time, the nutrition component of school policies has been weakened, and there are no clear standards. His department is also preparing standards for school food and has published a document on public food procurement. As 43 million meals are delivered to children in schools, there is enormous potential for influence. Some governments are taking a lead; for example, the German Government is creating a school food coalition with Brazil, Finland and Sri Lanka. An integrated service delivery model should not just be preached but also practised. Maternal nutrition is an area of concern, as nutrition services cannot be provided to pregnant women. Alternative means must be found, integrated into communities.
### Day 1: 27 April 2021 (Time in CEST)

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<td>Opening remarks Zsuzsanna Jakab, Deputy Director-General, WHO (3 mins)</td>
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<td>Welcome and Update (Chair STAGE)</td>
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<td>Caroline Homer, Chair, STAGE (5 min)</td>
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<td>Update and Follow up of November STAGE Recommendations: Anshu Banerjee, Director, MCA (10 min)</td>
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<td>Feedback from STAGE members (12 mins)</td>
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<td>13:30</td>
<td>Impact of Covid 19 on MNCAHN services: Sustainable Mitigation Strategies. Initial Lessons Learned: Anayda Portela</td>
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<td>Discussion and decision-making (Chair STAGE)</td>
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<td>Reflections from Partners – (UNFPA, UNICEF, GFF, WB)</td>
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<td>Discussion</td>
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<td>Impact of Covid 19 on MNCAHN services</td>
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<td>Caroline Homer</td>
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<td>15.30</td>
<td>Finalizing Recommendations (closed session)</td>
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<td>Kangaroo Mother Care:</td>
<td>1hr 30 min</td>
<td>Discussion and Decision making</td>
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<tr>
<td></td>
<td>Background and Next Steps: Rajiv Bahl</td>
<td></td>
<td>(Chair STAGE)</td>
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<tr>
<td></td>
<td>(15 min)</td>
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<tr>
<td>14:30</td>
<td>Break</td>
<td>10 min</td>
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<tr>
<td>14:40</td>
<td>Role of Private sector in MNCAHN service</td>
<td>45 min</td>
<td>Discussion</td>
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<tr>
<td></td>
<td>delivery</td>
<td></td>
<td>(Chair, STAGE)</td>
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<tr>
<td></td>
<td>Blerta Maliqi (15 min)</td>
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<tr>
<td>15:25</td>
<td>Wrap up for open session</td>
<td>5 min</td>
<td>Wrap up</td>
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<tr>
<td></td>
<td>Caroline Homer</td>
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<tr>
<td>15:30</td>
<td>Finalizing Recommendations (closed session)</td>
<td>30 min</td>
<td>Decision making</td>
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<td></td>
<td>STAGE members</td>
<td></td>
<td>(Chair STAGE)</td>
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<tr>
<td>Time (CET)</td>
<td>Session</td>
<td>Duration</td>
<td>Purpose (Chair/Lead)</td>
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<tr>
<td>13:00</td>
<td>Maternal - Child Health Redesign—Life course approach</td>
<td>2hr</td>
<td>Discussion and Decision Making (Chair STAGE)</td>
</tr>
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<td>Next Steps, Wilson Were (12 min)</td>
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<tr>
<td></td>
<td>Health Promoting Schools, Valentina Baltag (7 min)</td>
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<td>Maternal Health Scoping Review, Allsyn Moran (7 min)</td>
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<td>Reflections from key partners (UNICEF, UNFPA, UNESCO) (10 min)</td>
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<tr>
<td>15:00</td>
<td>Wrap up Session</td>
<td>10 min</td>
<td>Closure of meeting</td>
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<td></td>
<td>Caroline Homer; Anshu Banerjee, Director MCA; Ian Askew, Director SRH; Francesco Branca, Director, NFS</td>
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<tr>
<td>15:20</td>
<td>Finalizing recommendations (closed session)</td>
<td>40 min</td>
<td>Discussion (Chair STAGE)</td>
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<td>Next Steps</td>
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<tr>
<td></td>
<td>STAGE members</td>
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**MCA**: Maternal, Newborn, Child and Adolescent health and Ageing

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

**NFS**: Nutrition and Food Safety

Annex 2: Feedback report from STAGE November 2020 Recommendations

Directors Progress report, April 2021

The STAGE recommendations have long term trajectories that stimulate internal and external alignment. This is the first report of progress to recommendations and feedback to STAGE made at the April 2021 STAGE Meeting. A feedback report will be provided to STAGE at every meeting. Recommendations in full are in the November 2020 report.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Progress</th>
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| COVID Impact and Mitigation | • WHO has shared these STAGE recommendations with various entities such as the Global Preparedness Monitoring Board; and the WHO COVID-19 Strategic Preparedness and Response Plan 2021.  
• The secretariat of the Global Preparedness Monitoring Board has expressed interest in this recommendation - especially capturing real-time quality data during crises. The STAGE recommendation will be highlighted to the upcoming meeting of the Monitoring Framework Working Group.  
• Some of the STAGE recommendations are incorporated as part of lessons learned or as recommendations in the COVID-19 Strategic Response Preparedness and Response Plan. Operational plan is yet to be finalized, where we expect further incorporation of the recommendations from STAGE.  
• Some internal discussion started within WHO for better coordination between Emergency response and Health system responses during crises.  
• To monitor the continuity of essential health services (EHS), MCA, Nutrition and Food Safety and Sexual and Reproductive Health and Research advised on the RMNCAH content that was included in various tools such as the EHS pulse survey on service disruption and mitigation strategies and suite of health service capacity assessments.  
• MCA team conducted training on LiST for regions, countries and partners; a review of all modelling assessing impact of COVID-19 on RMNCAH is to be published soon. |
### Measurement in real time:
**WHO to work with countries to strengthen real-time national RHIS to enable collection and analysis of quality data in a timely manner**—requires increased investment; development of SOPs for pre-identified list of indicators

- The COVID-19 Mitigation project also uses data from RHIS in the 19 countries and have mapped indicators that can be monitored, and this will be published.
- There is renewed interest and momentum to strengthen and use RHIS data. WHO is seeking additional resources to work and support this effort.
- WHO’s Division of Data, Analytics, and Delivery for Impact (DDI) has set up a mortality data portal with information collected weekly/monthly from countries—currently 30 countries are providing weekly data on Covid and other deaths by age and sex. Other countries are expected to provide similar data into this portal.
- The Global Preparedness Monitoring Board is interested in strengthening the real time data collection processes in countries during crises that extends beyond the direct health consequences of a crisis. WHO’s effort as it evolves, will be synergistic to the work of the Global Preparedness Monitoring Board (as it develops indicators for a monitoring framework to assess preparedness, response, and recovery.
- Recommendations have been shared with the RHIS working group of the Health Data Collaborative and internally with DDI group working on RHIS.

### Mitigate and learn for the future:
**WHO to work with global partners to strengthen investments on documenting lessons learned (both in short and long term) and developing methods for implementation and operational research including rapid evaluation to enable countries to assess the impact of mitigation measures and to identify sustainable measures beyond the pandemic to improve MNCAHN outcomes and address health system resilience, with special attention to the health workforce**

- The WHO project to maintain essential MNCAH services during COVID-19 will publish findings on lessons learned and actions taken by 19 countries, and findings of systematic scoping review of actions taken and lessons learned from past service disruptions and COVID-19.
- The Health Workforce Department, WHO will soon publish the Standardized measurement and reporting of impact of COVID-19 on health and care workers.
- An interim guidance was published in December 2020 –Health Workforce Policy and Management in the context of the COVID-19 pandemic Response.

### Knowledge Translation
**WHO to support national and regional technical advisory groups (TAGS) and sub-national committees.**

There has been a dialogue with all regional offices in relation to this recommendation and of note, the AFRO Regional Director has recently established a RTAG and are in early consultation regarding national TAGS.

In terms of the landscape of TAGS (or similar structures that exist already):

- SEARO has an established Technical Advisory Group (TAG) since 2015.
- WPRO has an Independent Review Group for early essential newborn care with technical experts to review progress and provide technical support on implementation.
- EURO established a TAG on Schooling during the time of COVID-19.
- PAHO has a TAG on newborn health
- There are various national committees for different topics across the regions but only a few national TAGs for MNCAHN.
**Strategies to improve guideline uptake:**

**Produce limited number of consolidated comprehensive guidelines bringing together all recommendations, which are regularly updated as new evidence becomes available.**

- The departments have started discussions on further consolidating guidelines beyond the existing compilations and developing an operational handbook in a modular form that addresses MNCAHN programme implementation as part of Universal Health Care and Primary Health Care. Principles behind this work include to build on and be complementary to existing resources, use human centered design methods to identify scope, purpose and use and consider digital technologies for presentation, distribution and use.

**Develop a comprehensive operational handbook.**

**Support national MOH websites to house locally endorsed WHO guidelines**

- On 18 February 2021, WHO launched its vision for SMART guidelines and released its first SMART guideline on antenatal care, which aims to accelerate the availability and impact of WHO recommendations within digital systems at the country level. This approach is being promoted by the Science Division (the department of Quality Norms and Standards and the department of Digital Health and Innovation), which will enable adoption across WHO.

**Support National MNCAHN quality improvement programs**

- In terms of updating guidelines so products remain up to date, in addition to established processes, the living guideline approach has been used by Sexual and Reproductive Health and Research and has been valuable especially for areas that have rapid evolution of evidence. Under the guidance of Department of Quality Norms and Standards, this approach is being used increasingly across WHO, especially in the context of COVID-19.

- The Network for Improving Quality of Care for Maternal, Newborn and Child Health is one of the mechanisms that WHO is using to support countries to build sustainable systems able to scale up quality of care (QoC) for MNCH and other programmes. The network is assisting countries to implement their national QoC strategies and plans, and has a very strong learning agenda.

- During 2020, in response to country needs and demands, the Network supported over 34 webinars organized four series on delivering QoC during COVID-19 pandemic that were attended by over 8000 participants from 93 countries.

- The Network implementation guidance was adapted by all WHO programmes as part of the “Quality health services: A planning guide” and is leading the work on community engagement for QoC, with the guidance on “Integrating stakeholder and community engagement in quality of care initiatives for maternal, newborn and child health”, both released in quarter four of 2020.

- WHO will continue to assist countries to introduce, implement and monitor the implementation of QoC Standards for MNCH, including the newly launched standards for the small and sick newborn.
### Use of multi-media outputs in multiple languages

Relevant work in the realm of multi-media in multiple-languages include:

- Work is ongoing with the WHO Academy to support knowledge translation with associated changes in practice. The WHO Academy is supporting the development of training modules including distance Integrated Management of Neonatal and Childhood Illness, Mental Health in Primary Care and an Interprofessional Midwifery education toolkit for maternal, newborn, sexual, reproductive and perinatal mental health.
- WHO is developing a new health in emergencies mobile application – Em Care. Adapting and integrating clinical pathways for neonatal and child health including nutrition is the pathfinder for Em Care and a prototype should be available by the end of 2021; it will later expand to other populations and areas of health care across the life-course.

### WHO to take a lead on the coordination of guidelines between other agencies that produce health guidelines, including international professional bodies, international NGOs and other UN agencies.

- WHO follows rigorous procedures on guideline development, so rather than arbitrating other guidelines at a global level, it is more efficient and effective to develop WHO recommendations. There are multiple examples where other UN agencies have contributed to development of these guidelines and are acknowledged accordingly.
- WHO continues to act as a convener of stakeholders, thereby contributing to alignment of guideline updates and their contextual interpretation. This alignment could be supported by TAGs, as also recommended by STAGE in November 2020.

### HCW worker training support to increase teaching of WHO guidelines; Pediatric nurse training

There are ongoing initiatives that relate to this recommendation and there has been further engagement with the Health Workforce Department.

- The [UHC Compendium](#) is a database of health services and intersectoral interventions designed to assist countries in making progress towards universal health coverage. Within the universal health coverage framework, the Health Work Force Department is developing a Global Competency and Outcomes Framework. This will link competencies with undergraduate educational curricula for health workers within 12-48 months programmes that lead to diplomas or degrees.
- For in-service or life-long learning the WHO Academy will develop a series of on-line courses that can be adapted and used by government education institutes, national professional associations, NGOs, UN and other partners to provide credit for continued professional development (see under “strategies to improve guideline uptake” for initial modules). This will use the learning-transfer evaluation model (measuring behavioral change) plus the use of learning outcomes through which to assess achievement of competency. This modular approach supports national ownership of curricula for specialized post-graduate courses as countries can utilize them according to their needs and timeframes from updates.
Monitor guideline implementation and report lesson learned from operational research

Quality Assurance of Norms and Standard Department (QNS) is supporting WHO departments to improve the process of developing and designing guidelines so they are locally adaptable, user-friendly and increasingly incorporate user feedback.

- In 2020, WHO developed a monitoring and evaluation framework to better understand and improve the uptake and use of WHO guidelines and other normative and standard setting products, at the country level. The intention is to pilot this framework with countries and departments, including MCA.
- A review of literature “Improving WHO’s Understanding of WHO Guideline Uptake and Use in Member States” by QNS and University of Ottawa/Bruyere Research Institute study, will to be published in the last quarter 2021. It will contribute to what is known about the uptake and use of WHO’s normative and standard setting products by policy makers, managers and health professionals at practice level in low- and middle-income countries. The review covers a broad scope of recommendations and includes: breastfeeding, anaemia, pre-eclampsia and eclampsia. The findings and recommendations from this initial review intends to inform the WHO about the existing evidence, that could potentially be used to guide and further strengthen the framework for Monitoring, Evaluation, and Learning on the uptake and use of WHO guidelines in low- and middle-income countries.

Existing experiences within the departments will continue to support future work in this realm including most recently Implementing antenatal care recommendations in South Africa.

Another related activity is the Global Reproductive, Maternal, Newborn, Child and Adolescent Health Policy Survey (2018-19) which tracks adoption of specific WHO SRMNCASHN recommendations into country policy. This work is imminently to be complemented with a searchable publicly available repository on the WHO website to enable access to country guidelines, policies and laws. This will be an excellent resource for countries that are yet to incorporate policy changes in line with WHO recommendations, as they may benefit from approaches employed elsewhere.