
Global roadmap for hypertensive disorders of pregnancy from 2026 to 2035 and beyond



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**World Health
Organization**



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Foreword



Every woman has the right to a safe pregnancy and childbirth. Yet for many women, pregnancy is still marked by preventable illness, disability or death.

Hypertensive disorders of pregnancy, particularly

pre-eclampsia and eclampsia, remain among the leading causes of maternal death and severe morbidity worldwide. Their consequences extend beyond women themselves, contributing to stillbirth, preterm birth, and newborn death and illness. The burden falls disproportionately on women and babies in low- and middle-income countries, where timely access to quality prevention, diagnosis and treatment is often most limited.

This situation is unacceptable. We have made important progress in maternal and newborn health over recent decades, but progress in reducing deaths from hypertensive disorders of pregnancy has been far too slow. We already know how to prevent many of these deaths, yet proven interventions do not consistently reach the women who need them. At the same time, important gaps remain in our understanding of these conditions, in the development of better diagnostics and treatments, and in ensuring equitable access to quality-assured health products.

This *Global Roadmap for Hypertensive Disorders of Pregnancy from 2026 to 2035 and Beyond* provides a shared path forward. Developed through a global process culminating in the Global Pre-eclampsia Summit in Kigali, Rwanda, in May 2026, it brings together the perspectives of women with lived experience, governments, researchers, health workers, professional associations, civil

society, international organizations, funders, innovators and industry.

The Roadmap calls for coordinated action across five interconnected areas: research and innovation; norms and standards; access to quality health products; implementation; and advocacy and accountability. Its central message is simple: progress in any one of these areas will not be enough. New evidence must lead to better guidance; better guidance must be accompanied by access to effective and affordable health products; and proven interventions must be translated into high-quality care for every woman, everywhere.

The Roadmap also recognizes that women must be at the centre of this effort – not only as recipients of care, but as equal partners in shaping research, policies, programmes and accountability.

WHO is committed to providing leadership and working with Member States and partners to translate this Roadmap into action. But its success will depend on collective commitment: from governments, health workers, researchers, professional associations, civil society, funders, industry, communities and women themselves.

We know what is at stake, and we know that faster progress is possible. The task now is to turn knowledge into action, fragmentation into collaboration, and global ambition into better care and better outcomes for women and their babies.

Dr Tedros Adhanom Ghebreyesus

Director-General

World Health Organization

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Overall coordination of the Global Pre-eclampsia Summit, held in Kigali, Rwanda, in May 2026, and the development of this Roadmap was provided by the **WHO coordination team**: Doris Chou, Ioannis Gallos, Tina Lavin and Olufemi Oladapo (Department of Sexual, Reproductive, Maternal, Child, Adolescent Health and Ageing).

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SEEK Development supported the preparation of background materials, meeting facilitation resources and Summit logistics, including facilitation guides and session run-of-show documents. The team also co-facilitated the plenary and breakout sessions alongside the WHO coordination team and synthesized key discussions and outputs throughout the Summit.

The initial draft of the Roadmap was prepared by the WHO coordination team drawing on Summit outputs synthesized by SEEK Development during the Summit. Olufemi Oladapo (WHO) and Caitlin R. Williams (Mirae Insights, United States of America) led the consolidation of successive drafts and coordinated the integration of inputs from Steering Committee, Scientific Committee, Summit participants and other stakeholders. Deborah Armbruster (independent expert, United States of America), Cherrie Evans (Meridian Global Health, United States of America) and Justus Hofmeyr (University of Botswana, Botswana) peer-reviewed the document.

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Abbreviations

CHAI	Clinton Health Access Initiative
CSO	civil society organization
DOI	Declaration of Interests
EWENE	Every Woman Every Newborn Everywhere
FIGO	International Federation of Gynecology and Obstetrics
HELLP	Haemolysis, Elevated Liver enzymes, and Low Platelet count
HRP	UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction
ICM	International Confederation of Midwives
ISSHP	International Society for the Study of Hypertension in Pregnancy
LMIC	low- and middle-income country
LMICs	low- and middle-income countries
MMR	maternal mortality ratio
MoHs	Ministries of Health
NGO	nongovernmental organization
PMNCH	Partnership for Maternal, Newborn and Child Health
SUPREME	Sustained Uptake of Products for Pre-Eclampsia and Maternal Anemia
TPP	target product profile
TPoP	target policy profile
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
United Kingdom	United Kingdom of Great Britain and Northern Ireland
WHO	World Health Organization

Executive summary

Introduction and rationale

Hypertensive disorders of pregnancy, notably pre-eclampsia and eclampsia, constitute a major and persistent global public health challenge. They are among the leading causes of maternal death and severe morbidity, have lasting consequences for women's cardiovascular health and contribute substantially to stillbirth, preterm birth, newborn mortality and morbidity and health-system costs. The burden is inequitably distributed, with women and newborns in low- and middle-income countries (LMICs) disproportionately affected by gaps in timely access to quality care. Despite progress in reducing maternal mortality from several other direct causes, deaths attributable to hypertensive disorders of pregnancy have declined too slowly over the past three decades, underscoring the need for a renewed and coordinated global response.

The barriers to better outcomes for hypertensive disorders of pregnancy extend across the full pathway from knowledge generation to delivery at the point of care. Investment in research and development remains uneven, with greater attention to selected diagnostic and predictive innovations but chronic underinvestment persists with respect to the prevention and treatment of these conditions. Although several promising therapeutics are emerging for pre-eclampsia and eclampsia, there are still no medicines specifically developed and approved by regulators for prevention or treatment. Variation exists among international and national clinical practice guidelines on hypertensive disorders despite using the same evidence, creating uncertainty for policy-makers, programme managers and health-care providers. Equitable access to quality-assured health products (medicines, diagnostics and devices) remains constrained in many settings due to inadequate financing, fragmented demand, limited commercial incentives, regulatory and procurement weaknesses and supply-chain failures. These challenges have substantially limited the consistent implementation and scale-up of the few proven interventions available at global, national, subnational and community levels. Advocacy efforts directed at hypertensive disorders of pregnancy, although growing, remain insufficiently aligned to sustain political attention, financing and accountability.

Underlying these persistent gaps is a broader ecosystem challenge: the failure to sufficiently connect and align research and innovation, norms and standards, access to health products, implementation, and advocacy and accountability. This fragmentation is compounded by the absence of a compelling global investment case that translates the substantial health, social and economic consequences of hypertensive disorders of pregnancy into a clear case for political prioritization and sustained financing. Addressing this challenge requires a coherent agenda that aligns stakeholders and their efforts around shared priorities.

Recognizing the urgent need for a more coordinated global response, the World Health Organization (WHO), together with a broad coalition of partners and stakeholders, developed this *Global roadmap for hypertensive disorders of pregnancy from 2026 to 2035 and beyond* (hereafter referred to as the Roadmap). The Roadmap articulates a shared vision, strategic priorities and coordinated actions across five interconnected areas – research and innovation; norms and standards; access to health products; implementation; and advocacy and accountability – to accelerate progress towards ending

preventable stillbirth, maternal and newborn mortality and morbidity associated with hypertensive disorders of pregnancy and contribute to achieving Sustainable Development Goal targets 3.1 and 3.2. It provides an integrated strategic framework that aligns technical, policy and investment priorities, with particular emphasis on strengthening health systems and improving equitable access to quality care, especially in LMICs. By fostering collaboration among governments, women and communities, researchers, innovators, professional associations, implementers, civil society organizations (CSOs), advocates, nongovernmental organizations (NGOs), donors, industry and development partners, the Roadmap seeks to reduce fragmentation, promote collective action and accelerate the translation of evidence into policy and practice, ultimately delivering greater impact for women, newborns and families.

How the Roadmap was developed

The Roadmap was developed through a structured, evidence-informed and consultative process led by WHO. Preparatory work included landscape analyses, evidence reviews, country case studies, stakeholder mapping, pipeline assessments and priority-setting exercises across the five strategic areas of the Roadmap. This work was undertaken with oversight from a multidisciplinary Steering Committee and supported by Scientific Committee-led workstreams that prepared the background evidence and analyses underpinning the Roadmap.

These findings informed deliberations at the Global Pre-eclampsia Summit, (hereafter referred to as the Summit) convened by WHO in Kigali, Rwanda, from 5–8 May 2026. The Summit brought together representatives from ministries of health, professional associations, researchers and academic institutions, CSOs and NGOs, United Nations (UN) agencies and partnerships, donors, industry, innovators and other global stakeholders. Through plenary discussions and facilitated technical workstreams in breakout sessions, participants reached consensus on the key gaps and priority actions within each strategic area. The Roadmap was subsequently drafted by the WHO coordination team and refined through iterative review by the Steering Committee, Scientific Committee, Summit participants and external peer reviewers. Further details of the development process are provided in Chapter 2.

The Roadmap

The Roadmap provides a coordinated global agenda across five interdependent strategic areas – research and innovation, norms and standards, access to quality health products, implementation, and advocacy and accountability, as agreed by stakeholders at the Summit. Rather than representing independent workstreams, these strategic areas form an integrated pathway through which new evidence is generated and translated into clinical recommendations, supported by accessible medicines, diagnostics and devices, implemented at scale through strengthened health systems, and sustained through coordinated advocacy and political commitment. Progress will therefore depend on synchronized action across all five strategic areas, with each area reinforcing and enabling the others. Figure 1 provides an overview of some of these actions and deliverables. The main elements of the Roadmap are summarized below, with further detail provided in Chapter 3 of this document.

Strategic area – Research and innovation

The research and innovation agenda aims to strengthen both the evidence base and the product pipeline needed to improve screening, prevention, diagnosis and treatment of hypertensive disorders of pregnancy. Assessment of the hypertensive disorders of pregnancy innovation landscape revealed a highly unbalanced pipeline, characterized by a concentration of candidate diagnostic technologies but chronic underinvestment in novel preventive and therapeutic interventions. Priority activities therefore include strengthening the scientific foundation for innovation, defining clear target product profiles and development pathways, generating the evidence needed for product progression and

regulatory approval, designing products with implementation and affordability in mind, and fostering stronger collaboration across researchers, funders, industry, regulators, implementers and women with lived experience to create a healthier and more sustainable innovation ecosystem. WHO will work with partners to undertake these activities beginning in the last quarter of 2026.

A total of 20 priority research questions were identified across three complementary themes – innovation (seven questions), implementation (five questions) and cross-cutting (eight questions) – that require further investment to generate actionable evidence for screening, preventing, diagnosing and treating hypertensive disorders of pregnancy. The highest-priority questions focus on improving the diagnostic and predictive value of angiogenic biomarkers, including in LMICs; developing integrated prevention and management strategies, including care bundles; establishing standardized core outcome sets; and evaluating community-based approaches to improve early detection, timely referral and care-seeking. The research and innovation agenda also recognizes the importance of meaningfully involving women in shaping research priorities and evaluating interventions.

Between the third quarter of 2026 and the first quarter of 2027, WHO and partners will refine these research priorities, map them against ongoing research, define appropriate study designs, develop target policy profiles (TPoPs) to clarify evidence needs for policy decisions, specify innovation pathways and data requirements, identify funding gaps and promote coordinated investment. Donors and research funders are expected to use these priorities to guide future investment beginning in the third quarter of 2027, with funded studies generating the evidence needed to inform updates of the forthcoming consolidated global guidelines for hypertensive disorders of pregnancy, using the living guideline approach. In this way, the research and innovation agenda provides the evidence base for continuous learning and improvement in care, driving progress across all the remaining strategic areas.

Strategic area – Norms and standards

To reduce fragmentation and address gaps and inconsistencies in guidance for hypertensive disorders of pregnancy, strengthened collaboration is required among key guideline developers, particularly those operating at the global level, such as WHO, the International Federation of Gynecology and Obstetrics (FIGO), the International Confederation of Midwives (ICM), and the International Society for the Study of Hypertension in Pregnancy (ISSHP). To support this objective, WHO will establish a Steering Group to review existing coordination mechanisms across several of these organizations and assess the feasibility of jointly developing and publishing consolidated global guidelines for hypertensive disorders of pregnancy. The aim is to harmonize recommendations, reduce areas of inconsistency and ensure that guidance reflects the best available evidence while incorporating previously underrepresented topics, including women's perspectives and the specific needs and contexts of LMICs.

By the fourth quarter of 2026, the Steering Group will define the overarching scope of the guidelines and propose membership for the Guideline Development Group. Collaborating organizations are expected to pool resources during 2027 to commission evidence syntheses and prepare evidence profiles, with the aim of publishing consolidated guidelines in late 2027. In the interim, WHO and partners will continue to respond rapidly to important emerging evidence through the living guideline approach, ensuring that high-impact findings can be translated promptly into policy and practice. Following publication, the consolidated guidelines will provide the normative foundation for the implementation activities described in this Roadmap, informing national policy adaptation, development of implementation tools, workforce training and quality improvement efforts, while continuing to evolve through a living guideline approach as new evidence becomes available.

Strategic area – Access to health products

The access to quality health products agenda aims to strengthen the innovation and market ecosystem needed to ensure that women have equitable access to safe, effective, affordable and cost-effective medicines, diagnostics and devices for hypertensive disorders of pregnancy. The Summit identified major barriers affecting both existing and emerging medicines, diagnostics and medical devices. For existing products, the principal barriers include fragmented and inconsistent normative guidance, weak demand forecasting and procurement systems, inadequate quality assurance, poor affordability and limited sustainable financing, fragmented supply chains and weak referral and service delivery systems that prevent women from receiving timely and effective care. For emerging products, additional barriers arise earlier in the product pathway, including insufficient investment, limited support for product development, regulatory complexity, and delays in generating the evidence (particularly, context-specific evidence from LMICs) and policy recommendations needed to support country adoption.

To address these challenges, the Roadmap proposes a coordinated package of actions across the product lifecycle and health-product access ecosystem, with differentiated approaches for existing and emerging products. For existing products, priorities include strengthening quality assurance, sustainable financing and market shaping; improving forecasting, procurement and supply systems; expanding and sustaining the availability of quality-assured suppliers; strengthening inventory and supply information systems; and generating appropriate demand among providers, women and communities. For new and emerging products, the Roadmap prioritizes accelerating evidence generation, promoting earlier engagement between product developers and regulatory authorities (e.g., European Medicines Agency, U.S. Food and Drug Administration), supporting product development that reflects the needs of LMICs, and ensuring timely policy and guideline development and introduction pathways to facilitate rapid uptake following regulatory approval. Building on the normative agenda, priority activities will clarify the pathway from innovation to implementation by defining the evidence needed for policy decisions, developing TPoPs that reflect the needs of LMICs and different levels of care, and strengthening collaboration among normative agencies, researchers, regulators, developers and manufacturers from the earliest stages of product development. Together, these activities seek to accelerate the translation of innovation into products that are ready for policy adoption and country implementation.

Implementation of the access agenda will require coordinated action by multiple stakeholders across the product lifecycle and access ecosystem, from product development and quality assurance through financing, market shaping, procurement and supply to appropriate use at the point of care. Governments will lead policy and process development, financing, procurement and health system strengthening. WHO and partner agencies will provide normative leadership, convene stakeholders and support evidence generation and country implementation. Regulatory authorities will strengthen regulatory convergence and reliance mechanisms to accelerate access to priority health products. Manufacturers, innovators and procurement agencies will improve product availability, affordability and market resilience. Researchers and funders will accelerate evidence generation, product development and innovation. Professional associations, civil society and women's organizations will strengthen advocacy, accountability and community engagement.

In practical terms, beginning in the third quarter of 2026, Unitaïd and partners will establish a coordinated access workstream for priority health products. Product-specific access plans and activities to accelerate product readiness will begin in late 2026, followed in 2027 by coordinated action to strengthen country readiness including regulatory environment, market readiness, policy adoption, procurement and supply systems, and country introduction for select priority products. By the fourth quarter of 2028, priority products should have coordinated product development, regulatory and country introduction plans in place, with agreed milestones, clearly defined partner responsibilities and mechanisms for monitoring progress towards equitable access.

Together, these activities seek to ensure that priority products are not only developed and recommended, but are also quality-assured, appropriately financed, registered, procured, distributed and consistently available at the point of care, providing the critical bridge between innovation and implementation.

Strategic area – Implementation

The implementation agenda bridges the gap between global recommendations and routine clinical practice, ensuring that evidence-based interventions for hypertensive disorders of pregnancy are consistently delivered through well-functioning health systems. The Summit identified several barriers to implementation, including insufficient political commitment, fragmented policies and clinical guidance, inadequate financing, limited health workforce capacity, weak referral systems, inconsistent quality of care, and insufficient monitoring and accountability to drive continuous improvement. Addressing these barriers requires coordinated action across policy, programme, service-delivery, community and multi-sectoral levels to create an enabling environment for effective implementation.

The Roadmap identifies seven priority implementation domains spanning policy, programming and clinical practice, namely:

- ▶ strengthening legislative and political commitment;
- ▶ integrating hypertensive disorders of pregnancy into national health policies, clinical protocols and emergency preparedness plans;
- ▶ securing sustainable financing;
- ▶ supporting country adoption and contextualization of harmonized global guidance;
- ▶ strengthening the health workforce through competency-based pre-service and in-service education, supportive supervision and task-sharing where appropriate;
- ▶ establishing effective referral pathways across all levels of care; and
- ▶ strengthening quality improvement, routine monitoring and implementation learning to support continuous adaptation and accountability.

Together, these actions provide countries with a coordinated framework for translating global recommendations into high-quality, equitable care for women with hypertensive disorders of pregnancy.

Implementation will be phased over the next decade, beginning with global preparatory activities in the fourth quarter of 2026. WHO, UNFPA, FIGO, ICM, ISSHP and other partners will work with ministries of health, national professional associations and development partners to establish or strengthen national technical working groups, support countries in adapting the global Roadmap into national roadmaps, develop costed national implementation plans, and prepare standardized implementation resources, including care pathways, training materials and other implementation tools. Following publication of the consolidated global guidelines in the fourth quarter of 2027, WHO, UNFPA, FIGO, ICM, ISSHP and other professional associations will support countries in adopting, adapting and implementing the new recommendations through national policies, clinical guidelines and practical implementation tools. Beginning in 2028, organizations such as Align, Jhpiego and Laerdal Global Health, together with academic institutions, professional associations and other implementation partners, will support competency-based pre-service and in-service education, mentoring, simulation-based training and supportive supervision – under the leadership of ministries of health – while WHO regional and country offices, UNFPA, UNICEF and other partners provide ongoing technical assistance to strengthen implementation, referral systems, quality improvement, monitoring and accountability. Throughout the implementation period to 2035, governments,

legislators, professional associations, CSOs and development partners will work together to sustain political commitment, mobilize financing, monitor progress and strengthen implementation, ensuring that lessons learned from country implementation inform future updates to national guidance and successive revisions of the consolidated global guidelines through the WHO living guideline process.

Strategic area – Advocacy and accountability

The advocacy and accountability agenda provides the cross-cutting political and public engagement platform needed to sustain progress across all other strategic areas of the Roadmap. The Summit identified several barriers that continue to limit progress, including the low prioritization of hypertensive disorders of pregnancy on national and global health agendas, fragmented advocacy efforts and inconsistent, unconvincing messaging, inadequate political commitment and financing, weak accountability mechanisms, limited engagement of women and communities, and insufficient data to monitor commitments and drive action. These challenges are compounded by shortages of skilled health workers, weak infrastructure and equipment, and competing national priorities that reduce sustained attention to hypertensive disorders of pregnancy.

The Roadmap proposes a coordinated global advocacy strategy built around four complementary pillars: advocacy, accountability, political mobilization and financing. Priority actions include developing a shared global advocacy framework and harmonized messaging; developing a compelling global investment case to support sustainable domestic and international financing; strengthening partnerships across governments, professional associations, civil society, academia, industry and development partners; building broader coalitions beyond the pre-eclampsia community; promoting meaningful engagement of women, families and communities, including women with lived experience; and strengthening data systems and accountability mechanisms to monitor commitments and progress. The Roadmap also promotes advocacy for strengthened health workforce capacity, improved infrastructure and equipment, and greater investment in research, implementation and access to quality health products.

Beginning in the third quarter of 2026, the Partnership for Maternal, Newborn and Child Health (PMNCH), WHO, UNICEF, UNFPA and partners will establish a Pre-eclampsia Advocacy Working Group to create a shared vision with a coordinated global advocacy framework and identity. It will develop harmonized and compelling messaging, advocacy tools, and governance arrangements to align global, regional and national advocacy efforts. Early activities will also include development of a global investment case for hypertensive disorders of pregnancy, coordinated advocacy around the existing World Pre-eclampsia Day (22 May), and support for countries to strengthen political leadership and accountability through national champions, parliamentary engagement and other context-appropriate mechanisms. Following publication of the consolidated global guidelines in the last quarter of 2027, advocacy efforts will increasingly focus on supporting country adoption and implementation of the Roadmap, mobilizing sustainable financing, strengthening accountability, and amplifying the voices of women with lived experience. By the end of 2028, the global advocacy framework, investment case and accountability mechanisms are expected to be operational across global, regional and national advocacy efforts, providing a sustainable platform to maintain political commitment, mobilize resources and support implementation of the Roadmap through 2035.

A global Call to Action

To accelerate implementation of the Roadmap, a consensus-driven global Call to Action was developed to complement the strategic priorities outlined in this document. Building on the outcomes of the Summit, it articulates the case for urgent action, demonstrates that meaningful progress is achievable, and defines the commitments expected from the key stakeholder groups

whose collective action will determine the Roadmap's success. It is underpinned by three overarching themes that emerged consistently throughout the Summit, namely:

- ▶ ensuring that hypertensive disorders of pregnancy receive the visibility, political commitment and investment they deserve;
- ▶ placing women – particularly those in LMICs – at the centre of research, policy, implementation and accountability; and
- ▶ accelerating equitable access to proven interventions and emerging innovations through harmonized guidance, strengthened health systems and sustainable financing.

The Call to Action complements the Roadmap by translating its strategic priorities into coordinated commitments for the diverse stakeholders responsible for delivering them.

Recognizing that implementation depends upon collective action, the Call to Action invites governments, women and communities, UN agencies, researchers, civil society, professional associations, implementers, industry, funders, development partners and the wider international community to align around a shared vision and coordinated priorities. By setting clear expectations for each stakeholder group, the Call to Action seeks to strengthen political commitment, mobilize investment, foster accountability and maintain momentum towards ending preventable maternal and newborn mortality and morbidity associated with hypertensive disorders of pregnancy. By aligning efforts around a common set of priorities, the Call to Action seeks to transform the Roadmap from a strategic vision into a coordinated global movement for implementation.

Dissemination, implementation and monitoring of the Roadmap

Successful implementation of the Roadmap will require sustained commitment, adequate financing and coordinated action at global, regional, national and subnational levels. Implementation will reflect the interconnected nature of the five strategic areas, recognizing that progress in research and innovation, norms and standards, access to health products, implementation, and advocacy and accountability is mutually dependent. The Roadmap therefore seeks to promote deliberate linkages across these areas so that progress in one enables and accelerates progress in others, rather than pursuing individual activities in isolation.

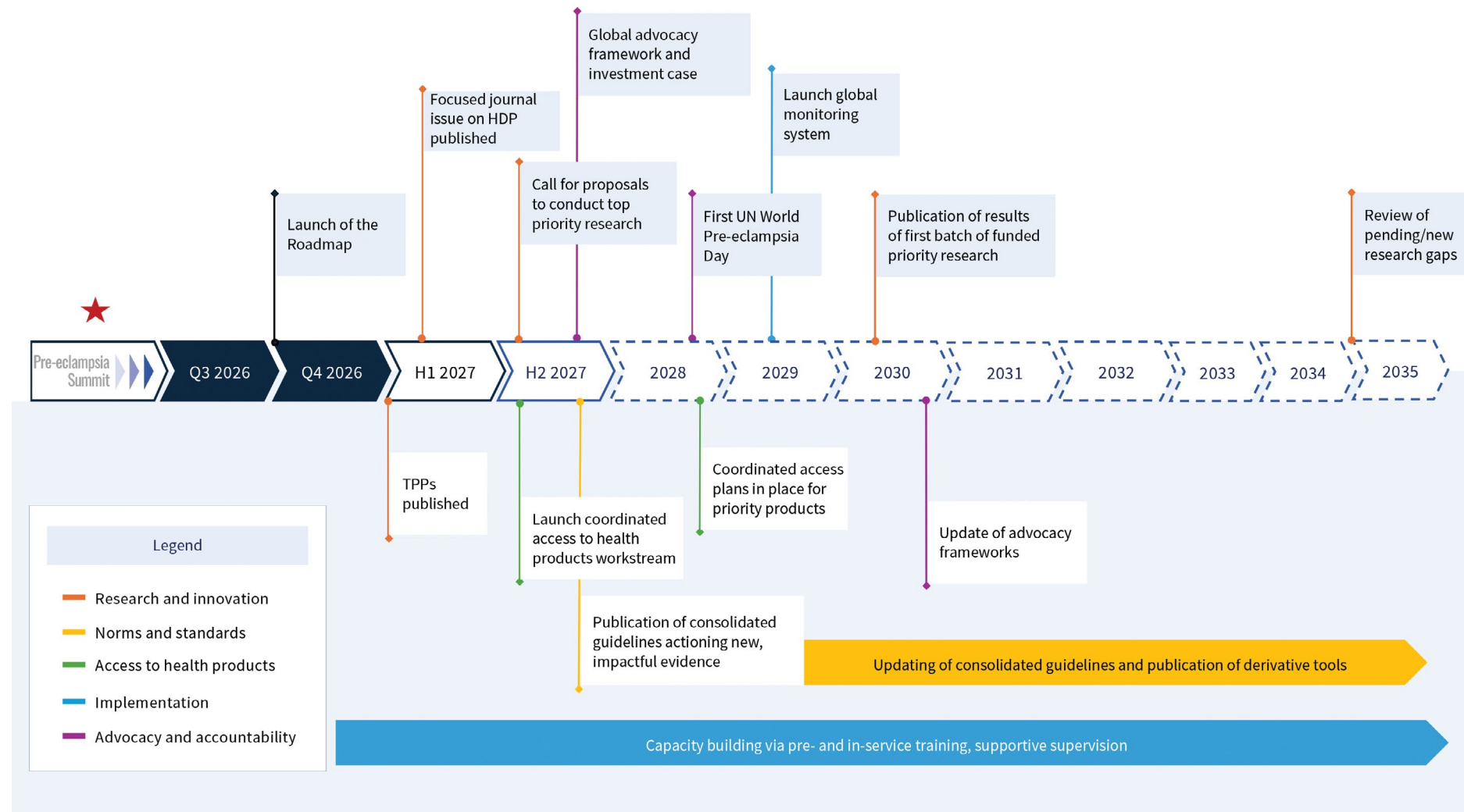
Shared leadership and clear accountability will be central to this approach. WHO will initially play a catalytic and convening role, providing normative leadership, initiating priority activities and supporting countries, while other organizations lead activities aligned with their respective mandates and comparative advantages. A global coordination mechanism will provide overall stewardship, maintain coherence across the five strategic areas and monitor progress against major milestones. At country level, ministries of health and partners will be encouraged to adapt the global Roadmap into national roadmaps or equivalent implementation frameworks, reflecting local priorities, health-system realities, financing needs and implementation barriers. The Call to Action provides a framework for the complementary roles of governments, women and communities, professional associations, civil society, researchers, donors, implementation partners, industry and other stakeholders.

The Roadmap and Call to Action will be launched at the Society for Maternal-Fetal Medicine Global Congress in October 2026, accompanied by a WHO press release and coordinated communications activities. Following publication, the Roadmap and supporting resources will be disseminated through WHO regional and country offices, ministries of health, professional associations, UN agencies, WHO collaborating centres, CSOs, media outlets, parliamentarian and other partner networks. The Roadmap will be translated into the six official UN languages, while the background analyses that informed its development are planned for peer-reviewed publication as part of a focused journal issue in the first quarter of 2027. Dissemination will be used not simply to increase

awareness, but to mobilize stakeholders, support country adaptation and translate the Roadmap's priorities into action.

Monitoring, evaluation and learning will be aligned with the Roadmap's Theory of Change and integrated, wherever possible, with existing maternal and newborn health monitoring systems, including Every Woman Every Newborn Everywhere (EWENE). A focused monitoring framework will combine existing indicators with a limited set of additional standardized indicators to track progress at three complementary levels: delivery of priority activities and milestones; achievement of outputs and intermediate outcomes across the five strategic areas; and ultimately improvements in maternal, fetal and newborn outcomes and reductions in inequities. Regular review of progress will identify bottlenecks, strengthen accountability and enable course correction as new evidence, innovations and implementation experience emerge. In this way, implementation, monitoring and learning will operate as a continuous cycle through 2035, helping sustain momentum towards the Roadmap's vision of a future in which no woman or baby dies from preventable complications of hypertensive disorders of pregnancy.

Figure 1. Top-level milestones in the global roadmap for hypertensive disorders of pregnancy from 2026 to 2035 and beyond



1. Introduction and rationale

1.1 The persistent global burden of hypertensive disorders of pregnancy

Hypertensive disorders of pregnancy are a leading cause of maternal and perinatal mortality and morbidity worldwide and continue to pose a major challenge to achieving the Sustainable Development Goal targets related to maternal and newborn survival. They comprise a spectrum of conditions – including chronic hypertension, gestational hypertension, pre-eclampsia, eclampsia, chronic hypertension with superimposed pre-eclampsia and HELLP syndrome – that differ in their clinical presentation but share common pathophysiological mechanisms leading to placental dysfunction, endothelial injury, maternal organ damage and adverse fetal outcomes. Pre-eclampsia, the most complex manifestation, is a pregnancy-specific multisystem disorder characterized by new-onset hypertension accompanied by maternal organ dysfunction and/or uteroplacental dysfunction (1).

Globally, hypertensive disorders complicate an estimated 10–15% of pregnancies, while pre-eclampsia alone affects approximately 3–5% of pregnancies (2). Together, these disorders account for approximately 16% of all maternal deaths globally, equivalent to an estimated 42 000 maternal deaths and more than 500 000 fetal and neonatal deaths each year (3). Beyond mortality, millions of women experience severe maternal complications including stroke, pulmonary oedema, heart failure, acute kidney injury, liver dysfunction and disseminated intravascular coagulation, while babies born to mothers with hypertensive disorders of pregnancy have substantially increased risks of fetal growth restriction, preterm birth, low

birthweight, stillbirth and early neonatal death (4–6). Despite important advances in screening, prevention, diagnosis and treatment over recent decades, these conditions continue to place an enormous burden on women, families, health systems and societies worldwide.

Importantly, the consequences extend far beyond pregnancy. For affected women, hypertensive disorders of pregnancy are now recognized as important predictors of chronic, lifelong morbidities that may emerge years after the affected pregnancy, such as essential hypertension, cardiovascular disease, stroke, chronic kidney disease and metabolic disorders later in life (7). Children exposed to these conditions in utero face increased risks of preterm birth and its complications and long-term cardiovascular and metabolic disease in later life (8). These life-course consequences for women and babies underscore that hypertensive disorders of pregnancy are not solely obstetric complications, but major public health and development challenges with profound social and economic implications, including increased health-care costs, productivity losses and long-term disability.

The global burden is unevenly distributed. Women living in low- and middle-income countries (LMICs) continue to experience disproportionately higher rates of severe disease and preventable mortality. Persistent inequities in access to high-quality antenatal care, emergency obstetric services, essential medicines, diagnostics, referral systems and appropriately trained health workers drive these disparate outcomes. Within countries, women affected by poverty, humanitarian crises, geographic isolation and social marginalization bear a disproportionate burden. As global reductions in maternal mortality have slowed,

hypertensive disorders of pregnancy remain one of the conditions for which the greatest gains in survival and health equity are still achievable.

1.2 Why progress has stalled

Scientific understanding of hypertensive disorders of pregnancy has advanced considerably over the past three decades. Major discoveries in placental biology, disease mechanisms, biomarkers and clinical management have improved the ability to identify women at risk and to prevent or manage severe complications. The World Health Organization (WHO) and other organizations have developed evidence-based recommendations for prevention and treatment. Nevertheless, reductions in mortality and morbidity attributable to hypertensive disorders of pregnancy have been slower than anticipated, particularly in settings with the highest burden.

A key reason for the stagnation is that progress across the continuum from research to implementation has remained fragmented. Researchers, innovators, manufacturers, funders, regulators, policy-makers and implementers frequently operate independently, with limited coordination across the product development and policy pathway. Consequently, research priorities are often disconnected from country needs, evidence generation does not always anticipate policy requirements and promising innovations can take many years to translate into clinical practice. The absence of prospectively defined target product profiles (TPPs) and, more recently, target policy profiles (TPoPs) has further limited alignment between innovation, regulatory approval, policy development and implementation (9–11).

The normative landscape has also become increasingly complex. WHO has maintained its portfolio of recommendations on hypertensive disorders of pregnancy through a living guideline approach (12), while numerous international organizations, professional associations and countries have developed their own guidelines (13). Although these efforts have broadened the normative landscape, differences in methodology, scope and interpretation of evidence, and differing access to resources

for guideline development have resulted in inconsistencies across recommendations. Such variations tend to create uncertainty for policy-makers and health-care providers, contribute to uneven adoption of best practices and ultimately slow implementation.

Persistent failures in access to essential health products further undermine progress. Many women continue to lack reliable access to basic blood pressure measurement devices, urine protein testing, aspirin, antihypertensive medicines, magnesium sulfate and other essential commodities. Weak procurement systems, fragmented markets, limited demand forecasting, regulatory uncertainty, inadequate quality assurance and poor alignment between global recommendations and national procurement systems all contribute to persistent shortages. Moreover, many medicines currently used for hypertensive disorders of pregnancy were originally developed for non-pregnant populations and continue to be used off label in many settings, reflecting the limited investment historically directed towards pregnancy-specific therapeutics.

Health system constraints further compound these challenges. Inadequate risk stratification tools, weak referral pathways, shortages of trained health workers, inadequate laboratory capacity and limited emergency obstetric services continue to impede timely diagnosis and effective management. Preventive interventions such as low-dose aspirin remain inconsistently implemented, while administration of magnesium sulfate for eclampsia prophylaxis often depends on the availability of appropriately trained personnel. At the same time, advocacy efforts have frequently lacked coordination, limiting public awareness, political commitment and sustained investment.

Collectively, these challenges demonstrate that global progress for hypertensive disorders of pregnancy has been constrained by fragmentation across the entire innovation-to-impact pathway. Important gaps remain in research and product development, while existing evidence and interventions are not consistently translated into policy,

practice or equitable access. Addressing these interconnected challenges requires a coordinated global approach that aligns discovery science, innovation, normative guidance, access, implementation and advocacy around shared priorities and measurable outcomes.

1.3 Why is a Roadmap needed?

The challenges described above point to a system failure that cannot be solved through isolated actions within the single domains of research and innovation, guideline development, access to health products, implementation or advocacy. Each of these areas is essential, but progress in one would have limited impact if the conditions required in the others are not in place. A promising innovation cannot improve outcomes if the evidence needed for regulatory and policy decisions is not generated; a new recommendation cannot change practice if appropriate products are unavailable or health systems are unprepared to deliver it; and proven interventions cannot achieve scale without adequate financing, political commitment, a competent workforce and effective implementation.

A Roadmap is therefore needed to connect and align the different parts of the evidence-to-impact pathway. Research and innovation generate evidence and solutions that inform global norms and standards; normative recommendations help shape regulatory, policy and product-access decisions; access to quality-assured medicines, diagnostics and medical devices enables implementation; and country implementation generates experience and evidence that reveal new research questions, gaps in guidance and barriers to access. Advocacy and accountability cut across the entire pathway, mobilizing the political commitment, financing and public attention needed to initiate and sustain progress.

These relationships are neither linear nor one-directional. Rather, they form a reinforcing cycle in which progress – or failure – at one point influences what can be achieved elsewhere (Figure 1.1). New evidence may change recommendations; emerging products may

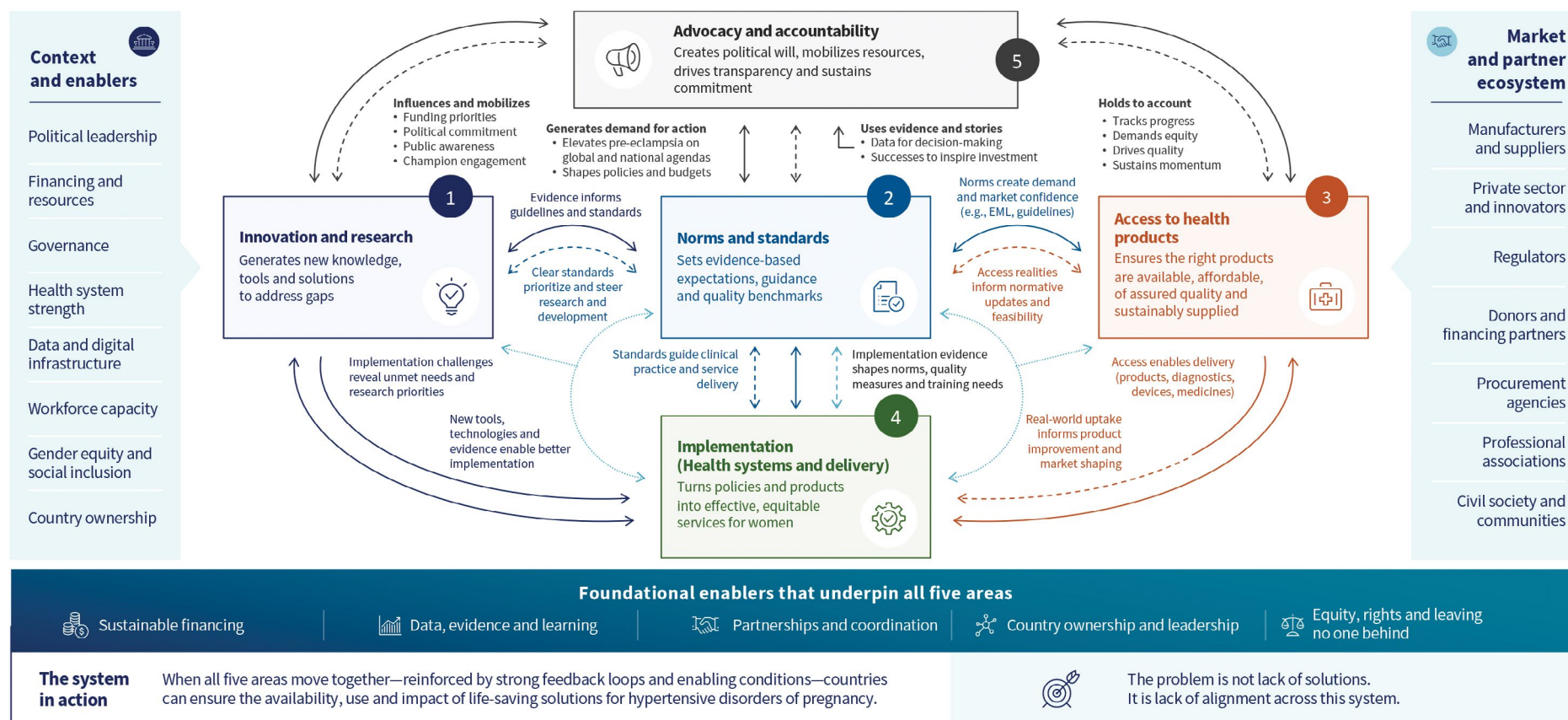
require new evidence, regulatory pathways or models of service delivery; implementation experience may expose previously unrecognized research, normative or access gaps; and advocacy can accelerate progress across all areas by mobilizing attention, commitment and resources. Without deliberate coordination, these dependencies can become bottlenecks. When effectively aligned, they can instead become accelerators of progress.

The purpose of a Roadmap is therefore not simply to assemble priorities across different strategic areas into a single document. It is to make their interdependencies visible and actionable, strengthen the critical connections and hand-offs between them, and align stakeholders, investments and timelines around shared goals and milestones. This means anticipating what needs to happen both upstream and downstream of individual activities – for example, ensuring that research generates evidence suitable for regulatory and policy decision-making; that promising innovations have viable pathways to quality assurance, market introduction and country access; that global recommendations can be translated into national policy and practice; and that health systems are prepared to deliver effective interventions as they become available.

A Roadmap also provides a common framework through which stakeholders with different mandates, expertise and comparative advantages can contribute to a shared agenda. By establishing common priorities and milestones and clarifying responsibilities and dependencies, it can help reduce duplication, identify critical gaps requiring investment, improve coordination among governments, funders and partners, and strengthen accountability for progress. Importantly, it connects global action with national and subnational implementation, recognizing that impact will ultimately depend on whether advances in evidence, guidance, products and investment translate into accessible, high-quality care for women, particularly in settings where the burden is greatest.

In this way, a Roadmap seeks to shift the global response from fragmented progress within

Figure 1.1. The five strategic areas: a complex, interdependent system



individual areas to coordinated, system-wide action across the entire evidence-to-impact pathway. Its value lies not only in identifying what needs to be done, but also in aligning who needs to act, when different actions need to occur, and how progress in one strategic area can enable and accelerate progress in the others.

Recognizing this need, WHO and the UNDP–UNFPA–UNICEF–WHO–World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) convened a broad coalition of international stakeholders to develop the “Global Roadmap for hypertensive disorders of pregnancy from 2026 to 2035 and beyond” (hereafter referred to as the Roadmap). The Roadmap brings together five interdependent strategic areas – research and innovation; norms and standards; access to health products; implementation; and advocacy and accountability – within a coordinated global framework. It identifies shared priorities, catalytic actions, milestones and stakeholder responsibilities intended to accelerate the development, introduction, scale-up and equitable use of effective interventions, while supporting countries, particularly those with the highest burden, to strengthen health systems and accelerate progress towards global maternal and newborn health targets and ending preventable stillbirths.

1.4 Target audience

The Roadmap is intended for public health leaders and the full range of stakeholders involved in the hypertensive disorders of pregnancy ecosystem, including the international community, governments including ministries of health, researchers and academia, innovators and industry, professional associations and guideline developers, implementing organizations (including civil society organizations [CSOs] and nongovernmental organizations [NGOs]), funders, and the wider public, particularly women. It is designed as a practical resource for governments, relevant ministries, national and subnational health authorities, public health institutes and associations and other organizations and agencies to adapt global

priorities and actions to their specific contexts and needs.

1.5 Objective and scope of the Roadmap

The Roadmap has three overarching objectives:

- ▶ align stakeholders in the field around a shared vision, strategic priorities and coordinated actions to reduce preventable mortality and morbidity from hypertensive disorders of pregnancy, over the next decade and beyond;
- ▶ focus investments and collective efforts on the highest-priority activities, reducing fragmentation, minimizing duplication and maximizing impact of available resources; and
- ▶ mobilize stakeholders to strengthen collaboration, accountability and sustained action across countries over the coming decade and beyond.

The Roadmap is intended as a high-level strategic framework rather than a detailed implementation plan. It identifies the critical milestones, actions and roles required to achieve meaningful global impact while allowing flexibility for countries and partners to adapt implementation to their own contexts. It is not a detailed project plan that delineates every step that needs to be taken but rather outlines key dependencies to be actioned. These include alignment on the goals to be achieved; a timeline with major milestones, sequencing of activities and allocation of roles and responsibilities; and clear indications of how success will be measured.

The Roadmap is based on a shared set of priorities identified at the Global Pre-eclampsia Summit (hereafter referred to as the Summit), convened by WHO and HRP in May 2026 and described further in Chapter 2. These priorities are organized across five strategic areas:

- ▶ research and innovation;
- ▶ norms and standards;
- ▶ access to health products;
- ▶ implementation; and
- ▶ advocacy and accountability.

Within each area, the Roadmap identifies priority solutions and catalytic actions to address persistent challenges and substantially reduce mortality and morbidity related to hypertensive disorders of pregnancy.

The Roadmap is designed to reinforce – not replace – existing global, regional and national

efforts and initiatives to improve quality of care and reduce maternal and newborn mortality and morbidity and stillbirths. It provides a platform for stronger collaboration and coalition-building, supporting progress not only on hypertensive disorders of pregnancy but across the broader maternal, perinatal and newborn health agenda.

2. How the Roadmap was developed

A structured and consultative process was undertaken to develop the Roadmap, centred around the Summit. The process combined background evidence reviews, landscape analyses, stakeholder engagement and consensus-building to identify priority gaps, agree on strategic actions and develop a coordinated global framework for reducing the burden of hypertensive disorders of pregnancy.

WHO and HRP convened the Summit from 5–8 May 2026 in Kigali, Rwanda, with the following objectives:

- ▶ to review progress in research and development for innovations in the pipeline and identify priority research gaps across the continuum from discovery science, epidemiology and implementation research to post-marketing evaluation for hypertensive disorders of pregnancy in the short, medium and long term;
- ▶ to identify and build consensus on top priority gaps in norms and standards for hypertensive disorders of pregnancy;
- ▶ to identify priority barriers to access to health products and the market-shaping actions – including regulatory, manufacturing, pricing, procurement, supply chain and quality assurance strategies – needed to enable timely, equitable and sustainable access to essential and innovative health products for hypertensive disorders of pregnancy, particularly in LMICs;
- ▶ to identify priority implementation gaps and agree on strategies to support the equitable delivery and scale-up of interventions for hypertensive disorders of pregnancy;
- ▶ to identify priority gaps in advocacy and accountability and build consensus on sustainable strategies to address them;

- ▶ to synthesize the challenges identified across strategic areas and develop a clear Roadmap for addressing them; and
- ▶ to facilitate networking and foster future collaboration among key stakeholders working across the hypertensive disorders of pregnancy landscape, including researchers, innovators, industry, guideline developers, funders, implementers, policy-makers, professional associations, CSOs and NGOs.

The Roadmap was developed through four sequential steps: (i) selection of participants and contributors; (ii) systematic identification of research, innovation, normative, access, implementation, advocacy and accountability gaps to inform prioritization; (iii) convening the Summit to achieve consensus on the highest-priority gaps and the strategic actions needed to address them; and (iv) translating the agreed priorities into the Roadmap and its accompanying global Call to Action. These steps are elaborated in the four sections of this chapter.

2.1 Summit participants and contributors to the Roadmap

To guide the development of the Roadmap, WHO established a Steering Committee to provide strategic oversight and methodological guidance throughout the process. The Steering Committee advised on the overall approach to the Roadmap, including the design of the Summit, review of the background materials and the consensus-building process. Its membership was selected to ensure an appropriate balance of technical expertise, geographical representation and gender. WHO and HRP coordinated the overall process and ensured that all methods and procedures were consistent with WHO's established standards for the development of normative and strategic documents.

WHO also established a Scientific Committee, comprising the leads of the Summit's six workstreams, which collectively covered the five strategic areas of the Roadmap. The Scientific Committee led the systematic identification and analysis of gaps within each strategic area and prepared the background analyses that informed the Summit deliberations and priority-setting.

A total of 143 participants attended the Summit. They represented a broad range of stakeholders working at global, regional and country levels, including ministries of health; academic and research institutions; professional associations; health-care providers; advocates; women with lived experience, United Nations (UN) agencies; donor organizations; CSOs; NGOs; regulatory authorities; innovators; manufacturers; and representatives from the pharmaceutical, diagnostics and medical devices industries. Participants attended the Summit in their individual expert capacities rather than as formal representatives of their respective organizations, enabling open technical discussions and independent consensus-building. A full list of contributors is provided in the Annex.

2.2 Identifying gaps in the strategic areas before the Summit

In advance of the Summit, several background activities were undertaken by the Steering and Scientific Committees to identify gaps in all five of the strategic areas.

Research and innovation

A comprehensive assessment of the research and innovation landscape was undertaken to identify opportunities for accelerating the development, evaluation and implementation of new approaches for the risk screening, prevention, diagnosis and treatment of hypertensive disorders of pregnancy. The work combined an innovation pipeline mapping exercise (14) with a structured global research priority-setting process to identify both immediate opportunities for product development and the evidence gaps requiring future investment.

The innovation assessment mapped the global pipeline of medicines and diagnostics (including medical devices and digital technologies) relevant to hypertensive disorders of pregnancy across the full research and development continuum. The exercise characterized existing, emerging, stalled and discontinued innovations and assessed their stage of development, intended use and readiness for implementation. In parallel, the assessment examined alignment with available TPPs, regulatory pathways, market barriers and implementation requirements, with particular attention to the needs of LMICs. Evidence was synthesized from published and grey literature, product development pipelines and consultations with researchers, product developers, manufacturers and implementation partners.

The assessment identified a growing but fragmented innovation landscape. Promising advances were identified across therapeutics and diagnostics (including medical devices and digital health technologies). Relatively few products, however, had progressed to late-stage development or implementation. The pipeline remained dominated by repurposed medicines and technologies originally developed for other conditions, with comparatively limited investment in products designed specifically for pregnancy. Important gaps were identified in affordable diagnostics, predictive biomarkers, point-of-care technologies and products suitable for lower-level health facilities. Cross-cutting barriers – including limited investment, exclusion of pregnant women from clinical research, regulatory complexities, fragmented product development efforts and insufficient alignment between innovation and country implementation needs – were found to constrain progress across the innovation pathway.

Building on the innovation assessment, a structured research priority-setting exercise was undertaken using WHO's established approach for health research priority setting and a modified Child Health and Nutrition Research Initiative methodology. Research questions were identified through a review of WHO and international guidelines, systematic reviews, previous research prioritization

exercises, TPPs, innovation pipeline analyses and submissions from Summit participants. Following consolidation, removal of duplicates and refinement for clarity, 94 research questions were grouped into three domains: innovation, implementation and cross-cutting research. An online prioritization survey invited all confirmed Summit participants to independently score the proposed research questions against five predefined criteria: answerability, effectiveness, deliverability, potential impact and equity. A total of 127 participants completed the scoring exercise. The 40 highest-ranked questions were subsequently reviewed and refined through structured deliberations during the Summit to establish a consensus set of 20 priority research questions.

Norms and standards

To identify priorities for the norms and standards strategic area, WHO commissioned a systematic mapping and gap analysis of international and national evidence-based clinical practice guidelines for hypertensive disorders of pregnancy. The objective was to identify areas of agreement and inconsistency across recommendations, assess whether the evidence underpinning existing recommendations had evolved, and determine where new or updated recommendations may be required.

A systematic search of bibliographic databases and the websites of major international and national guideline development organizations was undertaken to identify clinical practice guidelines published within the previous 15 years. Eligible guidelines were required to be evidence-based, developed using systematic review methods, produced through multidisciplinary processes, and include explicit assessments of the quality of evidence and strength of recommendations. Guidelines that were adapted from other guidance documents, opinion papers, position statements without supporting systematic evidence reviews or publications lacking sufficient methodological information were excluded.

Recommendations from eligible guidelines were extracted and mapped according to major thematic areas, including definitions

and classification, risk assessment and prediction, prevention, diagnosis, clinical management, postpartum care and health system interventions. Recommendations were compared to identify areas of agreement, partial agreement and disagreement, as well as topics not addressed by existing guidance. In parallel, a structured evidence-based surveillance and updating exercise was undertaken to identify newly published evidence relevant to existing WHO recommendations and topic areas where new recommendations might be warranted. The findings were used to identify WHO recommendations that could potentially be prioritized for updating and to inform the identification of new recommendation questions for future guideline development.

The guideline mapping and the evidence surveillance and updating exercises identified both important areas of convergence and significant opportunities to strengthen normative guidance. Across the 19 clinical practice guidelines included, there was broad agreement on the definition of hypertensive disorders of pregnancy, clinical risk assessment, diagnosis of hypertension and proteinuria and the management of severe disease (including the use of antihypertensive medicines, magnesium sulfate, hospital admission and delivery planning). Partial agreement or disagreement was observed for several important areas, including disease classification, aspirin and calcium supplementation, the use of biomarkers, uterine artery Doppler, predictive algorithms, management of non-severe hypertension, maternal and fetal monitoring, and intrapartum and postpartum care.

The analysis also identified substantial opportunities to strengthen WHO guidelines. More than 40 recommendations included in other international guidelines were not addressed in current WHO guidelines, particularly in relation to angiogenic biomarker testing, predictive algorithms, advanced diagnostic approaches, maternal and fetal monitoring, and other aspects of clinical management. Health system interventions were also largely absent from existing clinical practice guidelines despite their importance

for implementation. In addition, the evidence surveillance and updating exercise identified 15 existing WHO recommendations as priorities for updating and highlighted several areas where new recommendations may be required. Together, these findings informed the prioritization of the norms and standards actions included in this Roadmap.

Access to health products

A comprehensive landscape assessment was undertaken to identify barriers and opportunities for improving equitable access to quality-assured health products for the prevention, diagnosis and management of hypertensive disorders of pregnancy. The assessment examined the full product pathway – from product development and regulatory approval to procurement, financing, supply chains, service delivery and use at the point of care – with particular attention to the challenges faced by LMICs.

The assessment considered three broad product groups: preventive interventions (including aspirin and calcium supplementation), products for diagnosis and monitoring (including blood pressure devices, proteinuria tests, biomarkers and ultrasound) and medicines for treatment (including magnesium sulfate, labetalol, nifedipine, hydralazine and methyldopa). Access was examined across seven complementary dimensions: availability, affordability, quality and safety, accessibility, acceptability, appropriateness, and sustainability and market resilience.

Evidence was synthesized from four complementary sources: a review of the published and grey literature; global key informant interviews involving 47 stakeholders across the product value chain; pharmacist insight-board discussions conducted in collaboration with the International Pharmaceutical Federation; and country case studies from Guatemala, Nigeria, Pakistan and Sierra Leone. Together, these activities brought together perspectives from regulators, manufacturers, procurement specialists, ministries of health, multilateral organizations, academia and implementing partners to

identify recurrent barriers, enabling factors and opportunities for market shaping.

The assessment found that products recommended in policies, clinical guidelines or essential medicines lists often remained unavailable at the point of care because of weaknesses in procurement, forecasting, supply chains and service delivery. Blood pressure devices and diagnostic equipment were frequently unavailable, non-functional or poorly maintained. Access to medicines was often constrained by stock-outs, fragmented procurement systems and limited financing. Country case studies demonstrated that policy adoption alone does not ensure product availability or use.

The assessment also highlighted important gaps across the access pathway. Guidance on the selection and use of medicines, diagnostics and medical devices was often incomplete or inconsistent across organizations, while several products lacked supporting operational specifications or guidance to facilitate registration, procurement, quality assurance and implementation at country level. Many products used for hypertensive disorders of pregnancy had originally been developed for other clinical indications and were not optimized for pregnancy care or for use in resource-constrained settings. Weak market incentives, fragmented demand, limited numbers of quality-assured suppliers and dependence on external financing further contributed to fragile markets for maternal health products. Together, these findings informed the prioritization of the access to health products actions included in this Roadmap.

Implementation

To understand the contextual challenges responsible for the slow uptake of evidence-based recommendations, WHO commissioned three country case studies: Guatemala, Nigeria and Pakistan. The countries were selected from the three regions with the highest burden of hypertensive disorders of pregnancy (Latin America and the Caribbean, sub-Saharan Africa and South Asia), considering their absolute number of maternal deaths per year, latest

estimates on maternal mortality ratio (MMR), and slow progress in MMR reduction over the last decade (3). Through desk reviews of peer-reviewed and grey literature, interviews with key stakeholders and collection of facility-level data on service delivery, the country case studies sought to document the policies, guidelines, and programmes that shaped prevention, diagnosis and treatment of hypertensive disorders of pregnancy over the past decade; understand the implementation status of WHO-recommended interventions at the national and sub-national levels; and identify important enablers and barriers for implementing interventions for hypertensive disorder of pregnancy. Data were analysed using a multilevel framework that categorized considerations as related to multisectoral/non-health context, community factors, health systems, or health policies and programmes.

To present a contrast, mixed-methods analyses were also conducted for seven exemplar countries that have achieved significant progress in reducing maternal and neonatal mortality: Bangladesh, Ethiopia, India, Morocco, Nepal, Niger and Senegal. Using the Lives Saved Tool (15), the cumulative additional maternal lives saved via the scale-up of detection and treatment of hypertension during antenatal care, treatment of eclampsia with magnesium sulfate, and the use of caesarean section were modeled for all seven countries. To better understand how these countries had achieved such progress, deeper analyses were conducted for Bangladesh and Ethiopia, which drew on intervention coverage data from Demographic and Health Survey and facility surveys, policy documentation, and outreach to in-country research partners to characterize pathways to success.

Summit participants were also consulted to gather insight into the primary bottlenecks hindering implementation globally. WHO and HRP previously developed a framework for mapping bottlenecks in health systems that restrict the translation of global guidelines into routine clinical practice (16). This framework was used to develop an online survey on the extent to which each bottleneck poses a challenge

to implementation of 13 WHO-recommended interventions for the prevention and treatment of pre-eclampsia and eclampsia. The survey consisted of six questions for each intervention, with four additional access-related questions for recommended medications, and open fields for participants to provide additional context and comments they deemed relevant. Summit participants were invited to complete the survey reflecting on their setting; participants working at the global level were asked to respond considering LMIC settings in general. A total of 128 out of 146 participants pre-registered for the Summit submitted responses. Responses were aggregated and reported with heatmaps to show which bottlenecks posed the greatest challenges for which recommendation. Together these findings informed the discussions and priority setting exercises of the implementation actions included in this Roadmap.

Advocacy and accountability

A mixed-methods landscape assessment was undertaken to examine the current state of advocacy, accountability and political mobilization for hypertensive disorders of pregnancy at global, regional and national levels. The assessment sought to identify existing advocacy efforts, key actors, accountability and financing mechanisms, barriers to political prioritization and opportunities to strengthen sustained commitment and coordinated action, with particular attention to LMICs.

The assessment drew on multiple complementary sources of evidence, including a scoping review of published and grey literature; a global stakeholder survey; key informant interviews; country case studies from Bangladesh, Ghana and Suriname; and synthesis workshops involving a broad range of stakeholders. The analysis examined six interconnected dimensions: advocacy, accountability, political mobilization and financing, barriers and challenges, solutions and strategies, and the roles and actions of different stakeholder groups. Findings were interpreted using political economy and transitions science frameworks to better understand the institutional, political and societal factors influencing prioritization and change.

The assessment found that advocacy and accountability for hypertensive disorders of pregnancy remain fragmented despite the substantial health burden. Evidence on effective advocacy and accountability strategies was limited and largely derived from high-income country settings. Multiple interconnected barriers were identified, including competing political and health priorities, financing constraints, governance and policy discontinuity, weak surveillance systems, supply chain challenges, workforce limitations, inadequate infrastructure, and persistent cultural and community barriers. The assessment also highlighted the influence of broader changes in the global health architecture and the positioning of hypertensive disorders of pregnancy within the wider reproductive, maternal, newborn and child health agenda as important contextual factors shaping future advocacy opportunities.

The assessment identified opportunities to strengthen advocacy and accountability through coordinated action by governments, civil society, professional associations, researchers, communities, industry, media, development partners and multilateral organizations. Strategies included strengthening patient and survivor organizations, developing consistent global narratives and knowledge translation approaches, leveraging global advocacy platforms and multi-stakeholder partnerships, integrating indicators into routine health information systems and maternal and perinatal death surveillance and response mechanisms, strengthening facility-based audit systems, and improving accountability through community and political engagement. These findings informed the advocacy, accountability and political mobilization priorities that were subsequently deliberated during the Summit and incorporated into this Roadmap.

2.3 Building consensus on priority gaps and solutions during the Summit

The Summit was designed as a structured consensus-building process to translate the evidence generated through the preparatory workstreams into a coordinated global strategy. The programme was organized around the five strategic areas of the Roadmap – research and innovation; norms and standards; access to health products; implementation; and advocacy and accountability – with each area following a common process of evidence presentation, facilitated discussion, multidisciplinary breakout sessions and/or plenary consensus-building.

Each strategic area was introduced through presentations summarizing the findings of the pre-Summit assessments, highlighting key evidence gaps, barriers, opportunities and proposed priority actions. Participants then engaged in facilitated breakout discussions to critically review the findings, assess their relevance across diverse country contexts, identify interdependencies between strategic areas and refine the proposed priorities. Breakout groups were generally multidisciplinary, except for the research priority breakout where groups were based on expertise and experience regarding the research domains (innovation, implementation and cross-cutting).

Following each breakout session, facilitators synthesized the discussions and presented the outputs in plenary for further deliberation. Areas of agreement were consolidated, differing perspectives were openly discussed, and refinements were made through iterative consensus-building. This process ensured that the strategic actions presented in the Roadmap reflected both the evidence generated before the Summit and the collective discussion, judgement and experience of participants.

Research and innovation

The ‘Research and innovation’ breakout discussions focused on identifying the key barriers and solutions to accelerating the innovation-to-impact pipeline, while refining the priority research agenda needed to drive progress over the coming decade. Participants

considered the fragmented innovation ecosystem, including limited progression of medicines and diagnostics through later stages of development, persistent evidence gaps, limited commercial incentives, regulatory complexity, insufficient understanding of disease biology and the historical exclusion of pregnant women from clinical research. Discussions emphasized that accelerating innovation requires coordinated action across the entire product development pathway, including stronger scientific foundations; clearer regulatory pathways and TPPs; greater inclusion of pregnant women in research; stronger industry engagement; and closer collaboration among researchers, funders, regulators, manufacturers, implementers and women with lived experience. Participants also agreed that innovations should be designed with implementation, affordability and equitable access in mind from the earliest stages of development, particularly for LMIC settings.

The discussions also resulted in a final set of 20 high-priority research questions across the three research domains (innovation, implementation and cross-cutting). Innovation research priorities emphasized the development and evaluation of novel therapeutics,¹ diagnostics, biomarkers and precision medicine approaches, together with research to accelerate the translation of promising innovations into clinical practice and public health programmes. Implementation priorities focused on identifying effective models of care, strategies to improve coverage and quality of interventions across different health system settings, as well as approaches to increasing equitable access to prevention, diagnosis and treatment. Cross-cutting priorities focused on improving prediction and early detection, evaluating integrated care packages, strengthening surveillance and monitoring systems, understanding women's experiences

of care, and identifying effective strategies for preventing progression to severe disease. Together, the agreed innovation priorities and research agenda formed the basis of the research and innovation actions presented in this Roadmap.

Norms and standards

The 'Norms and standards' sessions focused on identifying priorities for future normative development and opportunities to strengthen alignment across the global policy landscape for hypertensive disorders of pregnancy. Participants reviewed areas where international recommendations converged, where important inconsistencies remained, and where WHO guidance was absent or required updating. Discussions recognized that differences between guidelines may legitimately arise from evolving evidence, differing methodological approaches, update cycles and target audiences. At the same time, participants acknowledged that such variation could create challenges for countries adapting international recommendations and highlighted the importance of greater transparency around the reasons for divergence.

A facilitated panel discussion involving representatives of major international professional associations explored opportunities to strengthen collaboration in evidence synthesis, guideline development and future updating processes, while preserving the flexibility needed for different health system contexts. Participants agreed that reducing unnecessary duplication and strengthening coordination across organizations would improve efficiency and provide countries with a more coherent foundation for developing national guidance. The session concluded by identifying priorities for future normative work, including areas requiring new or updated WHO recommendations, greater harmonization where appropriate and additional evidence generation to address persistent gaps. These priorities formed the basis of the 'Norms and standards' actions presented in this Roadmap.

¹ Although no question on the development of novel therapeutics was included in the top set of innovation track questions following the initial round of pre-Summit ranking, the consensus of the innovation track breakout group was that it would be critical for research on novel therapeutics to be prioritized within the next decade. Based on this decision, the group opted to include a new question on novel therapeutics among their top-priority questions that would be included within the Roadmap agenda.

Access to health products

The 'Access to health products' sessions examined the barriers preventing existing and emerging interventions for hypertensive disorders of pregnancy from reaching women, with the objective of identifying coordinated actions across the product lifecycle to strengthen availability, affordability and equitable access. Participants worked in facilitated breakout groups focused on existing health products and on new and emerging products before reconvening in plenary to synthesize common themes and priorities. Discussions considered the broader ecosystem required to ensure that medicines, diagnostics and devices successfully progress from development through regulatory approval, procurement and sustained availability within health systems.

Participants emphasized that access begins well before health products reach the market and requires consideration of affordability, feasibility and health system needs from the earliest stages of development. Discussions highlighted the need for stronger collaboration among researchers, product developers, manufacturers, regulators, procurers and end users to strengthen TPPs, align evidence generation with regulatory requirements, and streamline product development pathways. Participants also recognized that regulatory approval alone is insufficient to ensure access, emphasizing the importance of coordinated regulatory pathways, quality assurance, resilient supply chains, sustainable financing, and market-shaping strategies to improve affordability while maintaining incentives for innovation.

The plenary discussions reinforced that improving access depends on coordinated action across research, normative guidance, implementation and political commitment, rather than isolated interventions within the product ecosystem. These deliberations informed the 'Access to health products' actions presented in this Roadmap.

Implementation

The 'Implementation' sessions focused on identifying the priority actions needed to translate evidence-based interventions for hypertensive disorders of pregnancy into routine practice across diverse health system settings. Participants reviewed the implementation barriers identified through the preparatory analyses and worked in facilitated breakout groups organized around three complementary domains: national context, programme and investment, and service delivery. Discussions validated the findings from the pre-Summit assessments, refined their interpretation based on country experience and identified practical actions to address the most important implementation bottlenecks.

Across all three breakout streams, participants consistently emphasized that implementation challenges are interconnected and extend beyond individual technical interventions. Discussions highlighted the importance of coordinated action across governance, financing, service delivery, workforce capacity, referral systems, quality improvement and community engagement, while recognizing the strong interdependencies with the components of research and innovation, norms and standards, access to quality health products and advocacy and accountability. These deliberations informed the implementation actions presented in this Roadmap by translating a diverse set of implementation challenges into a coordinated systems approach for moving evidence into routine practice.

Advocacy and accountability

The 'Advocacy and accountability' sessions focused on identifying the political, institutional and societal actions needed to strengthen commitment, accountability and coordinated advocacy for hypertensive disorders of pregnancy. Participants reviewed the findings of the advocacy landscape assessment before engaging in a panel discussion featuring representatives from CSOs, patient advocacy groups and women with lived experience, whose perspectives highlighted the importance of placing women and families at the centre

of advocacy and accountability efforts, using their experiences not only as inspirational, but truly instructive and collectively serving as representative voices of diverse communities.

Building on these discussions, participants worked in facilitated breakout groups to identify priority advocacy actions, responsible stakeholders and indicative timeframes for implementation. Discussions emphasized that sustained progress requires more than raising awareness alone, calling instead for coordinated political mobilization, evidence-informed communication, meaningful engagement of women and families, stronger accountability mechanisms, and collaboration among governments, professional societies, civil society, researchers, development partners, the private sector and the media. These deliberations informed the 'Advocacy and accountability' actions presented in this Roadmap.

2.4 Integrating priority solutions into the Roadmap and Call to Action

The final sessions of the Summit focused on integrating the priorities identified across the five strategic areas into a single global Roadmap for hypertensive disorders of pregnancy. Participants discussed the overall concept of a strategic roadmap, why one was needed to organize coordinated global action and the essential components required for its success. Building on the outputs from the previous sessions, participants reviewed and refined the proposed high-level agenda for each strategic area, considered the roles and responsibilities of different stakeholder groups and committed to supporting the implementation of the agreed priorities.

Following the Summit, the WHO Secretariat translated these consensus recommendations into a draft global Roadmap. This process drew on the synthesis of the Summit plenary and breakout deliberations, meeting documentation, feedback from the Steering and Scientific Committees, consultations with funding partners and a targeted desk review for the research questions to further elaborate

priority actions, strengthen linkages across the five strategic areas, refine stakeholder roles and responsibilities, and develop an implementation-oriented framework. The resulting Roadmap integrates the evidence generated before the Summit with the consensus reached during the Summit to provide a coordinated framework for action over the coming decade.

Alongside the Roadmap, the Summit produced a second key deliverable: a consensus-based Call to Action. Whereas the Roadmap provides the strategic framework for coordinated action, the Call to Action articulates the shared commitment of the global community to accelerate progress. It sets out the case for change, demonstrates that meaningful progress is achievable, and outlines the contributions expected from governments, multilateral organizations, professional societies, civil society, academia, funders, the private sector and women with lived experience. The Call to Action was drafted from the discussions and commitments made during the Summit and subsequently refined through review by the Steering Committee. All Summit participants agreed to be signatories to the final Call to Action (Chapter 4), reflecting a collective commitment to advancing the implementation of the Roadmap.

2.5 Declaration of interests by external contributors

In accordance with WHO regulations, all external contributors were asked to declare in writing any competing interests prior to their engagement in the processes and meetings that led to the development of the Roadmap. All external contributors completed and signed a standard WHO Declaration of Interests (DOI) form and sent it to the responsible technical officer at WHO. All contributors were instructed to notify the WHO responsible technical officer of any change in relevant interest during the course of their engagement. The WHO coordination team reviewed all declarations on an ongoing basis to determine whether any declared conflict of interest was serious enough to pose any risk to the process of developing the Roadmap or reduce its credibility. All findings

from the DOI statements received were managed in accordance with the WHO DOI guidance on a case-by-case basis. Conflicts of interest arising from academic research, normative activities, implementation, advocacy or private sector participation in the area of hypertensive disorders of pregnancy were

noted but not considered serious enough to preclude contribution to the development of the Roadmap. During meetings, all external contributors were required again to openly state any conflicts of interest to all meeting participants. A summary of the DOI statements can be found in the Annex.

3. The Roadmap

The Roadmap provides a coordinated framework for accelerating progress in the screening, prevention, diagnosis and treatment of hypertensive disorders of pregnancy over the next decade. It translates the evidence reviewed before the Summit and the consensus reached during the Summit into a shared agenda for action to support countries in reducing the burden of hypertensive disorders of pregnancy and preventing associated maternal, fetal and newborn deaths.

The Roadmap is organized around five interconnected strategic areas – research and innovation; norms and standards; access to health products; implementation; and advocacy and accountability – that together provide a coordinated approach for achieving sustainable improvements in maternal and newborn health. For each strategic area, the Roadmap identifies priority actions, deliverables and indicative milestones for 2026–2035, providing a shared reference for coordinated action over the coming decade and beyond.

Recognizing that progress depends on coordinated action across multiple sectors and levels of the health system, the Roadmap highlights common priorities and opportunities for collaboration at global, regional and country levels. Its successful implementation will require sustained commitment from ministries of health, governments, multilateral organizations, research and academic institutions, professional associations, implementing partners, CSOs, the private sector, and women with lived experience and their representative organizations. Through these collective efforts, the Roadmap aims to accelerate progress towards ending preventable maternal, fetal and newborn deaths associated with hypertensive disorders of pregnancy while contributing to broader global targets for reducing maternal and newborn mortality.

Sections 3.1–3.5 in this chapter detail the priority actions for each of the five strategic areas. Interdependencies and interlinkages between the five strategic areas are described in Section 3.6.

3.1 Strategic area: research and innovation

Objective

To accelerate the development, evaluation and uptake of innovations, and the generation of high-quality evidence needed to improve the screening, prevention, diagnosis and treatment of hypertensive disorders of pregnancy.

One of the major barriers to advancing progress for hypertensive disorders is under-investment in research and development. Limited progress in research and innovation constrains efforts to reduce associated mortality and morbidity. The Roadmap prioritizes coordinated investment to strengthen the product pipeline, accelerate the development and evaluation of new medicines, diagnostics, medical devices and models of care, and ensure that innovations are translated efficiently into policy and practice. Assessment of the hypertensive disorders of pregnancy innovation landscape identified several strategic priorities for implementation. These include strengthening the scientific foundation for innovation; defining and refining TPPs, TPOPs, and product development pathways; generating the evidence needed for product progression, regulatory approval and policy adoption; designing products with implementation, affordability and scalability in mind; and fostering stronger collaboration among researchers, innovators, funders, industry, regulators, implementers and women with lived experience to create a more coordinated and sustainable innovation ecosystem.

The Roadmap also establishes a global research agenda comprising 20 priority research questions across three complementary domains – innovation (seven questions), implementation (five questions) and cross-cutting (eight questions) – to guide investment towards the most time-sensitive evidence needs over the next decade (Table 3.1). These priorities focus on generating actionable evidence to improve screening, prevention, diagnosis and treatment, including improving the diagnostic and predictive value of angiogenic biomarkers, developing integrated prevention and treatment strategies such as care bundles, establishing harmonized core outcome sets for research and regulatory evaluation, and strengthening community-based approaches for early detection, timely referral and care-seeking. The priorities are intended to guide coordinated investment while allowing additional research questions to emerge as scientific knowledge evolves.

Successful implementation of this strategic area will require more than the delivery of individual research projects. Alignment and collaboration among stakeholders on priority research gaps can focus investment to reduce waste or duplication of funding and research efforts, enabling swifter and more effective responses to public health needs. As the agenda is implemented, particular attention should be given to ensuring that innovations are designed with implementation and equity in mind from the outset; that women and CSOs are meaningfully engaged throughout research, innovation and evaluation processes, including in protocol development, study implementation and interpretation and dissemination of findings; that evidence requirements for regulatory approval, policy adoption and guideline development are transparent and aligned; and that research investments are coordinated across funders to maximize impact and minimize duplication. These considerations will help accelerate the translation of innovation and research into improved health outcomes. Finally, greater transparency is needed across innovation and translation pathways, particularly in defining the evidence thresholds

required to inform global guidance for medicines and devices, along with clearly-articulated expectations for innovators to support timely uptake into policy and practice.

WHO and its partners will refine the priority research questions, map them against ongoing research, define appropriate study designs, further develop TPPs and TPoPs, clarify innovation pathways and evidence requirements, identify funding gaps and promote coordinated investment. Research funders and development partners are expected to align future investments with these priorities, while the resulting evidence will inform iterative updates through the living guideline process and future editions of the consolidated global guidelines for hypertensive disorders of pregnancy. In this way, the research and innovation agenda provides the scientific foundation for continuous learning and improvement across all remaining strategic areas of the Roadmap.

Research undertaken to address these priorities should adhere to internationally accepted ethical standards and promote equitable partnerships, meaningful engagement of affected communities, and leadership of researchers and institutions in the settings where studies are conducted. Particular attention should be given to ensuring that study design, consent processes and approaches to benefit–risk assessment are appropriate to local contexts, while maintaining consistent standards for the protection of research participants.

3.1.1 Key activities and milestones

For the research priorities, the immediate step is to undertake the preparatory work needed to enable calls for proposals to be issued in the third quarter of 2027 to implement the research agenda. Preparatory activities will include:

- ▶ **in the third quarter of 2026**, WHO will refine the framing of the 20 prioritized research questions to improve clarity;
- ▶ **in the last quarter of 2026**, WHO, Cochrane, the Gates Foundation and other interested research partners and funders will conduct a rapid scan of ongoing research to identify

Table 3.1. Top 20 priority research questions, by track

Rank	Track	Question
1	Innovation	What should be the core maternal, fetal, and neonatal outcomes (including composite endpoints) for research, development, and regulatory approval of new interventions to prevent and treat pre-eclampsia and other hypertensive disorders of pregnancy?
2		What is the predictive value, diagnostic accuracy and feasibility of angiogenic biomarker tests, including placental growth factor (PlGF), soluble fms-like tyrosine kinase-1 (sFlt-1) and the sFlt-1/PlGF ratio, individually and in combination with clinical markers, as point-of-care approaches for identifying women at high risk of pre-eclampsia and for early detection and disease severity assessment in LMICs?
3		Which clinical and laboratory diagnostic criteria, including their optimal thresholds, most accurately define pre-eclampsia for the purposes of improving maternal and newborn outcomes?
4		What are the effects of the aetiological, pathophysiological, genetic, ethnic, and inherited factor differences between pre-eclampsia subtypes, including early vs. late onset and angiogenic vs. non-angiogenic phenotypes on disease classification, clinical management, and maternal and newborn outcomes?
5		What is the predictive value of a multi-parameter first-trimester screening algorithm (e.g., combining maternal clinical characteristics, mean arterial pressure, uterine artery Doppler indices, and biochemical markers) for identifying women at high risk of pre-eclampsia?
6		What is the diagnostic accuracy of novel point-of-care proteinuria testing methods for diagnosing pre-eclampsia?
7		What are the most effective, safe and feasible molecular targets and interventions for the prevention and treatment of pre-eclampsia?*
1	Implementation	For women with warning signs of pre-eclampsia or eclampsia, what is the effectiveness of community-based interventions in increasing care-seeking behavior?
2		What are the most effective, cost-effective, and scalable early screening and referral strategies for pre-eclampsia among pregnant women accessing antenatal care, including in resource-constrained and fragile health system settings?
3		What implementation strategies are most effective in increasing equitable coverage, timely delivery and adherence to evidence-based recommendations for the prevention, diagnosis and treatment of pre-eclampsia and other hypertensive disorders of pregnancy?
4		What implementation strategies are most effective for scaling up successful service delivery models for pre-eclampsia and eclampsia care?
5		What are the major barriers to the availability of commodities for the prevention, diagnosis and treatment of pre-eclampsia and other hypertensive disorders of pregnancy in LMICs?
1	Cross-cutting	What is the effectiveness, feasibility, acceptability, and cost of a bundle strategy for preventing, detecting and treating pre-eclampsia and eclampsia to improve maternal and newborn outcomes?
2		What are the most effective, cost-effective, feasible, and acceptable strategies for monitoring maternal and fetal wellbeing during expectant management of preterm pre-eclampsia in low-resource settings?
3		What is the effectiveness and safety of approaches to improve access to magnesium sulfate, including simplified protocols, training of health workers, local production, and non-injectable (oral, rectal) administration?
4		Among women with pregnancies complicated by pre-eclampsia, which postpartum screening and monitoring strategies are most effective in improving maternal, newborn and child outcomes, and what is the appropriate duration of these interventions?

Rank	Track	Question
5	Cross-cutting	What is the comparative effectiveness and cost of different educational interventions for women (e.g., mass media campaigns, patient-based education) to improve knowledge of signs and symptoms of pre-eclampsia and other hypertensive disorders of pregnancy to promote appropriate and timely care?
6		What is the most effective care strategy for improving maternal and newborn outcomes in women with non-severe hypertension in pregnancy at primary and community care levels in low-resource settings?
7		Which interventions for the prevention, diagnosis, and treatment of pre-eclampsia and other hypertensive disorders of pregnancy are more effective among adolescents, compared to adult women, for improving maternal and newborn outcomes?
8		Among women with pre-eclampsia, does treatment with antihypertensive medications to prevent progression to severe pre-eclampsia improve maternal and newborn outcomes?

* Question included by consensus given the importance of prioritizing the development of novel therapeutics specifically for hypertensive disorders of pregnancy.

studies that are already addressing, or poised to respond to, the priority research questions;

- ▶ **in the first quarter of 2027**, WHO will articulate the ideal research question(s) for each priority question and provide guidance on research design;
- ▶ **in the first quarter of 2027**, WHO, the Gates Foundation and other interested funders and partners will conduct a rapid assessment of funding needs to determine the high-level budget required to execute the research agenda, including mapping of existing funding commitments and identifying remaining funding gaps.

As the detailed research agenda is developed, it will be socialized with donor agencies for input and feedback. Research funders and donor agencies, including the Gates Foundation, Unitaaid and other interested funders, will be encouraged to align ongoing and future investments with the prioritized research agenda and participate in coordinated efforts to identify and address critical funding gaps. Donor agencies are expected to:

- ▶ prepare calls for proposals to conduct priority research;
- ▶ coordinate with each other in a donor coordination forum to ensure that the full research agenda is captured in their calls for

proposals and that there is no duplication; and

- ▶ launch the calls for proposals **in the third quarter of 2027**, such that research grantees will begin to execute the research agenda starting in 2028.

While some results will become available earlier than others, most research should take 2–4 years to complete, with the bulk of new evidence expected by 2030. A few questions within the innovation track may take longer. As research results are published, WHO and other guideline developers will conduct iterative updates of their pre-eclampsia guidance to reflect the emerging evidence. Progress in research and development in the context of these research priorities will be monitored and, by 2035, a review of any pending or new research gaps will be conducted to identify new and emerging priorities. This strategic area is closely linked to that addressing gaps in norms and standards relating to hypertensive disorders of pregnancy (see section 3.2), as results of the prioritized research will be integrated into global and national guidelines and policies to influence practices on a continual basis.

For the innovation priorities, the immediate step is for organizations with the technical expertise, implementation capacity and funding mechanisms to initiate activities that will accelerate the development, evaluation

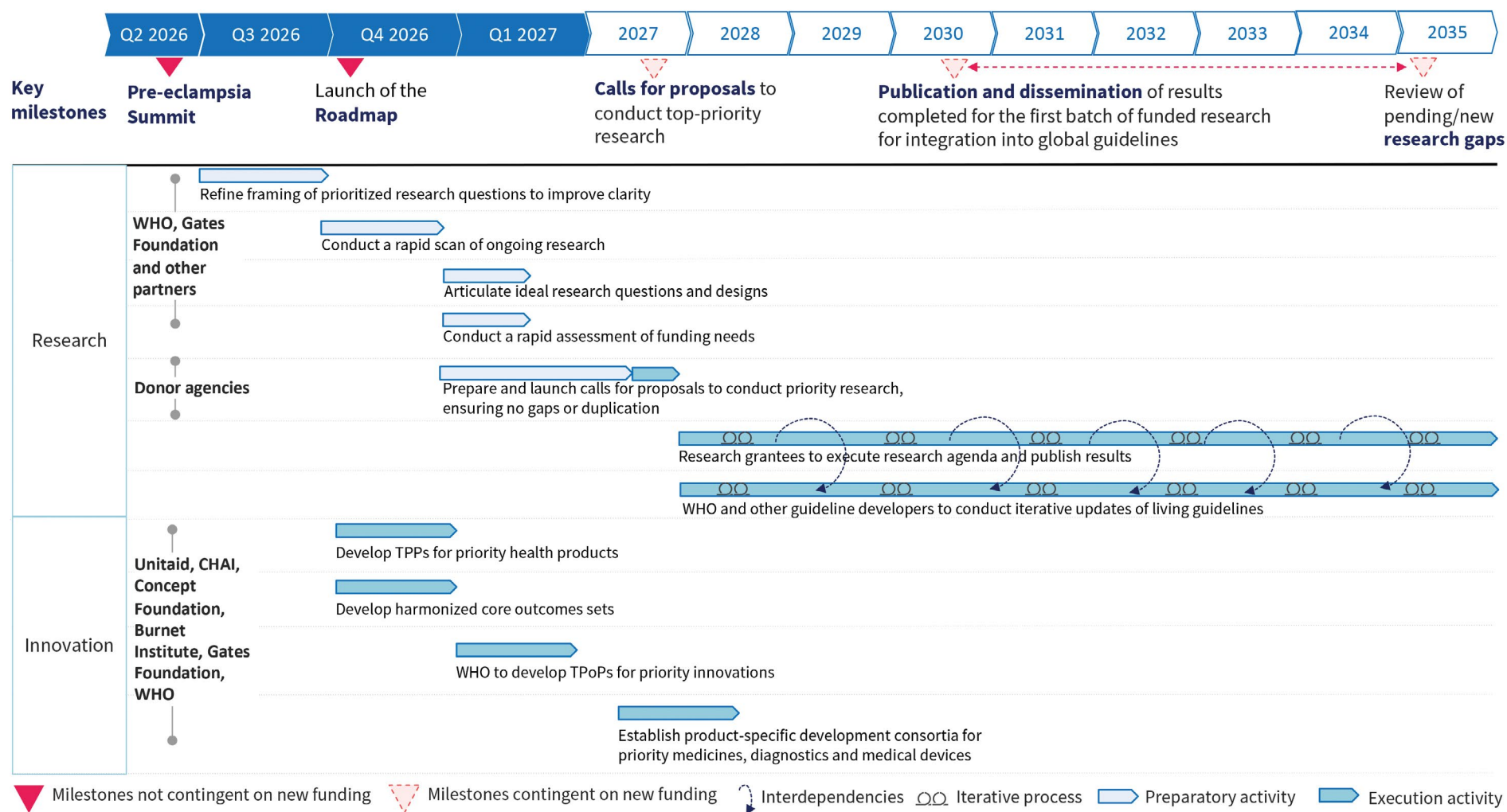
and introduction of priority innovations for hypertensive disorders of pregnancy. Preparatory activities will include:

- ▶ **in the last quarter of 2026**, Unitaid (under the Sustained Uptake of Products for Pre-eclampsia and Maternal Anemia [SUPREME] Secure programme (17) led by the Clinton Health Access Initiative (CHAI), Concept Foundation, WACI Health, the Aurum Institute and the Burnet Institute) and partners to prioritize and develop TPPs for priority medicines, diagnostics and medical devices to guide product developers towards innovations that address the greatest public health needs;
- ▶ **in the last quarter of 2026**, Concept Foundation and partners (including the Gates Foundation; regulatory bodies such as the European Medicines Agency [European Union], the U.S. Food and Drug Administration [United States of America], the Medicines and Healthcare products Regulatory Agency [United Kingdom], the National Agency for Food and Drug Administration and Control [Nigeria], and the Therapeutic Goods Administration [Australia]; clinical trialists; and patient advocacy organizations) to develop harmonized core outcome sets and associated evidence requirements for priority innovations to support product evaluation, regulatory review and future policy recommendations;
- ▶ **in the first quarter of 2027**, WHO to develop TPOPs for priority innovations to define the evidence required to inform future WHO recommendations and country adoption;

- ▶ **in the second quarter of 2027**, Unitaid (under the SUPREME Secure programme) and other partners to establish product-specific development working groups for priority medicines, diagnostics and medical devices, with clear product development plans, defined partner roles and coordinated financing to accelerate progression from concept to country implementation.

As the innovation agenda is operationalized, organizations with the relevant expertise and capacity should work collaboratively to implement these activities, leveraging their complementary roles in product development, evidence generation, regulatory review, financing and implementation. Progress in product development and innovation will be monitored throughout the implementation period, with priority innovations reviewed periodically to identify bottlenecks, accelerate translation into policy and practice, and refine priorities as new technologies and evidence emerge.

The innovation agenda is expected to generate a pipeline of priority medicines, diagnostics and medical devices that progress through coordinated development, evaluation and regulatory pathways, with successful innovations informing future global recommendations and country adoption. By 2030, progress across the innovation pipeline will be reviewed to identify remaining barriers and define priorities for the next phase of product development and implementation.

Figure 3.1. Key activities and milestones for strategic area one: research and innovation

3.2 Strategic area: norms and standards

Objective

To harmonize and strengthen global, national and local guidance for the prevention, diagnosis and treatment of hypertensive disorders of pregnancy, ensuring that evidence is translated consistently into policy and clinical practice.

Variation in international recommendations for hypertensive disorders of pregnancy contributes to inconsistent clinical practice, inequities in care, and delays in the adoption of new evidence. Differences exist among guideline developers in recommendations for several aspects of prevention, diagnosis, and treatment, despite largely using the same evidence base. The rationale for enhanced collaboration among international guideline developers was discussed in detail during the Summit. The Roadmap therefore prioritizes greater harmonization of norms and standards to ensure that women receive evidence-based care regardless of where they live.

The Roadmap proposes a three-tier architecture for translating evidence into practice. At the global level, international guideline developers – including WHO, the International Federation of Gynecology and Obstetrics (FIGO), the International Confederation of Midwives (ICM), the International Society for the Study of Hypertension in Pregnancy (ISSHP) and other organizations with aligned operational and legal frameworks – should work towards a common set of high-level recommendations that establish a minimum global standard of care for hypertensive disorders of pregnancy while recognizing that implementation considerations may differ across settings. At the national and subnational levels, countries should adopt, adapt and contextualize global recommendations to reflect individual country settings, including local epidemiology, health system capacity and resource availability. At the facility level, guideline derivatives – including clinical protocols, job aids, training packages, toolkits and handbooks – should translate recommendations into practical guidance for frontline health workers.

Achieving this vision will require closer collaboration among international guideline developers throughout the guideline development process. Initial efforts should focus on sharing evidence syntheses and reducing duplication of systematic reviews, with the longer-term objective of jointly developing consolidated global guidelines for hypertensive disorders of pregnancy. Such collaboration will improve efficiency, reduce inconsistencies across recommendations and provide countries with a single, authoritative source of evidence-informed guidance.

The burden of mortality and morbidity from hypertensive disorders of pregnancy can be reduced through timely risk assessment, early biologically informed detection and diagnosis, and evidence-based preventive and therapeutic interventions across the continuum of care, including where possible before progression to clinically manifest severe disease. Variation in existing international guidance, however, continues to limit the consistent implementation of best practices. While there is broad agreement across current guidelines on fundamental aspects of care, including the diagnosis of hypertension and proteinuria and the management of severe disease, important differences remain in disease classification, aspirin and calcium supplementation, the use of biomarkers and angiogenic biomarker testing, uterine artery Doppler scans, predictive algorithms, management of non-severe hypertension, maternal and fetal monitoring, and intrapartum and postpartum care. To facilitate the development of comprehensive national programmes and policies for hypertensive disorders of pregnancy, these areas should be harmonized within a single, consolidated set of global guidelines that provides a consistent, evidence-based standard of care while supporting adaptation to country contexts.

In addition, there are several important areas with limited or no recommendations in the current WHO guidance on which Member States rely for policy development. These include biomarkers and angiogenic biomarker testing, predictive algorithms, advanced diagnostic

approaches, maternal and fetal monitoring, other aspects of clinical management, and patient and community education. Health system interventions and implementation considerations are also largely absent from current clinical practice guidelines despite their importance for translating recommendations into routine practice. Furthermore, the evidence surveillance exercise identified 15 existing WHO recommendations as priorities for updating and highlighted several areas where new recommendations are required. Consolidated guidelines therefore provide an opportunity not only to harmonize existing recommendations but also to update and expand global guidance to reflect advances in diagnostics, therapeutics, implementation science and models of care, providing countries with a single, comprehensive and authoritative source of evidence-informed recommendations.

The Roadmap also recognizes the need to strengthen the evidence underpinning future recommendations. Although guideline development will continue to identify critical evidence gaps, many current recommendations – particularly those relating to established clinical practices – are based predominantly on evidence generated in high-income countries and may not always be generalizable to LMIC settings. Future research should deliberately expand evidence generation in LMICs across the continuum of care, focusing on areas where the burden of disease is greatest and where important evidence gaps remain. Women's perspectives and lived experiences should also be systematically incorporated throughout the development of the guidelines to ensure that recommendations are person-centred, acceptable and responsive to the needs of those most affected.

This strategic area is closely linked to the research and innovation agenda (Section 3.1), which will generate the evidence needed to update recommendations through WHO's living guideline process and future consolidated global guidelines. It also provides the normative foundation for improving access to health products, strengthening implementation and supporting advocacy and accountability across all remaining strategic areas of the Roadmap.

3.2.1 Key activities and milestones

With a view to potentially publishing joint multiorganizational consolidated guidelines on the prevention, diagnosis and treatment of hypertensive disorders of pregnancy, the following activities are planned:

- ▶ **Starting from the third quarter of 2026,** WHO will establish a Steering Group comprising nominees from developers of global guidelines to explore internal mechanisms across organizations to determine the feasibility of joint publication of consolidated guidelines, considering the organizations' different governance arrangements, operating models, guideline development processes, guideline methodologies, and approval processes.
- ▶ **By the end of the third quarter of 2026, define the scope and priority questions.** If joint publication has been deemed feasible, the Steering Group will apply the priority topics identified by the WHO Technical Advisory Group for Maternal and Perinatal Health Guidelines to the scope of the consolidated guidelines. A standard guideline development procedure, that complies with the internal approval procedures of all participating organizations, will be followed to develop these joint guidelines. The Steering Group will propose the membership of the consolidated guideline development panel and identify other potential contributors, such as guideline methodologists, systematic review teams, external peer reviewers and observers, by the last quarter of 2026. In the event that a joint publication is not feasible, WHO will proceed with its usual approach for developing consolidated guidelines and invite signatories from global guideline developers for endorsement at the time of publication.
- ▶ **From the last quarter of 2026 and during the course of 2027,** the participating organizations will pool resources and commission academics and research institutions (such as, the Aga Khan University, Burnet Institute, Centro Rosarino de Estudios Perinatales, Cochrane, Cochrane Canada, Cochrane Netherlands, McMaster University,

and Oxford University) to conduct systematic evidence syntheses for priority questions and development of evidence profiles (including evidence domains covering efficacy/effectiveness, importance of priority outcomes driving the recommendations, acceptability, feasibility, impact on equity, resource use and cost-effectiveness).

- ▶ **By the third quarter of 2027**, it is expected that the evidence profiles will be ready for the guideline panel to formulate new, and update existing, recommendations. These will then undergo peer-review and external consultation.
- ▶ **The fourth quarter of 2027** is the target launch date for the joint global guidelines on hypertensive disorders of pregnancy.

Following publication of the guidelines, participating organizations will coordinate a global dissemination and implementation campaign throughout 2028. Activities will include global and regional launch events, webinars and regional workshops, together with the development of guideline derivatives – including policy briefs, clinical protocols, job aids, training materials, digital decision-support tools and implementation toolkits – to facilitate translation of recommendations into policy and clinical practice. WHO, working with partner organizations, will coordinate translation of the guidelines into WHO official languages and support additional language requests where feasible.

Pending publication of the consolidated guideline, WHO and other guideline developers will continue to respond to important emerging evidence through their existing guideline development mechanisms, including WHO's living guideline approach, ensuring that new evidence can be translated rapidly into policy and practice. Following publication, the consolidated guidelines will be maintained through a living guideline approach, allowing recommendations to be updated as new evidence becomes available.

3.3 Strategic area: access to health products

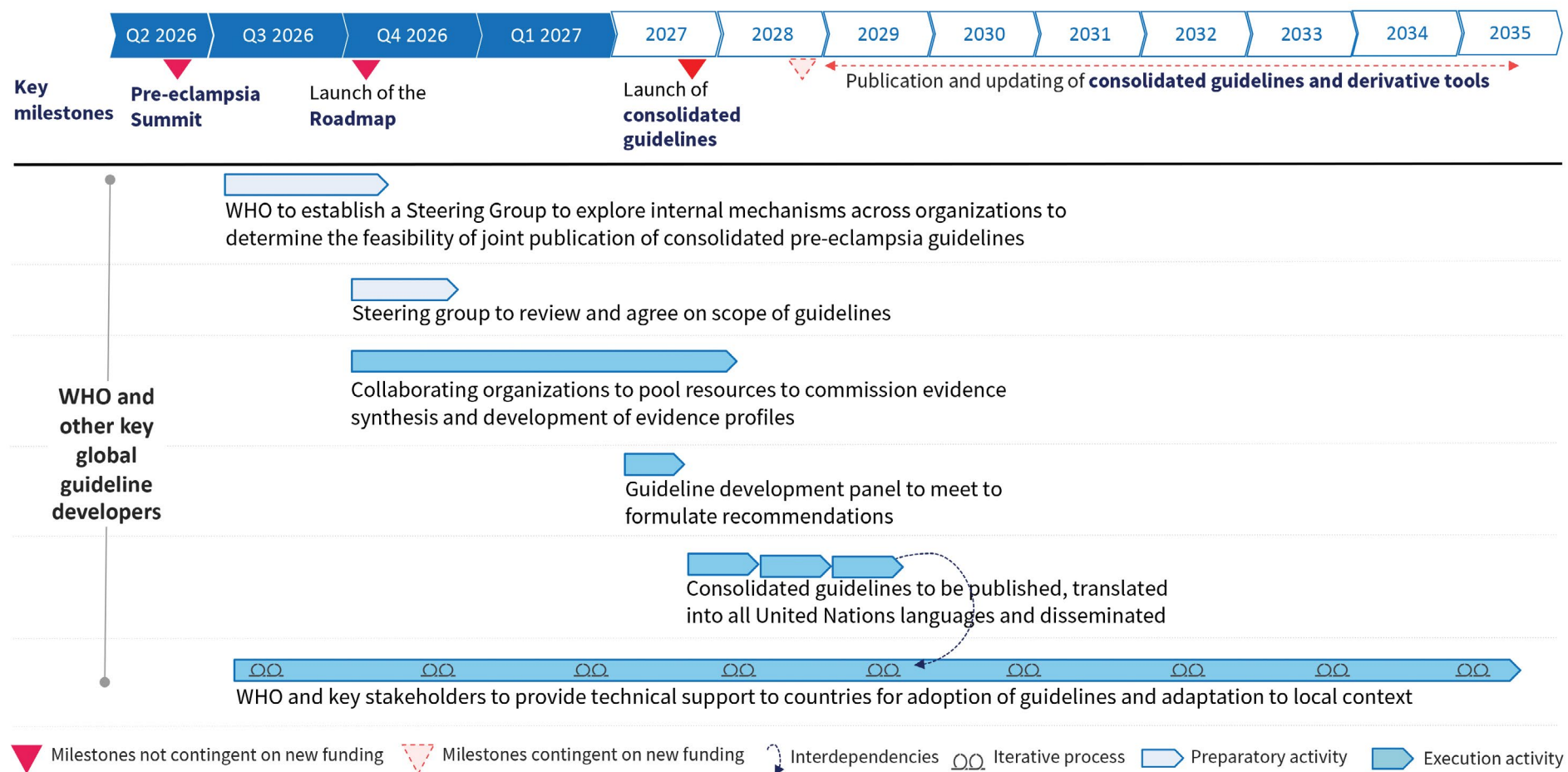
Objective

To accelerate the pathway from product development to country access by strengthening the product, regulatory, market and health system processes needed to ensure equitable, timely and sustainable access to affordable quality-assured medicines, diagnostics and medical devices for the prevention, diagnosis and treatment of hypertensive disorders of pregnancy.

The benefits of existing and innovative medicines, diagnostics and medical devices can only be realized when effective health products are consistently available to the women who need them. Delays in access to proven interventions contribute to avoidable maternal and perinatal morbidity and mortality, while inequitable availability between and within countries widens existing health disparities. Ensuring timely access to quality-assured health products is therefore an essential component of improving outcomes for women with hypertensive disorders of pregnancy and achieving universal health coverage.

Access to quality-assured health products depends on more than product development. It requires a coordinated ecosystem that enables innovations to progress efficiently from research and development, through global normative recommendations and regulatory approval, to national policy adoption, procurement and routine availability within health systems. Weaknesses at any point along this pathway can delay or prevent access, even when safe, effective and affordable products already exist. The Summit identified persistent barriers across this pathway, including fragmented normative and regulatory processes, limited market incentives, inadequate product and manufacturing readiness, weak forecasting and procurement systems, affordability challenges, fragmented supply chains, and insufficient coordination among researchers, product developers, manufacturers, regulators, procurement agencies, financing partners and implementers. This systems approach is aligned with the Every Woman, Every Newborn, Everywhere (EWENE) pathway to

Figure 3.2. Key activities and milestones for strategic area two: norms and standards



improving access to quality maternal and newborn health products, which emphasizes the interdependence of manufacturing; market shaping; regulatory and quality systems; normative policy and guidance; forecasting and quantification; procurement and distribution; demand generation; financing; service delivery and data systems (18).

The Roadmap therefore proposes a coordinated access ecosystem that strengthens the entire product access pathway. Building on the outputs of the research and innovation and the norms and standards strategic areas, priority activities in the access to health products strategic area focus on:

- ▶ accelerating product readiness, market readiness and country readiness;
- ▶ strengthening regulatory coordination;
- ▶ improving sustainable financing and market shaping;
- ▶ supporting quality-assured manufacturing and resilient supply systems;
- ▶ strengthening procurement and supply chain readiness; and
- ▶ facilitating timely policy adoption and country introduction.

The Roadmap further promotes the integration of access considerations throughout product development so that products are designed, evaluated and introduced with implementation, affordability and sustainability in mind from the earliest stages of development. Together, these activities seek to ensure that priority medicines, diagnostics and medical devices – including innovative technologies such as point-of-care diagnostics, where appropriate – can move rapidly, equitably and sustainably from development into routine use, particularly in LMICs where the burden of disease is greatest.

This strategic area builds directly on the outputs of the research and innovation and the norms and standards strategic areas. TPPs, TPoPs, evidence-generation strategies and consolidated global guidelines provide the scientific and normative foundation for regulatory approval, market introduction and country adoption. Strengthening access to

health products therefore provides the critical bridge between innovation and implementation, enabling countries to translate evidence-based recommendations into improved health outcomes for women and newborns.

3.3.1 Key activities and milestones

Improving equitable access to quality-assured medicines, diagnostics and medical devices for hypertensive disorders of pregnancy will require coordinated action across product developers, manufacturers, regulators, procurement agencies, normative bodies, financing organizations, implementing partners and governments. Organizations with complementary expertise – including the Unitaaid-funded SUPREME consortium partners (Amref Health Africa, Aurum Institute, Burnet Institute, CHAI, Concept Foundation, Jhpiego, Market Access Africa, Solthis and WACI Health), WHO, UNFPA and other partners – will work collaboratively to accelerate equitable access to selected priority health products, particularly in LMICs. Activities will include:

- ▶ **Beginning in the third quarter of 2026,** Unitaaid and partners will establish a coordinated product access initiative to align activities across product development, regulatory pathways, market shaping, financing, procurement and country introduction for priority medicines, diagnostics and medical devices.
- ▶ **Beginning in the fourth quarter of 2026,** Unitaaid and SUPREME consortium partners will develop product-specific access plans for priority health products that define the activities, timelines, responsibilities and milestones required to progress products through product development, evidence generation, regulatory approval, manufacturing readiness, commercialization, procurement and country introduction.
- ▶ **Beginning in the first quarter of 2027,** product developers, manufacturers and SUPREME consortium and other technical partners will accelerate selected product readiness by optimizing product design against agreed TPPs, generating verification and validation evidence aligned with

intended use and regulatory requirements, strengthening quality management systems, preparing technical documentation required for regulatory submissions, supporting manufacturing readiness, and ensuring that product development remains aligned with implementation needs in LMICs. The Gates Foundation and other funders and implementation partners will contribute to product readiness through field evaluation and generation of implementation evidence for priority diagnostic innovations in LMICs.

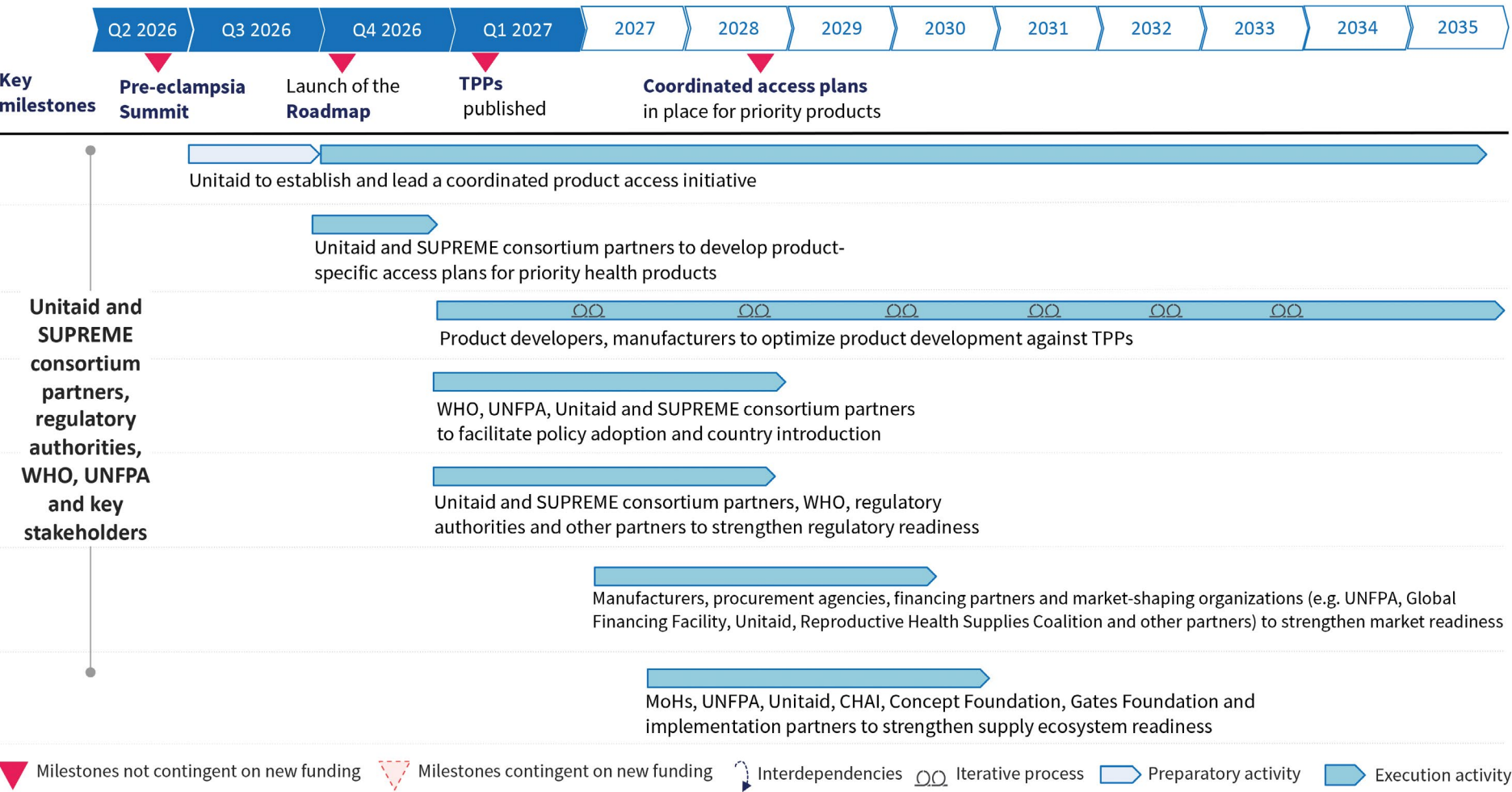
- ▶ **Beginning in 2027**, WHO, Unitaid and SUPREME consortium partners will facilitate policy adoption and country introduction by aligning regulatory milestones with future guideline recommendations, supporting consideration of priority products for the *WHO Model List of Essential Medicines* and the *WHO Model list of Essential in Vitro Diagnostics*, where appropriate, and assisting countries to integrate priority products into national policies, essential commodity lists and service delivery programmes.
- ▶ **Beginning in the first quarter of 2027**, the Aurum Institute, CHAI, Concept Foundation, regulatory authorities, WHO and partners will strengthen regulatory readiness by promoting regulatory convergence and reliance mechanisms, supporting product registration strategies, clarifying evidence requirements for policy adoption, and facilitating early dialogue among product developers, regulators and normative organizations. These efforts will also promote greater clarity and consistency in regulatory expectations for products intended for use in pregnancy, including approaches to maternal–fetal benefit–risk assessment and clinical development.
- ▶ **Beginning in the second quarter of 2027**, manufacturers, procurement and distribution agencies, financing partners and market-shaping organizations (e.g., African Union, the Aurum Institute, CHAI, Concept Foundation, Global Financing Facility, the Reproductive Health Supplies Coalition, UNFPA, Unitaid and other partners) will strengthen market readiness by supporting sustainable manufacturing; transparent and

affordable pricing approaches; coordinated procurement mechanisms; demand forecasting; reliable supply arrangements; product-specific market-shaping approaches; long-term market sustainability for priority products; and product visibility and access at the last mile.

- ▶ **Beginning in the first half of 2027**, ministries of health, CHAI, Concept Foundation, UNFPA, Unitaid and implementation partners will strengthen supply ecosystem readiness by supporting integrated forecasting, procurement planning, quality-assured procurement, inventory management and commodity security at all levels, including at service delivery points, while identifying opportunities to strengthen quality-assured local and regional manufacturing capacity where appropriate and consistent with international quality standards.
- ▶ **By the fourth quarter of 2028**, priority products should have coordinated product development, regulatory and country introduction plans in place, with agreed implementation milestones, clearly defined partner responsibilities and mechanisms for monitoring progress towards equitable access.

Progress will be monitored throughout implementation of the Roadmap. As new products advance through development and existing products become more widely available, partners will periodically review barriers across product development, regulatory systems, markets, financing, procurement and supply chains to refine access strategies and respond to emerging challenges. Together, these activities seek to ensure that priority medicines, diagnostics and medical devices are not only developed and recommended, but are also registered, procured, affordable and routinely available within health systems, particularly in LMICs where the need is greatest, even beyond 2035. Beyond product access, implementation of this strategic area should be closely linked to complementary activities already being advanced through existing programmes (e.g., the Unitaid-supported SUPREME programme that includes implementation research, models of care, provider capacity strengthening,

Figure 3.3. Key activities and milestones for strategic area three: access to health products



demand generation, community engagement, policy adoption and scale-up planning). These activities will help ensure that products are not only available, but also effectively introduced, adopted and used to improve maternal and newborn outcomes.

The following strategic area focuses on the complementary implementation strategies needed to ensure that these products, and the recommendations that support them, are consistently delivered as high-quality care for women and newborns.

3.4 Strategic area: implementation

Objective

To support countries in translating evidence-based global recommendations into the national policies and strengthened health systems that are needed to deliver high-quality and equitable care for the prevention, diagnosis and treatment of hypertensive disorders of pregnancy.

The benefits of research, innovation, evidence-based recommendations and improved access to health products can only be realized when they are effectively implemented within health systems. Despite the availability of evidence-based interventions for hypertensive disorders of pregnancy, many countries continue to experience preventable maternal and perinatal deaths because proven interventions are not consistently delivered at the right time, in the right place and with the required quality. Bridging this implementation gap is therefore essential to achieving meaningful improvements in maternal and newborn outcomes.

Implementation of proven interventions requires input from several actors and multiple layers of collaboration to be successful. For example, implementing an effective clinical practice requires not just training health workers, but also reconfiguring clinical workflows, integrating multidisciplinary teams, engaging facility leadership, broadening legal authorizations regarding the scope of practice, and potentially adjusting health sector budgets. In addition, the contextual nature of the many implementation barriers means that locally-tailored solutions will be needed in addition to global-level efforts.

Successful implementation will require sustained country leadership and coordinated action across ministries of health, professional associations, academic institutions, development partners, implementing organizations and communities of practice. Aware of the many implementation barriers that need addressing, stakeholders at the Summit prioritized seven categories of implementation barriers as those that are amenable to, and in critical need of, global and country-level action and articulated the priority actions that stakeholders can undertake to address each, as summarized in Table 3.2.

Several of the implementation priorities described in this strategic area are already being advanced through existing initiatives. These include the Unitaids-supported SUPREME Lifelines programme, led by Amref Health Africa in partnership with Jhpiego, Solthis and Market Access Africa, as well as Gates Foundation-supported implementation activities in several LMICs. Across participating countries, these and other initiatives are contributing to implementation efforts that include generating implementation evidence; developing and evaluating models of care; strengthening provider capacity; accelerating adoption of essential products; strengthening demand generation and community engagement; and supporting country planning and scale-up. Lessons emerging from these activities can inform implementation of other aspects of the Roadmap and provide practical examples of how evidence-based interventions for hypertensive disorders of pregnancy can be translated into routine practice.

This strategic area builds directly on the outputs of the research and innovation, norms and standards and access to health products strategic areas. New evidence informs updated recommendations; strengthened access ensures that essential medicines, diagnostics and medical devices are available; and implementation translates these advances into routine clinical practice. Effective implementation therefore provides the critical link between global guidance and improved health outcomes for women and newborns.

Table 3.2 Key categories of implementation barriers and priority actions to address them

Key categories of implementation barriers	Priority actions to address the barriers
Weak legislative and multisectoral leadership for hypertensive disorders of pregnancy: Weak or absent legislative frameworks and limited engagement beyond the health sector reduce political commitment and accountability for hypertensive disorders of pregnancy. In many countries, these conditions are not sufficiently prioritized within national development agendas, making implementation vulnerable to changes in political priorities and funding cycles.	Build multisectoral leadership and accountability: ▶ Integrate hypertensive disorders of pregnancy into national legislation and broader health and development policies. ▶ Build political leadership and identify champions beyond the health sector, including ministries responsible for finance, education and social protection. ▶ Strengthen governance and accountability mechanisms to sustain implementation beyond political and funding cycles.
Insufficient and fragmented investment for implementation: Implementation of evidence-based interventions is frequently constrained by inadequate and fragmented financing. Hypertensive disorders of pregnancy are often not explicitly reflected in national budgets or investment plans, limiting implementation at scale and long-term sustainability.	Secure sustainable investment for implementation: ▶ Develop costed national implementation plans linked to existing maternal and newborn health programmes. ▶ Integrate hypertensive disorders of pregnancy into national budgeting and financing mechanisms. ▶ Align investments across governments, development partners and donors to maximize efficiency and minimize duplication.
Lack of national health policy and implementation governance: National implementation of evidence-based care for hypertensive disorders of pregnancy is often constrained by fragmented health policies, weak coordination across the different levels of the health system, and limited integration into broader maternal and newborn health programmes. In many countries, implementation responsibilities are poorly defined, while engagement of subnational authorities and private-sector providers remains limited, reducing the consistency and reach of national programmes.	Strengthen national policy and implementation systems: ▶ Integrate hypertensive disorders of pregnancy into national quality-of-care programmes, emergency obstetric care policies and universal health coverage initiatives. ▶ Establish or strengthen national technical working groups to coordinate implementation across government, professional associations and development partners. ▶ Strengthen coordination between national and subnational health authorities and engage private-sector providers in implementation, monitoring and quality improvement. ▶ Develop an efficient and sustainable global monitoring system that includes common indicators, systematic data collection, and a common measurement platform, to track country progress against targets. Through this effort, develop national monitoring frameworks and implementation dashboards with key hypertensive disorders of pregnancy indicators to track progress and strengthen accountability. ▶ WHO and other key stakeholders will lead an ongoing network of ministry of health and professional associations champions who will spearhead this work.

Key categories of implementation barriers	Priority actions to address the barriers
Lack of harmonized national clinical guidelines: The absence of harmonized national clinical guidelines due to failure to adapt and adopt global recommendations, contributes to inconsistent standards of care and delays in adopting impactful evidence-based care. Differences in clinical guidance create uncertainty among health workers and hinder consistent implementation of evidence-based care across countries and health systems.	Translate global recommendations into clinical practices at national and subnational levels: ▶ As WHO, FIGO, ICM, ISSHP and other global normative organizations update global normative guidance, support countries' ministries of health and national professional societies to adapt global recommendations into national clinical guidelines, clinical protocols, job aids, implementation toolkits and other guideline derivatives appropriate for different levels of the health system. ▶ Disseminate updated guidance throughout the health system – from national and subnational authorities to hospitals, primary care facilities and community health workers – to promote consistent implementation. ▶ Establish mechanisms for regular review and updating of national guidance as new evidence and global recommendations become available.
Poor staffing, training and supervision of health-care providers: Health workers, including midwives, nurses and community health workers, frequently lack the authorization, competencies, training and supportive supervision required to deliver evidence-based care within their full scope of practice. Pre-service education often does not adequately cover advances in prevention, diagnosis and treatment of hypertensive disorders of pregnancy, while opportunities for in-service training, mentoring and supportive supervision remain limited. Workforce shortages, inappropriate distribution and poor retention further constrain implementation, particularly in underserved settings.	Ensure availability of competent, motivated and well-supported health workforce to deliver high-quality services: ▶ Strengthen pre-service and in-service education through harmonized competency-based curricula and standardized training packages. ▶ Promote task sharing and optimize scopes of practice for midwives, nurses and community health workers in accordance with national policies. ▶ Expand mentoring, supportive supervision, simulation-based training and continuing professional development to sustain competency and quality of care. ▶ Supplement these activities with broader human resource strategies to address shortages, distribution and retention of qualified health workers.
Weak referral pathways and fragmented models of care: Unclear or poorly functioning referral pathways between communities and health facilities, and across different levels of care, contribute to delays in diagnosis, treatment and referral. Fragmented service delivery and poor coordination reduce continuity of care and increase the risk of preventable maternal and perinatal morbidity and mortality.	Strengthen integrated referral systems and models of care: ▶ Develop standardized care pathways linking community, primary, secondary and tertiary levels of care. ▶ Establish clear referral protocols, communication systems and emergency transport mechanisms across the continuum of care. ▶ Incorporate referral monitoring into routine implementation, clinical audit and maternal and perinatal death surveillance and response systems.

Key categories of implementation barriers	Priority actions to address the barriers
Limited community awareness and engagement: Low awareness of the signs and symptoms of hypertensive disorders of pregnancy, combined with limited engagement with women, families and communities, contributes to delayed care seeking and missed opportunities for early detection and timely referral. Community perspectives are often insufficiently incorporated into programme implementation.	Empower communities and women to drive implementation: ▶ Develop culturally appropriate community education strategies to improve recognition of danger signs and promote timely care seeking. ▶ Engage women, families, community leaders and CSOs as partners in implementation and accountability. ▶ Strengthen community–facility linkages to improve early detection, referral and continuity of care.

3.4.1 Key activities and milestones

Build multisectoral leadership and accountability

- ▶ **Integrate hypertensive disorders of pregnancy into national legislation and broader health and development policies:**
 National legislators and executive leaders should embed maternal and newborn health commitments – including priority action on hypertensive disorders of pregnancy – within durable legal and policy frameworks that extend beyond individual government administrations and electoral cycles. Depending on the country context, this could include legislation establishing entitlements to essential maternal and newborn health services, mandating minimum standards of care, protecting long-term financing and requiring routine reporting to the legislature or public. Initial activities, **beginning in the fourth quarter of 2026 and continuing through 2027**, should include ministries of health, parliamentarians and other relevant sectors reviewing existing legislation and broader development policies to identify gaps, consulting stakeholders as needed, and exploiting opportunities to update relevant national policy frameworks. Longer-term activities through to 2035 and beyond include implementation of new or revised policies, allocation of resources and routine monitoring of implementation by relevant actors at the country level.

- ▶ **Build political leadership and identify champions beyond the health sector: Beginning in the last quarter of 2026 and continuing through 2027**, ministries of health, parliamentarians, professional associations, CSOs and development partners should cultivate champions across ministries responsible for finance, education, social protection and other sectors whose decisions influence women's health. These champions should promote sustained political commitment, mobilize domestic resources and strengthen accountability for implementation. Initial activities should include stakeholder mapping, recruitment of champions and development of common advocacy messages, followed by regular engagement to maintain hypertensive disorders of pregnancy as a national priority.
- ▶ **Strengthen governance and accountability mechanisms to sustain implementation:**
 Countries should establish or strengthen national and subnational governance structures with clearly defined roles, responsibilities and accountability mechanisms to oversee implementation of the Roadmap. Regular performance reviews, public reporting of progress, and integration of hypertensive disorders of pregnancy indicators into existing accountability mechanisms will help sustain implementation beyond political and funding cycles. These activities and the timeline can be consolidated into those for the champions described above.

Secure sustainable investment for implementation

- ▶ **Develop costed national implementation plans linked to existing maternal and newborn health programmes:** Ministries of health should prepare costed implementation plans that define priority activities, implementation milestones, financing requirements and expected outputs for hypertensive disorders of pregnancy. Wherever possible, these plans should build upon existing maternal and newborn health programmes to maximize efficiency and sustainability. **Beginning from the last quarter of 2026 and continuing through 2027**, ministries of health and development partners (such as the Gates Foundation and other bilateral and multilateral funders) will develop costed implementation plans. Initial activities should include costing priority interventions and identifying financing gaps, followed by integration into national planning and budgeting processes.
- ▶ **Integrate hypertensive disorders of pregnancy into national budgeting and financing mechanisms:** Governments should ensure that implementation activities are reflected within national health budgets and financing mechanisms, including maternal and newborn health programmes, universal health coverage reforms and other relevant financing platforms. Domestic financing should progressively increase while ensuring efficient use of available resources. Early activities **starting from the last quarter of 2026 and continuing through 2027** to realize the above objectives include ministries of health scoping of current funds allocated to hypertensive disorders of pregnancy, as compared to other areas of health. Governments and development partners should identify innovative financing mechanisms and mobilize additional domestic and international resources to sustain implementation over the long term. Periodic reviews of financing gaps should inform future resource mobilization efforts and investment priorities.

▶ **Align investments across governments, development partners and donors:**

Development partners and financing agencies should coordinate investments around nationally defined priorities to reduce duplication and maximize collective impact. Countries should use national implementation plans as the principal framework for coordinating partner contributions and monitoring resource allocation. This activity should be consolidated into activities of the national technical working groups and partner coordination fora.

Strengthen national health policy and implementation systems

- ▶ **Integrate hypertensive disorders of pregnancy into national maternal and newborn health strategies and health system programmes:** Ministries of health should ensure that prevention, diagnosis and treatment of hypertensive disorders of pregnancy are incorporated into national maternal and newborn health policies, quality of care programmes, emergency obstetric and newborn care strategies and universal health coverage initiatives. An important early activity **starting from the last quarter of 2026 and continuing through 2027** will be the development of national roadmaps for hypertensive disorders of pregnancy through adaptation of the global Roadmap to country contexts, priorities and health system capacities. These national roadmaps should define priority actions, implementation milestones, roles and responsibilities, financing approaches and monitoring frameworks to guide coordinated implementation. **During the first quarter of 2027**, WHO, UNFPA and key stakeholders will establish and lead a network of ministry of health Summit champions to drive all prioritized activities specified across the implementation strategic area, including guidelines adaptation and adoption support to in-country guideline dissemination and implementation.

- ▶ **Establish or strengthen national technical working groups to coordinate implementation.** National governments should establish multidisciplinary technical working groups, or strengthen existing coordination mechanisms, bringing together government, professional associations, academic institutions, implementing partners and development agencies. These groups should oversee implementation planning, coordinate technical assistance, monitor progress and facilitate collaboration across the different sectors and levels of the health system. **Beginning in the first quarter of 2027 and continuing through 2028**, ministries of health should establish or strengthen national technical working groups and partner coordination fora to coordinate implementation across stakeholders. These activities should include assessing readiness and assigning responsibilities and resources.
- ▶ **Strengthen coordination across all levels of the health system:** National and subnational authorities should work together to ensure that implementation responsibilities are clearly defined and adequately resourced. Private-sector providers, local opinion leaders, faith-based organizations and other non-state actors should be engaged in implementation, referral networks, quality improvement activities and routine monitoring to maximize the reach and consistency of national programmes. These activities can be consolidated into the operations of the national technical working group and/or partners' coordination fora above.
- ▶ **Establish a coordinated monitoring and accountability framework: Between the last quarter of 2026 and the end of 2027**, WHO, UNFPA, FIGO, ICM, ministries of health, national professional associations, and other stakeholders will work jointly on a scoping exercise to define the features of a global monitoring system for tracking changes in practice performance, health outcomes and inequities, together with sustainability plans for in-country leadership. This scoping exercise could include, for instance, the mapping of existing indicators

for hypertensive disorders of pregnancy collected by different countries, to ultimately define, and agree on, a joint list of indicators. To increase the likelihood of these indicators being measured by the highest number of countries, existing metrics and data collection efforts should be leveraged to the extent possible. Defining concrete targets will also be critical, providing countries with an objective and targets to which they can aspire. It will be instrumental to raise awareness on “what good looks like” and create momentum to adequately resource national strategies to reach ambitious, yet realistic, targets. The scoping phase should also focus on determining data reporting frequency; data disaggregation levels (e.g., by population strata or level of health system); and roles and responsibilities for data curation, analysis, and for production of regular progress reports. A high-level budget should be developed for both building and managing the global monitoring system. This system should be extendable to other leading causes of maternal and perinatal mortality and morbidity.

The scoping phase will be followed by a design and pilot phase. This phase will focus on further developing elements of design that will have been discussed during the scoping phase. These will include technological design choices for the common measurement platform as well as specifics on data management (e.g., data storage and data privacy considerations). Before launching at full scale, the common measurement platform will be piloted in a few representative geographies. The design and pilot phase will likely run until **the fourth quarter of 2028**, with a global launch and full implementation planned for **2029 through 2035**. The global monitoring system will be a critical tool for measuring progress against the priorities set out in this Roadmap and for other leading causes of maternal and perinatal death. Countries should use this framework to establish national implementation dashboards, monitor progress against agreed targets and support continuous quality improvement.

Translate global recommendations into clinical practices at national and subnational levels

- ▶ **Support countries to adapt global recommendations into national guidance and implementation tools:** As WHO, FIGO, ICM, ISSHP and other normative organizations develop harmonized global recommendations and implementation tools, ministries of health and national professional societies should systematically adapt and adopt these recommendations into national clinical guidelines, protocols, job aids, implementation toolkits and other guideline derivatives appropriate for different levels of the health system. Adaptation should consider local context, including health system capacity and available resources while maintaining fidelity to the evidence base. **Beginning in the fourth quarter of 2026 and continuing through 2027,** WHO, UNFPA, UNICEF, FIGO, ICM and other professional associations should map existing gaps in national guidance for hypertensive disorders of pregnancy, particularly in high-burden countries, provide technical support to adapt and strengthen national guidance based on existing global recommendations, and prepare countries for the adoption and implementation of the consolidated global guidelines following publication.
- ▶ **Disseminate updated guidance throughout the health system:** Updated guidance should be disseminated systematically from national authorities to subnational managers, hospitals, primary health care facilities and community health workers. Dissemination should be accompanied by implementation support activities, including orientation workshops, training, digital decision-support tools and supervision to promote consistent uptake across all levels of care. The Postpartum Hemorrhage Community of Practice (now with an expanded scope that includes pre-eclampsia), will facilitate country-to-country sharing of lessons learned and organize regional workshops and webinars to present the guidelines and

offer dedicated support to help countries contextualize new recommendations. To enhance access, countries are encouraged to leverage WHO regional and country offices to support the translation of global documents into languages other than English, and develop relevant derivative products, such as policy briefs or operational manuals. These activities will go hand in hand with those above and executed by the same actors based on the same timeline.

- ▶ **Establish mechanisms for continuous global guidance review and updating:** Countries should establish processes for routinely reviewing national guidance and incorporating new evidence generated through the WHO living guideline process and future updates to the consolidated global guidelines. National professional associations should play a central role in maintaining the scientific quality and relevance of national recommendations. **From the first quarter of 2028 through 2035,** WHO, UNFPA, UNICEF, FIGO, ICM, ISSHP and other professional associations should continue supporting countries in the adoption, adaptation and implementation of new and updated recommendations incorporated into the consolidated global guidelines through the WHO living guideline process. This support should include technical assistance for the periodic revision of national clinical guidelines, protocols, job aids, implementation toolkits and other guideline derivatives, together with capacity strengthening to facilitate the integration of new evidence into national policy and clinical practice.

Ensure availability of competent and supported health workforce to deliver relevant high-quality services

- ▶ **Strengthen pre-service and in-service training through harmonized competency-based curricula:** Ministries of health, ministries of education, professional associations and academic institutions should collaborate to integrate evidence-based prevention, diagnosis and treatment of hypertensive disorders of pregnancy into pre-

service education, competency frameworks and standardized in-service training programmes. Harmonized curricula should reflect the consolidated global guidelines and support consistent practice across all cadres of health workers. **Beginning in the first quarter of 2028**, WHO, UNFPA, UNICEF, FIGO, ICM, ISSHP, Jhpiego, Laerdal Global Health, ministries of health, national professional associations, academic institutions and credentialing agencies will work together to strengthen pre-service and in-service training as part of health workers' continuing professional development. They will develop and maintain a comprehensive set of resources to improve quality of care, using a combination of face-to-face learning and digital approaches as appropriate. Activities will include establishing mentoring networks; holding regular webinars; supporting remote coaching; and delivering practical team-based training and simulation exercises, particularly for obstetric and neonatal emergency response teams.

- ▶ **Promote task sharing and optimize scopes of practice: Beginning in the second quarter of 2027**, national professional associations and ministries of health will review workforce policies and regulatory frameworks to identify opportunities to strengthen task sharing, expand scopes of practice where appropriate, and prepare health systems for implementation of the updated consolidated guidelines. Countries should review regulatory frameworks to enable midwives, nurses and community health workers to provide evidence-based care within their competencies, including screening, early detection, referral and selected treatment interventions where appropriate. Task-sharing approaches should be supported by clear clinical protocols, supervision and competency assessment. WHO, UNFPA, FIGO, ICM, ISSHP, ministries of health and national professional associations will continue to advocate for stronger legislation and regulatory frameworks governing midwifery, nursing and other health workforce cadres.

▶ **Strengthen supportive supervision and continuing professional development:**

Implementation should be supported through mentoring networks, simulation-based training, supportive supervision and continuing professional development programmes that reinforce clinical competencies and promote continuous quality improvement. WHO, UNFPA, UNICEF, FIGO, ICM, ISSHP, Jhpiego, Laerdal Global Health, ministries of health and national professional associations should play a leading role in maintaining competency standards and supporting lifelong learning. These activities should be integrated with broader pre-service and in-service education initiatives, creating a coordinated programme of competency-based training, mentoring, supportive supervision and continuing professional development to sustain implementation of evidence-based care.

- ▶ **Strengthen broader health workforce capacity:** Countries should complement these interventions with broader human resource strategies addressing shortages, equitable deployment, retention and motivation of qualified health workers, particularly in underserved and rural settings where implementation challenges are greatest.

Strengthen integrated referral systems and models of care

- ▶ **Develop standardized care pathways across the continuum of care:** Countries should develop standardized care pathways that clearly define responsibilities and clinical management across community, primary, secondary and tertiary levels of care. Care pathways should support timely identification, diagnosis, stabilization, referral, treatment and postpartum follow-up of women with hypertensive disorders of pregnancy. **Beginning in the fourth quarter of 2026 and continuing through 2027**, WHO, UNFPA, UNICEF, FIGO, ICM, ISSHP, Unitaaid and other key partners should develop standardized care pathways that define responsibilities and clinical management

across community, primary, secondary and tertiary levels of care to support country adaptation and implementation.

- ▶ **Strengthen referral protocols, communication and emergency transport systems:** National implementation plans should include clear referral protocols, standardized communication systems between facilities, and strategies to strengthen emergency transport for women and/or newborns requiring higher levels of care. These activities should be undertaken by ministries of health and implementation partners as part of the adaptation and implementation of the standardized care pathways described above, taking into account national health system organization and available resources.
- ▶ **Integrate hypertensive disorders of pregnancy into existing maternal and newborn health programmes:** Implementation should build upon existing emergency obstetric and neonatal care services, maternal and newborn care packages and quality improvement initiatives to maximize efficiency and avoid creating parallel systems. Integration across programmes will strengthen continuity of care throughout pregnancy, childbirth and the postpartum period. This integration should be incorporated into the same national implementation processes used to adapt the standardized care pathways, ensuring coordinated implementation across maternal and newborn health programmes.
- ▶ **Incorporate referral monitoring into quality improvement systems:** Countries should integrate referral performance into routine implementation monitoring, clinical audit, maternal and perinatal death surveillance and response systems and quality improvement initiatives. Regular review of referral performance will help identify bottlenecks, strengthen accountability and support continuous improvement of service delivery. These activities need to be integrated into national monitoring and quality improvement

systems as countries implement and evaluate the standardized care pathways.

Empower communities and women to drive implementation

- ▶ **Develop culturally appropriate community education strategies to improve recognition of danger signs and promote timely care seeking:** Governments, professional associations, CSOs and community partners should develop and implement evidence-based communication strategies to increase public awareness of hypertensive disorders of pregnancy, their warning signs and the importance of early antenatal care and timely referral. Communication approaches should be adapted to local contexts and delivered through multiple platforms, including antenatal care, community health workers, mass and social media, and digital technologies. Initial activities, **beginning in the last quarter of 2026 and continuing through 2035**, should include WHO, UNFPA, Unitaaid, ministries of health, professional associations and CSOs developing and implementing innovative, culturally appropriate community-education strategies, including the development of standardized communication materials, integration of key messages into existing maternal and newborn health programmes, national scale-up of these interventions, and routine evaluation of their effectiveness.
- ▶ **Engage women, families, community leaders and CSOs as partners in implementation and accountability:** Women with lived experience, families, community leaders, faith-based organizations and CSOs should be actively involved in planning, implementing and monitoring programmes for hypertensive disorders of pregnancy. Their participation will strengthen the acceptability, responsiveness and accountability of implementation efforts while helping ensure that services respond to local needs and priorities. Countries should establish mechanisms for meaningful participation throughout implementation, including

representation within national technical working groups and quality improvement initiatives. The activities and timeline for these activities can be consolidated into those above as part of the initial processes.

- ▶ **Strengthen community–facility linkages to improve early detection, referral and continuity of care:** Countries should strengthen collaboration between communities and health facilities to facilitate early identification of women at risk, prompt referral and continuity of care throughout pregnancy and the postpartum period. Community health workers should be integrated within referral pathways and supported through clear communication systems, supervision and feedback mechanisms. Particular attention should be given to strengthening linkages between primary care and referral facilities to reduce delays in accessing appropriate care.

3.5 Strategic area: advocacy and accountability

Objective

To build and sustain the political commitment, public awareness and coordinated partnerships needed to accelerate action on hypertensive disorders of pregnancy and support implementation of the Roadmap.

Sustained progress in reducing maternal and newborn mortality and morbidity associated with hypertensive disorders of pregnancy will require more than technical advances alone. Lasting change depends on sustained political commitment, public awareness, coordinated advocacy and adequate investment across the global, regional and national levels. While important advocacy efforts already exist, they remain fragmented across organizations, countries and stakeholder groups. A more coordinated global advocacy effort is therefore needed to elevate hypertensive disorders of pregnancy on political agendas, mobilize resources, strengthen partnerships and sustain momentum for implementation of this Roadmap.

The Roadmap therefore proposes a coordinated global advocacy framework and identity that brings together governments, women and communities, CSOs and NGOs, patient advocacy organizations, United Nations (UN) agencies and partnerships, professional associations, researchers, implementers, donors, industry and private sector partners around a shared vision and common messages. Priority activities focus on five complementary areas:

- ▶ **building a unified global movement** through coordinated leadership, shared messaging and advocacy tools;
- ▶ **developing compelling evidence and investment cases** to support political prioritization and sustainable financing;
- ▶ **creating high-profile political moments and platforms** that elevate hypertensive disorders of pregnancy on global and national agendas;
- ▶ **sustaining public and political engagement** through coordinated campaigns, champions and partnerships; and
- ▶ **strengthening accountability** for political, financial and implementation commitments.

Together, these activities are intended to create a sustained advocacy infrastructure that can mobilize action throughout implementation of the Roadmap, creating greater impact than individual campaigns or events.

Women with lived experience of hypertensive disorders of pregnancy have a particularly important role in shaping and leading this agenda. Their participation should extend beyond sharing personal experiences to meaningful involvement as equal partners in advocacy priority-setting, governance, implementation and accountability. Patient advocacy organizations, women's organizations and communities can help ensure that advocacy priorities reflect the needs and experiences of those most affected, strengthen public demand for quality care and hold governments and other stakeholders accountable for commitments. Particular attention should be given to ensuring representation from LMICs and populations experiencing the greatest burden and inequities in access to care.

Figure 3.4. Key activities and milestones for strategic area four: implementation

Advocacy approaches need to be adapted to regional, national and local political contexts while remaining aligned around common global priorities. Engagement should extend beyond ministries of health to ministries of finance, education, transport and other sectors whose policies and investments influence maternal and newborn health. Global and regional platforms, professional congresses, media, existing advocacy initiatives – including relevant hypertension, cardiovascular health and noncommunicable disease advocacy platforms – and World Pre-eclampsia Day (22 May) provide opportunities to increase visibility and mobilize new constituencies, while the development of an investment case and context-specific advocacy tools can support engagement with policy-makers, donors and financing institutions. Sustained advocacy will require coordinated action between these actors and deliberate efforts to connect political attention with concrete policy, financing and implementation commitments.

This strategic area is closely linked to all preceding components of the Roadmap. Advocacy and political mobilization can generate investment for priority research and innovation, build political support for harmonized norms and standards, mobilize financing and demand for priority health products, as well as create the enabling environment needed for country implementation. In turn, evidence generated through research, implementation and monitoring can strengthen advocacy messages and provide the basis for accountability. By linking political mobilization with mechanisms to monitor commitments and results, this strategic area seeks to sustain momentum across the Roadmap and ensure that progress in evidence generation, policy development, access, and implementation ultimately translates into measurable improvements in maternal and newborn health outcomes.

3.5.1 Key activities and milestones

► **Beginning in the third quarter of 2026**, the Partnership for Maternal, Newborn and Child Health (PMNCH), WHO, UNICEF, UNFPA and partners will establish a Pre-eclampsia

Advocacy Working Group to develop a coordinated global advocacy framework and identity for hypertensive disorders of pregnancy. The framework will provide a shared vision, common messaging, visual identity, advocacy toolkit and governance structure to align global, regional and national advocacy efforts, strengthen coordination across partners, and support context-specific adaptation by countries and regions.

► **Beginning in the third quarter of 2026**, advocacy organizations, professional associations, UN agencies and partners will coordinate activities around the existing World Pre-eclampsia Day to strengthen visibility, align messaging and build momentum for the broader advocacy agenda. Building on these efforts, partners will work with Member States towards formal recognition of an official UN World Pre-eclampsia Day by 2028, creating a recurring global platform for political advocacy, public awareness and renewed commitments to action.

► **Beginning in the last quarter of 2026**, health economists, advocacy organizations (such as Action on Pre-eclampsia Ghana, EndPreeclampsia, Preeclampsia Foundation, Swedish Preeclampsia Association, Thrive Beyond Preeclampsia, White Ribbon Alliance Kenya) and partners will develop a global investment case for hypertensive disorders of pregnancy, supported by economic analyses and advocacy materials for adaptation to regional and national contexts. These resources will support engagement with ministries of finance, development partners and policy-makers by demonstrating the health, social and economic benefits of investing in prevention, early detection and high-quality care.

► **Beginning in the first quarter of 2027**, advocacy organizations, CSOs, ministries of health and partners will work together to establish and strengthen national accountability mechanisms that promote political ownership and monitor commitments and progress towards

implementation of the Roadmap. Activities may include development of budget-tracking tools, parliamentary-oversight mechanisms, identification of political champions, public reporting on progress and other context-appropriate accountability approaches that link political and financial commitments to measurable action and results.

- ▶ **Beginning in the last quarter of 2027**, patient advocacy organizations, CSOs and NGOs (such as Align:), professional associations (such as the Royal College of Obstetricians and Gynaecologists and the Society for Maternal-Fetal Medicine), UN agencies and partnerships, media, and ministries of health will implement coordinated advocacy campaigns that elevate the voices and priorities of women with lived experience, engage political champions and sustain public awareness of hypertensive disorders of pregnancy and the Roadmap. Advocacy efforts should extend beyond the health sector to engage finance, education, transport and other sectors whose policies influence maternal and newborn health, while leveraging major regional and global events to sustain visibility and political commitment.
- ▶ **By the end of 2028**, a coordinated global advocacy framework and identity, investment case and associated advocacy tools should be in use across global, regional and national advocacy efforts, with mechanisms established to sustain political engagement, support context-specific advocacy and monitor commitments to implementation of the Roadmap.

Progress across the advocacy and accountability agenda will be monitored throughout implementation of the Roadmap. Partners should periodically review progress in political commitment, financing, public awareness and stakeholder engagement while refining advocacy strategies in response to emerging opportunities and country experience. Together, these activities seek to establish a coordinated global movement on hypertensive disorders of pregnancy, strengthen political and financial commitments, sustain public and political

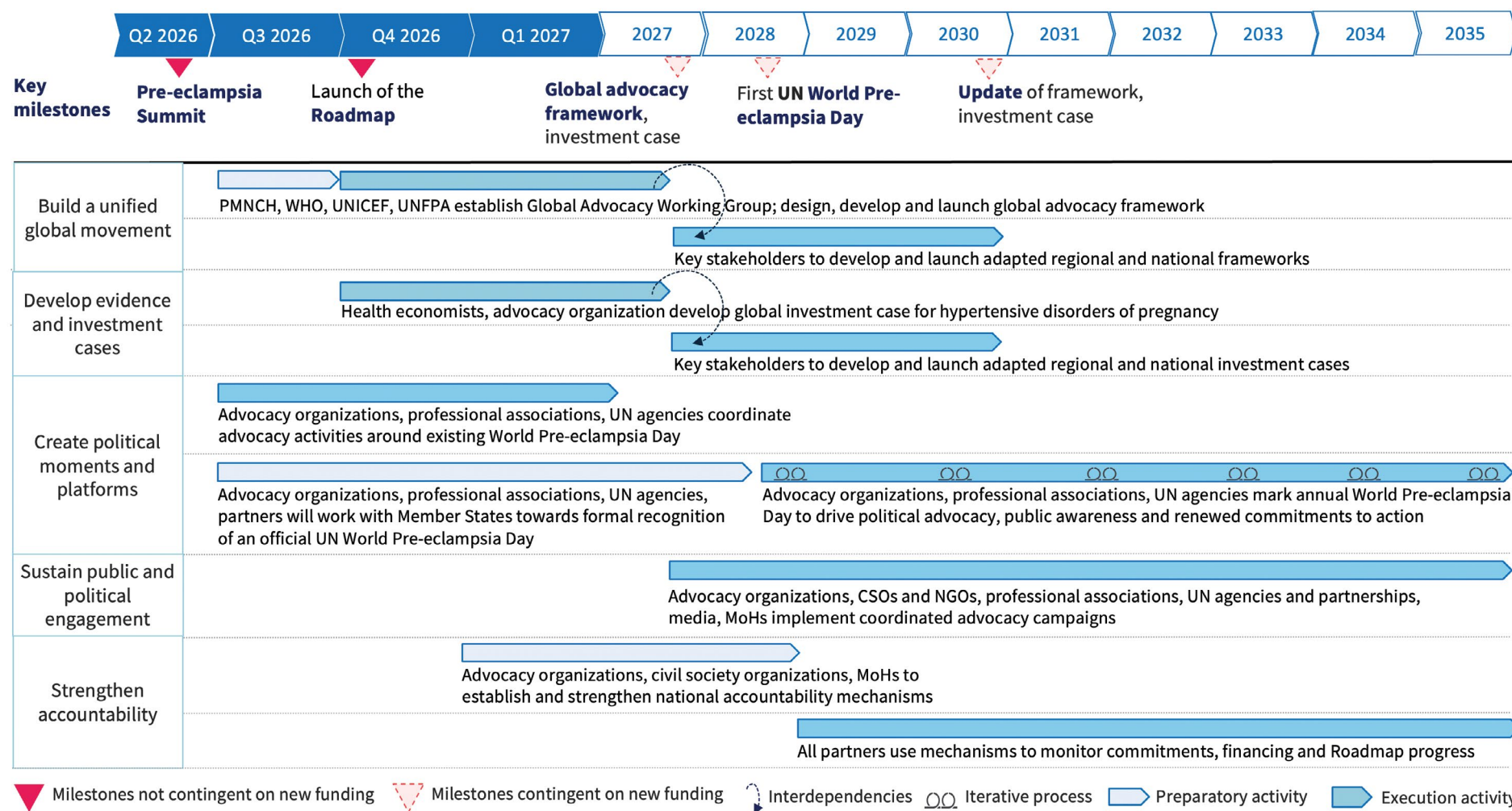
attention, and create mechanisms through which governments and partners can be held accountable for translating commitments into action. The advocacy and accountability agenda should build on existing initiatives and relevant advocacy platforms at the country, regional, and global level, wherever possible (e.g., Unitaids-supported SUPREME programme of activities). Lessons emerging from these efforts can help strengthen advocacy approaches, support country ownership, and connect global commitments with national implementation efforts.

As the final strategic area of the Roadmap, building advocacy and accountability will provide the political and social infrastructure needed to sustain momentum and reinforce coordinated action across the entire evidence-to-impact pathway.

3.6 Interdependencies across the five strategic areas in the Roadmap

The preceding sections describe the major activities and milestones within each of the Roadmap's five strategic areas. While presented separately for clarity, these strategic areas are intended to function as an integrated system rather than as independent workstreams. Together, they describe an interconnected evidence-to-impact pathway in which progress in each area both depends upon and creates enabling conditions for progress in others.

Research and innovation generate new evidence, technologies and interventions, but their impact depends on anticipating the evidence requirements of normative, regulatory and policy decision-making and the conditions under which interventions can ultimately be delivered. Norms and standards translate evidence into recommendations while also shaping research priorities, product development and access requirements. Access to health products depends on alignment across product development, regulatory pathways, policy adoption, financing, procurement and supply systems, while implementation depends on both appropriate guidance and reliable access to the products required to deliver recommended

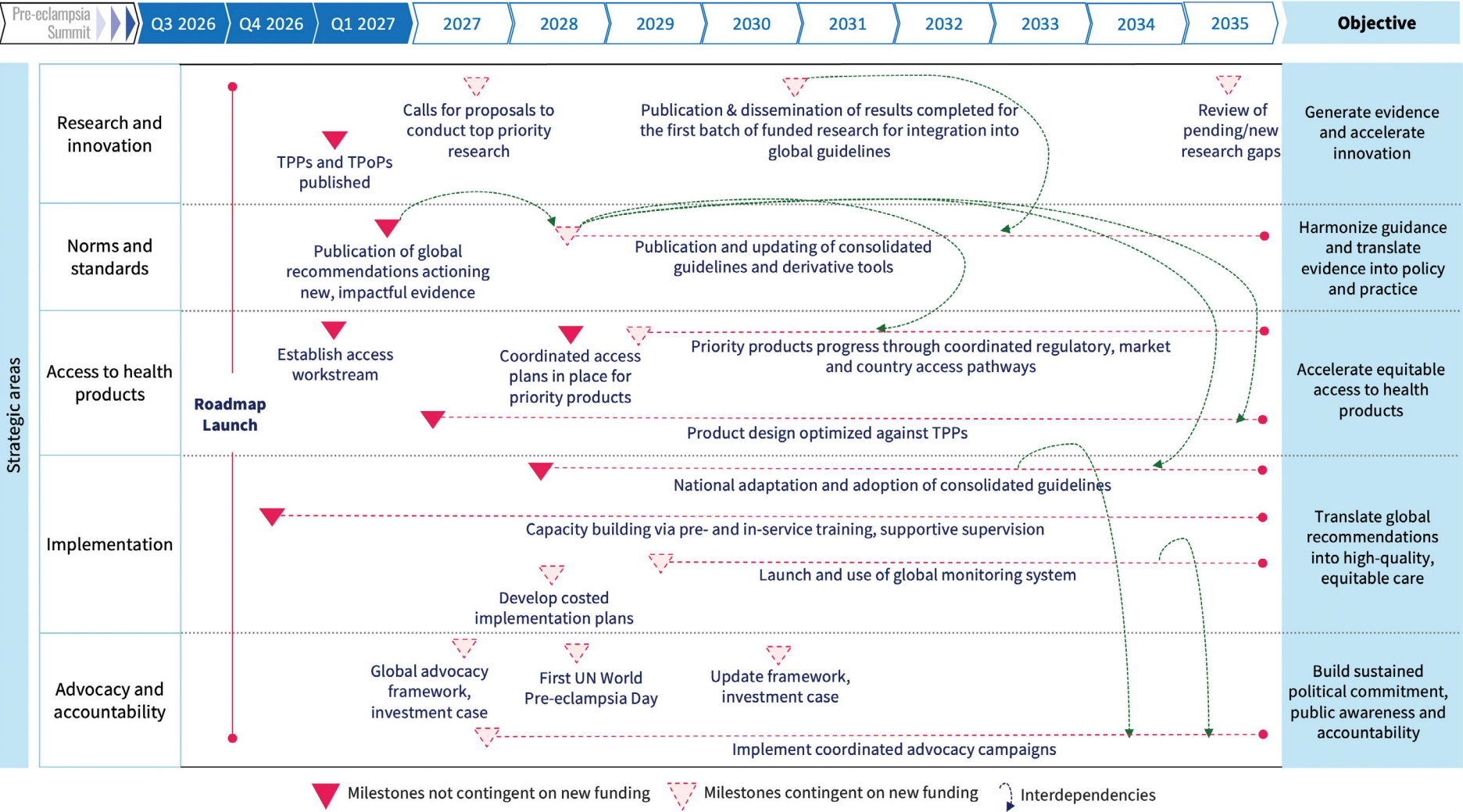
Figure 3.5. Key activities and milestones for strategic area five: advocacy and accountability

care. In turn, country implementation generates evidence and experience that can reveal new research questions, gaps in guidance and barriers to product access. Advocacy and accountability operate across this system rather than at a single point in the pathway, mobilizing political commitment, partnerships and investment; strengthening accountability for progress; and helping sustain action across all five strategic areas. These relationships are not purely sequential. Progress in implementation generates new evidence on feasibility, effectiveness and health system performance that informs future research priorities, guideline development and implementation strategies. Advocacy helps accelerate action across all strategic areas by strengthening political commitment, while monitoring and accountability mechanisms provide the information needed for continuous learning and improvement. Together, these reinforcing relationships create a continuous cycle of evidence generation, policy development, implementation, learning and refinement that supports sustained improvements in maternal and newborn health (Figure 3.6).

These interdependencies are what distinguish the Roadmap from a collection of parallel strategic priorities. Its value lies in creating a shared architecture through which innovation, evidence generation, normative guidance, product access, implementation, advocacy and accountability can reinforce one another over time. By making these relationships explicit, the Roadmap provides a basis for coordinating investments, sequencing activities, identifying bottlenecks early and adapting course as new evidence and implementation experience emerge.

Implementation of the Roadmap will be aligned with broader global maternal and newborn health initiatives, including the EWENE initiative and other relevant global and regional implementation platforms. Alignment with these initiatives will help integrate Roadmap activities into existing country-support mechanisms, promote coordination across partners and maximize opportunities to accelerate implementation at scale.

Figure 3.6. Interdependencies across the five strategic areas in the Roadmap



4. Global Call to Action

Delivering the ambitious agenda outlined in the Roadmap will require sustained and coordinated action from all stakeholders. No single intervention or strategic area will change the trajectory of hypertensive disorders of pregnancy. Progress requires coordinated action to generate evidence and accelerate innovation; translate evidence into harmonized global guidance; ensure equitable access to quality health products; strengthen health systems and implementation; and build the political commitment and accountability needed to sustain progress. These activities are interdependent, and investments in one area should anticipate and enable action in others.

The Summit surfaced three central imperatives that should guide all efforts that emanate from this Roadmap in the coming decade. These imperatives reflect the convergence of discussions and learnings across the Summit and provide an overarching frame for action across all five strategic areas:

- **Ensure that hypertensive disorders of pregnancy are widely known, understood and prioritized.** Hypertensive disorders of pregnancy should be recognized as a major maternal and newborn health issue and receive the visibility they deserve on global, regional and national agendas, supported by sustained political commitment, a compelling investment case, adequate financing and strong accountability for action.
- **Put women at the centre of the Roadmap.** Women, particularly those living in LMICs and other high-burden settings, should be meaningfully involved in the design, governance, and delivery of

the hypertensive disorders of pregnancy agenda. Their rights, priorities and lived experiences are the foundation of all action.

- **Accelerate innovations and proven interventions for high-burden settings.** Proven interventions and innovations should reach every woman who needs them, particularly in LMICs and other high-burden settings. These need to be supported by fit-for-purpose, harmonized guidance, appropriate health infrastructure and sustainable financing to make equitable access and high-quality care a reality.

A broader set of key learnings from the Summit underpin these three imperatives and point to the actions needed to translate them into impact.

- ▶ **Women should participate as equal partners throughout the evidence-to-impact pathway.** Women and communities must remain at the centre of research, guideline and policy development, product and solution design, implementation, advocacy and accountability. Particular attention should be given to meaningful participation of women in LMICs and other settings bearing the greatest burden, so that their priorities and lived experiences inform what questions are asked, which solutions are developed, how care is delivered and how progress is measured.
- ▶ **Greater political and public visibility must translate into sustained commitment and accountability.** Hypertensive disorders of pregnancy remain insufficiently prioritized despite their substantial contribution to maternal and perinatal mortality

and morbidity. A coordinated advocacy movement is needed to elevate their profile, supported by harmonized messaging, broader coalitions, political champions, a compelling investment case and mechanisms that hold governments and partners accountable for translating political and financial commitments into action.

- ▶ **Effective interventions must reach women now, while research and innovation accelerate better solutions for the future.** Reducing preventable morbidity and mortality cannot wait for future innovations. Effective interventions already exist, but persistent barriers related to workforce capacity, health system readiness, affordability, product availability and implementation prevent them from consistently reaching women who need them. These barriers should be addressed while sustained investment in research and innovation enables the next generation of interventions for high-burden settings to be developed, implemented and evaluated.
- ▶ **A fully funded and coordinated research and innovation agenda is needed to address the most important evidence and product gaps.** The 20 priority research questions identified through the Summit provide a shared agenda across innovation, implementation and cross-cutting research. Investment is also needed to strengthen the scientific foundation for innovation; develop and apply TPPs and TPOPs; establish harmonized core outcome sets; and accelerate promising products through development, evaluation, regulatory approval and policy adoption. Research should deliberately generate evidence relevant to LMICs and engage women with lived experience in research design and oversight.
- ▶ **Global guideline developers should work towards harmonized recommendations and a consolidated global standard of care.** Greater collaboration among WHO, FIGO, ICM, ISSHP and other guideline developers should reduce duplication of effort, beginning with sharing evidence

syntheses and progressively moving towards harmonized global recommendations and consolidated guidelines that can be adopted and contextualized by countries and translated into clinical protocols, job aids and other practical implementation tools. Global guidance should address important gaps and keep pace with emerging evidence and innovation. Future guidance should address areas where recommendations are currently absent, inconsistent or require updating. This will enable countries to benefit more rapidly from advances in evidence and innovation while providing a coherent standard for clinical practice.

- ▶ **Innovation must be designed with access and implementation in mind from the outset.** Developers, manufacturers, regulators, normative organizations, procurement agencies, funders and countries need to work together across the product pathway. Fit-for-purpose products, clearer development and regulatory pathways, quality assurance, affordable pricing, market readiness, effective procurement and resilient supply systems will be needed to ensure that medicines, diagnostics and medical devices move efficiently from development to country access and routine use.
- ▶ **Hypertensive disorders of pregnancy cannot be addressed in isolation from the broader maternal and newborn health agenda.** Implementation should be integrated within existing maternal and newborn health initiatives and programmes, universal health coverage, emergency obstetric care, quality improvement and national financing frameworks rather than creating parallel systems. Action must also extend beyond ministries of health to sectors including finance, education and social protection, with strong leadership at national and subnational levels. The Summit emphasized that delivering the Roadmap will require collective action extending beyond the maternal and newborn health community. Depending on the country context, the linkage with other relevant

programmes (e.g., noncommunicable diseases or HIV/AIDS) which may be offering routine blood-pressure checks may be beneficial.

► **A competent and supported health workforce and functional referral systems are prerequisites for high-quality care.**

Countries need sufficient numbers of appropriately trained and supported health workers, with scopes of practice that enable midwives, nurses and community health workers to contribute fully within their competencies. Clear care pathways linking communities with primary, secondary and tertiary care, are essential to ensure that women are identified early and receive the right care at the right level and time.

► **Greater coordination is needed across the entire evidence-to-impact pathway.**

Governments, normative organizations, professional associations, researchers, funders, implementers, civil society, communities, industry and other partners have distinct but complementary roles. Stronger coordination among organizations and donors can reduce duplication, align investment around shared priorities and create the sustained global and national leadership needed to advance the Roadmap.

► **Progress must be measured; learning must inform action; and commitments must be accountable.** The Roadmap establishes milestones through 2035, but achieving

them will require sustained mechanisms for monitoring, learning, accountability and course correction. Countries and global partners should monitor key processes, health outcomes and inequities; use emerging evidence and implementation experience to identify bottlenecks and refine approaches; and make progress visible to governments, communities, funders and other stakeholders.

Taken together, these learnings reinforce the three central imperatives: make hypertensive disorders of pregnancy visible and prioritized; put women at the centre; and accelerate innovations and proven interventions for high-burden settings. They also underscore that achieving these imperatives will require coordinated action across the five strategic areas of the Roadmap and across the full range of stakeholders responsible for turning evidence and commitments into better outcomes for women and newborns.

Participants in the Summit call on the international community to translate the consensus reflected in this Roadmap into sustained and coordinated action. While responsibilities differ across stakeholder groups, progress will depend on shared stewardship of the agenda and accountability for delivering its priorities. Table 4.1 translates this collective agenda into specific calls to action for the stakeholder groups whose participation will be essential to achieving the Roadmap's vision.

Table 4.1. Key actions to ensure effective and coordinated efforts towards eliminating preventable deaths due to pre-eclampsia

Actor	Key actions
 International community	▶ Establish a coordination mechanism with mandate and milestones to drive the Roadmap. ▶ Launch coordinated and unified initiatives to strengthen advocacy and increase awareness of hypertensive disorders of pregnancy. ▶ Champion midwives as pivotal actors reducing mortality and morbidity related to hypertensive disorders of pregnancy.
 Women and women's organizations	▶ Share learnings from experience, co-design and execute advocacy campaigns. ▶ Participate as equal partners in research, policy and solution design, and accountability, ensuring meaningful representation of women from low-income settings. ▶ Seek timely maternal and newborn health services, demand their right to quality care for hypertensive disorders of pregnancy, and promote social accountability for these services.
 Ministries of health, political actors and legislators	▶ Champion pre-eclampsia in national, regional and global political fora to elevate its priority, mobilize political commitment and financing, and maintain accountability for action. ▶ Strengthen country leadership and accountability by integrating hypertensive disorders of pregnancy into national universal health coverage plans and health budgets; setting targets; monitoring progress; mobilizing domestic financing and advocacy; and coordinating action with partners. ▶ Ensure national guidelines are updated based on harmonized global guidelines, contextualized to local settings, and disseminated. ▶ Steer national procurement to quality-assured medicines, diagnostics and devices; ensure appropriate staffing, training and equipment at health-care facilities; and work to improve supply chain reliability and efficiency.
 Implementers (including NGOs and CSOs)	▶ Advocate to governments and donors for increased prioritization and financing. ▶ Form coalitions with governments and professional associations to develop action plans to be implemented at the national and subnational levels. ▶ Champion women's rights and centre women's lived experience in the design of hypertensive disorders of pregnancy programmes. ▶ Collect and use community-level data to identify gaps, monitor implementation and feed community experiences into programme improvement and accountability.
 Professional associations	▶ Support national adaptation, adoption and implementation of harmonized evidence-based guidance. ▶ Champion harmonized guidelines within membership and promote adherence to recommended interventions. ▶ Support collaboration, knowledge dissemination, and the activities of communities of practice (within countries and internationally), acting as convening bodies. ▶ Lead coordinated, continuous, locally-led capacity building for frontline health workers, with built-in accountability measures.
 Guideline developers	▶ Coordinate the development, harmonization and updating of global recommendations and tools for hypertensive disorders of pregnancy through a collaborative normative process (starting with sharing the evidence synthesis work and jointly building the evidence ecosystem for hypertensive disorders of pregnancy). ▶ Support the development of national guidelines on hypertensive disorders of pregnancy, consistent with harmonized global recommendations.

Actor	Key actions
 Research community	▶ Execute the hypertensive disorders of pregnancy research agenda from the Summit with equal priority given to the three research tracks – innovation, implementation and cross-cutting. ▶ Develop and consistently apply standardized core maternal, fetal and newborn outcome sets to improve comparability across studies and support evidence synthesis, regulatory evaluation and policy decision-making. ▶ Ensure research is contextualized and directed towards the least-served communities, via engagement of women with lived experience, particularly from LMICs or high-burden areas, in research design and oversight. ▶ Strengthen equitable and global collaboration across researchers, industry and innovators to accelerate impact.
 Industry and innovators	▶ Focus research and development efforts on fit-for-purpose, demand-driven innovations that will address unmet public health needs, via application of LMIC-focused TPPs from the outset. ▶ Commit to WHO prequalification, where applicable, and pursue accelerated and harmonized regulatory pathways to support timely approval and introduction of quality-assured health products. ▶ Make commodities more affordable and accessible, especially for low- and middle-income settings by developing transparent access and pricing strategies for high-burden markets.
 Donor agencies	▶ Increase and make public, time-bound financial commitments aligned with the Roadmap priorities. ▶ Strengthen coordination across donors to fill critical gaps and avoid duplication of efforts and amplify impact. Consider establishing or expanding an existing donor forum to allow a single point of contact for countries. ▶ Support governments to increase domestic financing for hypertensive disorders of pregnancy and secure their commitment to reach the agreed targets.

Signatories: Participants at the Global Pre-eclampsia Summit, 5–8 May 2026, Kigali, Rwanda

5. Implementation of the Roadmap

The Roadmap sets out an ambitious agenda for transformational change in the prevention, diagnosis and treatment of hypertensive disorders of pregnancy. Achieving its goals will require sustained and coordinated action by stakeholders at global, regional, national and subnational levels, supported by adequate and predictable financing. While some priority activities can begin through existing programmes and investments, many will require additional resources and new partnerships to move forward at the pace and scale envisaged in the Roadmap.

Implementation should reflect the interconnected nature of the Roadmap's five strategic areas. Research and innovation; norms and standards; access to health products; implementation; and advocacy and accountability are not independent workstreams. Progress in each area creates opportunities – and dependencies – for progress in the others. Evidence generated through research informs normative guidance; guidance shapes product development, access and country implementation; implementation generates new evidence and learning; and advocacy and accountability mobilize the political commitment and financing needed to sustain action across the entire pathway. Implementation of the Roadmap should therefore promote coordination and deliberate linkages across strategic areas, rather than pursuing individual activities in isolation.

The Roadmap identifies indicative activities, milestones and actors across the period 2026–2035. These provide a common framework for coordinating action and monitoring progress, but implementation will necessarily evolve as new evidence, innovations and country experience emerge. The considerations below

are intended to guide global coordination, country adaptation and implementation of the Roadmap over the coming decade.

5.1 Global leadership and governance

The breadth and interdependence of actions within the Roadmap require a governance approach capable of coordinating a diverse group of actors while maintaining clear responsibility for delivery. No single organization has the mandate, expertise or resources to lead all five strategic areas, and successful implementation will therefore depend on shared leadership with clearly defined responsibilities and accountability for agreed milestones.

A global coordination mechanism should be established to provide overall stewardship of the Roadmap, monitor progress across the five strategic areas and maintain coherence between them. Within this mechanism, lead and supporting organizations should be identified for major activities and milestones according to their respective mandates, comparative advantages and capacities. Roles should be sufficiently clear to establish who is responsible for convening partners, mobilizing resources, delivering specific activities, monitoring progress and addressing bottlenecks when milestones are not achieved. The global Call to Action provides an important foundation for this shared responsibility by defining complementary actions across stakeholder groups.

WHO will initially play a catalytic and convening role, including initiating priority activities, facilitating coordination, providing normative leadership and supporting countries. Implementation of the Roadmap, however, cannot be WHO-led in its entirety. Other

organizations will need to assume leadership of activities aligned with their mandates and expertise, while governments, professional associations, research institutions, civil society, women's organizations, industry, donors and implementation partners contribute through the responsibilities articulated in the global Call to Action.

The governance mechanism should also provide a means of monitoring progress across the Roadmap as a whole, rather than only within individual strategic areas. A limited set of indicators linked to major milestones of the Roadmap should be used to identify progress, delays, and dependencies between strategic areas. Periodic review should provide opportunities to address bottlenecks, realign activities and investments, and respond to emerging evidence and opportunities. Monitoring and accountability should, wherever possible, build on existing global and national systems rather than create parallel reporting structures.

Given the complexity of the pre-eclampsia landscape, governance arrangements should remain sufficiently flexible to accommodate organizations with different mandates, operating models and constituencies. They should also connect with broader maternal and newborn health initiatives and implementation platforms, including the Every Woman Every Newborn Everywhere (EWENE) initiative and relevant regional and country mechanisms, so that the Roadmap strengthens rather than duplicates existing efforts. Such alignment is already envisaged in the Roadmap as a means of integrating activities into existing country-support mechanisms and accelerating implementation at scale.

Sustained leadership, financing and stakeholder commitment will be critical enabling conditions for this governance model. The Theory of Change developed for the Summit anticipated WHO leadership and coordination, donor engagement and funding, broad stakeholder commitment to the Roadmap, country adoption of priority actions and sufficient political space for governments to implement them. These remain important assumptions underpinning successful implementation through 2035.

5.2 Adaptation for national and local context

This global Roadmap provides a common direction for action, but its impact will ultimately depend on how effectively its priorities are translated into national and subnational action. Countries differ substantially in disease burden, health-system capacity, availability of health products, financing, research priorities and implementation barriers. This Roadmap should therefore provide a common global framework without prescribing a uniform pathway for every country.

Countries are encouraged to adapt this global Roadmap into national roadmaps or equivalent implementation frameworks, using participatory and consensus-based processes led by ministries of health and involving relevant government sectors, professional associations, women's organizations and CSOs, researchers, implementers, development partners and other stakeholders. National roadmaps should identify country priorities, responsible actors, financing requirements and time-bound milestones while remaining aligned with the overall goals and strategic areas of this global Roadmap. This approach is consistent with the implementation milestones already identified, which envisage support for countries to adapt this global Roadmap into national roadmaps and develop costing implementation plans.

Adaptation should begin with an assessment of the national context and existing initiatives rather than the creation of parallel programmes. Countries should identify where priorities in this global Roadmap are already reflected in national maternal and newborn health strategies, universal health coverage plans, quality-of-care programmes, research agendas, procurement systems and other relevant initiatives, and where important gaps remain. Existing national coordination structures should be used or strengthened wherever feasible, with new mechanisms established only where necessary.

The global Roadmap's research priorities should similarly be interpreted in light of national needs. The 20 priority research questions represent the most important global evidence gaps identified through the Summit, but national

and subnational settings may have additional or more urgent research questions. Countries and national research funding agencies should therefore use the global agenda as a reference while prioritizing research that responds to their epidemiological, health-system and implementation needs.

Global normative guidance should likewise be translated into national guidelines, protocols, care pathways, job aids and other tools that reflect local health-system realities and available resources while maintaining fidelity to the underlying evidence and recommendations. Ministries of health, national professional associations and implementation partners will have central roles in this process, supported by WHO and other global and regional partners. The planned consolidated global guidelines will provide an important normative foundation for these country processes, while continuing to evolve through the WHO living guideline approach as new evidence becomes available.

Countries should also identify their most important implementation barriers and develop context-specific responses. These may relate to political commitment, financing, workforce capacity, referral systems, commodity availability, community awareness or other constraints identified in Section 3.4. Solutions should be integrated into existing maternal and newborn health programmes and broader health-system strengthening efforts wherever possible, rather than establishing stand-alone programmes for hypertensive disorders of pregnancy.

Humanitarian and other fragile settings will require particular consideration, given the additional constraints affecting continuity of care, referral systems, health workforce capacity and access to essential health products. Tailored implementation approaches, tools and toolkits may therefore be needed alongside standard resources to address context-specific challenges while maintaining alignment with the principles and priorities of the Roadmap.

Advocacy will similarly require local adaptation. The global advocacy framework and investment case should provide common messages and

evidence, but countries and regions should tailor these to their political, social and financing environments. Audience segmentation, coalition building and engagement of credible messengers – including women with lived experience – can help translate a global movement into sustained national and subnational political action.

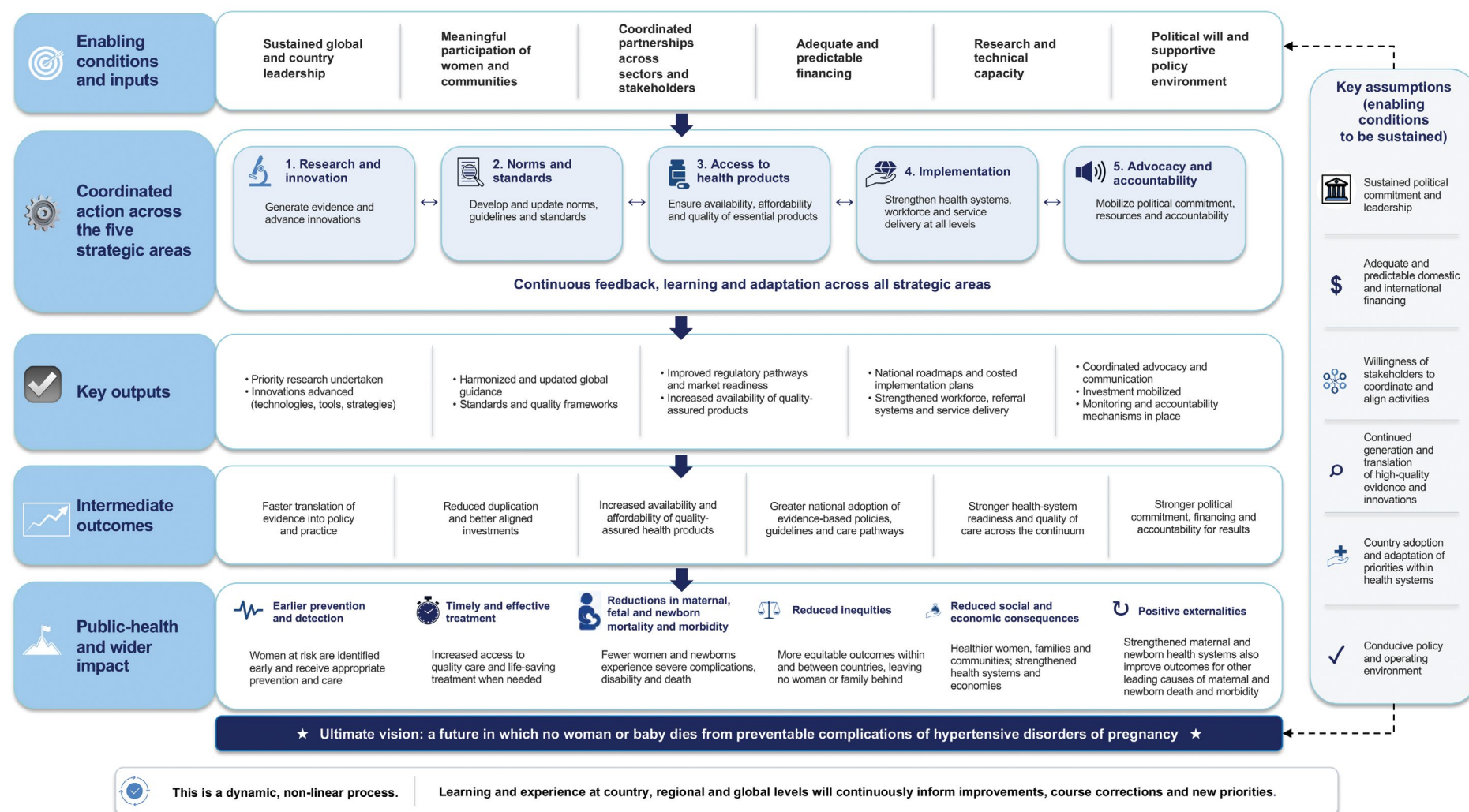
Experience from implementation of the *Roadmap to combat postpartum haemorrhage between 2023 and 2030* (19), developed by WHO and key stakeholders, provides an opportunity for cross-roadmap learning, particularly in country adaptation, partner coordination, guideline translation, implementation support, advocacy and monitoring. Relevant lessons should be deliberately captured and applied where appropriate rather than establishing entirely new approaches for hypertensive disorders of pregnancy.

Country-specific milestones and indicators should ultimately feed into the Roadmap's global monitoring and accountability mechanism. Wherever possible, data should be drawn from existing national information and accountability systems to minimize additional reporting requirements and enable countries to use the same information for national decision-making and global progress monitoring.

5.3 Theory of change and anticipated impact of the Roadmap

The Theory of Change developed for the Summit envisaged a progression from leadership, evidence generation and identification of gaps, through consensus on global priorities and establishment of coordinated partnerships, to improved knowledge translation and ultimately public health and economic impact. Its intended impacts include reductions in maternal, fetal and newborn deaths and pre-eclampsia morbidity, alongside faster translation of knowledge into policy and practice. The Roadmap builds on this Theory of Change by providing the strategic framework, activities and milestones through which these ambitions can now be pursued over the period to 2035 (Figure 5.1).

Figure 5.1. Theory of change for implementation of the global roadmap for hypertensive disorders of pregnancy from 2026 to 2035 and beyond



The Theory of Change recognizes that these effects will not arise through a simple linear sequence. The five strategic areas operate as a reinforcing system. New research may lead to changes in guidance; implementation experience may identify new research or normative gaps; introduction of innovative products may require changes in financing, service delivery and workforce competencies; and advocacy may accelerate progress at any point by mobilizing political attention and resources. This reinforcing cycle of evidence generation, policy development, implementation, learning and refinement is already central to the Roadmap's design.

The Roadmap is therefore intended to change not only individual aspects of pre-eclampsia care, but the way the global community organizes its response to hypertensive disorders of pregnancy. For too long, progress has been constrained by fragmented research and innovation, inconsistent normative guidance, gaps in access to quality-assured health products, persistent implementation barriers and insufficient political attention and investment. The Roadmap provides a mechanism for aligning these previously fragmented efforts around common priorities, milestones and responsibilities. It identifies the absence of such a comprehensive global framework as an important obstacle to coordinated progress.

In the near term, successful implementation should lead to a greater alignment of research and investment priorities; clearer pathways for promising innovations; closer collaboration among global guideline developers; stronger coordination around product access; the development of national roadmaps and implementation mechanisms; and a more unified advocacy and accountability movement. These are important outcomes in their own right because they create an enabling environment for faster and more equitable uptake of effective interventions.

Over the medium and longer term, these changes should accelerate the generation, and translation into practice, of evidence; reduce unnecessary duplication; improve the

availability and affordability of medicines, diagnostics and medical devices; strengthen health-worker capacity and referral systems; and enable countries to deliver evidence-based prevention, diagnosis and treatment more consistently and equitably.

The ultimate impact, however, will be measured in the lives and health of women and newborns. Hypertensive disorders of pregnancy cannot be eliminated entirely, but much of the associated mortality and morbidity is preventable. Earlier identification of women at risk; effective prevention; timely diagnosis and treatment; access to quality-assured health products; functional referral systems; and high-quality care across pregnancy, childbirth and the postpartum period can substantially reduce preventable maternal, fetal and newborn deaths and complications.

The Roadmap therefore offers an ambitious but achievable vision: a future in which no woman or baby dies from preventable complications of hypertensive disorders of pregnancy. Its greatest impact should be seen in the countries and communities where the burden is highest, and progress has been slowest. By aligning evidence, innovation, policy, products, health systems, financing and accountability around that shared objective, the Roadmap provides an opportunity to accelerate progress towards global maternal and newborn health targets while reducing the profound inequities that currently exist.

Achievement of this impact depends on several assumptions: sustained political commitment; adequate domestic and international financing; willingness among stakeholders to coordinate rather than duplicate efforts; continued generation and translation of high-quality evidence; and the ability and willingness of countries to adapt and implement the Roadmap priorities within their health systems. These assumptions were already explicit in the Summit Theory of Change, particularly around stakeholder commitment, country adoption and financing. They should therefore form part of the Roadmap's monitoring and periodic review, rather than being treated as external conditions beyond its influence.

Progress towards the anticipated outcomes should be periodically reviewed against the Roadmap's milestones through 2035. Implementation experience, emerging evidence

and new innovations should be used to refine approaches and priorities over time, ensuring that the Roadmap remains a dynamic framework for coordinated action rather than a static plan.

6. Disseminating the Roadmap and Call to Action

The Roadmap and its Call to Action are planned for launch at the Society for Maternal-Fetal Medicine Global Congress, to be held in Utrecht, Kingdom of the Netherlands, from 7–10 October 2026. The launch will provide a global platform to present the Roadmap’s vision, priorities and milestones, mobilize stakeholders around the Call to Action, and initiate the next phase of coordinated action towards implementation. Publication of the Roadmap by WHO will be accompanied by a WHO press release and coordinated communications activities to increase its visibility among policy-makers, health professionals, researchers, funders, civil society, women and communities, and the wider public.

Following the launch, WHO and its partners – including participants at the Summit – will promote the Roadmap and Call to Action through global, regional and country office channels, including conferences, webinars, partner networks and other dissemination activities. Dissemination should seek not only to raise awareness of the Roadmap, but also to mobilize stakeholders around its priorities and support their translation into action. Different products and communication approaches will therefore be needed for different audiences, including policy-makers, programme managers, professional associations, researchers, funders, industry, civil society, women and communities.

WHO will develop supporting resources to facilitate understanding, adaptation and implementation of the Roadmap in different settings. The Roadmap and related resources will be shared through WHO regional and country offices, ministries of health, professional associations, WHO collaborating centres, United Nations (UN) agencies, CSOs, NGOs and other partner networks. They will also be

made available on the WHO/HRP website and promoted through WHO/HRP News, a monthly newsletter reaching more than 14 000 clinicians, programme managers, policy-makers and health service users worldwide.

To ensure that the evidence underpinning the Roadmap is widely accessible, the background analyses that informed the Summit and the development of the Roadmap are also planned for peer-reviewed publication as part of a focused issue in a reputable scientific journal. These publications will document the evidence, methods and processes underpinning priorities across the five strategic areas and provide a complementary evidence resource for researchers, policy-makers and programme implementers. Countries and partners will be encouraged to draw on these analyses, where relevant, when adapting the Roadmap to national and subnational contexts, setting priorities and developing implementation plans. Further peer-reviewed publications may document implementation experience and emerging lessons as the Roadmap progresses.

To broaden access, the Roadmap will be translated into the six official UN languages and disseminated through WHO regional and country channels. Additional translations, communication materials and derivative products may be developed or adapted for specific audiences and contexts, including materials that facilitate national advocacy, policy dialogue and implementation planning, as well as tailored resources for humanitarian and other fragile settings where needed.

Relevant WHO departments, regional and country offices, together with WHO-hosted partnerships such as PMNCH, and partners including FIGO, ICM, ISSHP, Align: and national professional associations, will have important

roles in amplifying the Roadmap through their constituencies and networks. Participants in the Summit should similarly serve as champions for the Roadmap, helping to communicate its priorities and mobilize action within their countries, organizations and professional communities.

Dissemination should be regarded as the beginning of implementation rather than an endpoint. The objective is not simply for the Roadmap, Call to Action and supporting

evidence to be widely accessed, but for their priorities to inform research investments; global and national guidance; product development and access strategies; national roadmaps and implementation plans; advocacy agendas; and financing decisions. In this way, dissemination will provide an early bridge between the global consensus achieved through the Summit and the sustained action required to deliver the Roadmap.

7. Monitoring and evaluating impact

Monitoring, evaluation and learning will be essential to maintain momentum, strengthen accountability and determine whether implementation of the Roadmap is producing the changes needed to improve outcomes for women and newborns. The monitoring framework should reflect the Roadmap's Theory of Change (Figure 5.1), tracking progress from implementation of priority activities and milestones, through changes in policies, products, health systems and clinical practice, to improvements in maternal, fetal and newborn outcomes and reductions in inequities.

Monitoring should complement, rather than duplicate, existing global maternal and newborn health monitoring mechanisms, notably the *Every Woman, Every Newborn, Everywhere Results Framework, 2022–2025 (20)*. Established maternal and newborn health indicators, country reporting systems and existing data platforms should be used wherever possible. The EWENE dashboard already provides a mechanism for governments and partners to assess progress against maternal and newborn health targets across countries and regions. Alignment with these systems will help embed monitoring of the Roadmap within the broader maternal and newborn health agenda and minimize additional reporting burdens on countries.

Existing global monitoring frameworks, however, do not provide a sufficiently specific picture of progress on hypertensive disorders of pregnancy. The Roadmap will therefore require a focused monitoring framework that combines existing indicators with a limited set of additional standardized indicators needed to track priorities and milestones. These should capture progress across the five strategic areas, and include research and innovation; development and uptake of normative

guidance; availability, affordability and quality of priority health products; national adoption and implementation; health-system readiness and quality of care; advocacy, financing and accountability; and ultimately maternal, fetal and newborn outcomes.

Monitoring should operate at three complementary levels. First, process and milestone indicators should determine whether the activities and commitments set out in the Roadmap are being delivered and whether progress is occurring according to the agreed timelines. Second, output and intermediate outcome indicators should assess whether these activities are producing the changes anticipated in the Theory of Change – for example, faster translation of evidence into policy and practice; improved availability of quality-assured health products; greater adoption of evidence-based policies and care pathways; and stronger health-system readiness. Third, impact indicators should assess changes in pre-eclampsia-related maternal, fetal and newborn mortality and morbidity, as well as inequalities in these outcomes. This approach will enable stakeholders to identify not only whether impact is occurring, but also where, along the pathway, progress is advancing or being constrained.

As an early priority, WHO, UNFPA, UNICEF, ministries of health and CSOs should collaborate on a scoping exercise to shape a global monitoring system for the Roadmap. The exercise should map existing indicators and data sources; identify critical measurement gaps; define a core set of standardized indicators; and determine appropriate reporting frequency, disaggregation and responsibilities for data collection, curation, analysis and communication. It should also establish sustainable arrangements for country-led

oversight, with women, affected communities and civil society actively involved in interpreting findings and identifying priorities for corrective action.

Progress should be reviewed periodically against agreed baselines, milestones and targets, with findings communicated transparently at global, regional and country levels. Monitoring should function as a mechanism for learning and course correction, not simply as an exercise in reporting. Periodic evaluations should examine whether Roadmap activities were implemented as intended; whether they produced the

anticipated outputs and intermediate outcomes; whether these translated into measurable improvements in coverage, quality, equity and health outcomes; and why progress may have differed across countries and settings.

The findings should inform decisions on priorities, financing, and implementation, and feed directly into periodic reviews and future updates of the Roadmap. In this way, monitoring, evaluation and learning will create a continuous cycle of implementation, measurement, learning and adaptation through 2035.

8. Planning future updates

The Roadmap is intended to be a dynamic framework for action through 2035, rather than a static plan. The evidence base, innovation landscape, normative guidance, product pipeline, country implementation experience, and global maternal and newborn health environment will continue to evolve over the coming decade. Implementation priorities and approaches will therefore need to adapt as new evidence, opportunities and challenges emerge.

A formal mid-term review will be undertaken in 2030 to assess progress against the Roadmap's activities, milestones and anticipated outcomes across all five strategic areas. The review should draw on the monitoring framework described in Chapter 7; implementation experience from countries; emerging research and innovations; changes in global normative guidance and health-product availability; and progress in political commitment, financing and accountability.

The mid-term review should assess what has been achieved, where progress is off track and why. It should also consider whether the Roadmap's priorities, activities, partnerships and timelines remain appropriate for achieving its goals by 2035. Particular attention should be given to dependencies between strategic areas and to whether progress in the five strategic areas – research and innovation; norms and standards; access to health products; implementation; and advocacy and accountability – is translating into the intermediate outcomes and public-health impact anticipated in the Theory of Change.

Based on the findings, the Roadmap may be revised in 2030 to update priorities, activities, milestones, responsibilities and targets for the remaining period to 2035. New priorities may also be incorporated where emerging evidence, technologies or implementation experience warrant them. Activities that have been completed, superseded or shown to be ineffective may be retired or redesigned.

The 2030 review should not, however, preclude earlier course correction. Progress should be reviewed throughout implementation, and important new evidence, innovations, changes in the policy environment or major implementation challenges should inform adjustments as they arise. Updates to individual components of the Roadmap – particularly global normative guidance – may therefore occur on different timelines, including through WHO's living guideline process, without requiring revision of the Roadmap as a whole.

The findings of the mid-term review and any resulting revisions should be communicated transparently to countries, partners and other stakeholders. Towards 2035, a final evaluation should assess progress against the Roadmap's overall goals and anticipated impact and identify priorities for sustaining progress beyond 2035. This evaluation should inform decisions on whether a successor global framework is needed and help shape the next phase of coordinated global action on hypertensive disorders of pregnancy.

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Annex: List of contributors

Participants at the Global Pre-eclampsia Summit, 5–8 May 2026

Name and affiliation	Declared interest(s)
Steering Committee members	
Hadiza Galadanci (co-chair) Bayero University Nigeria	None declared.
Caroline Homer (co-chair) Burnet Institute Australia	None declared.
Sabaratnam Arulkumaran St. George's University of London United Kingdom	None declared.
Lina Bergman International Federation of Gynecology and Obstetrics (FIGO) United Kingdom	Collaborates with the Swedish Pre-eclampsia Patient Organization on research priorities and is a member of the ISSHP Guidelines Group, the FIGO Working Group, and the Swedish Pre-eclampsia Working Group.
Gagan Gupta UNICEF United States of America	None declared.
Solomon Hailemeskel International Confederation of Midwives Kingdom of the Netherlands	None declared.
Ananth Karumanchi Cedars-Sinai Medical Center United States of America	Consulting fees from Roche Diagnostics and Comanche Biopharma; co-founder of Aggamin; named inventor on intellectual property held by Beth Israel Deaconess Medical Center and Cedars-Sinai Medical Center; research grant to institution from Thermo Fisher Scientific.
Koiwah Koi-Larbi Action on Preeclampsia Ghana Ghana	None declared.
Pete Lambert* Monash University Australia	None declared.
Alison Morgan Global Financing Facility United States of America	None declared.
Rachel Msimuko Zambia Medicines and Medical Supplies Agency Zambia	None declared.
Richard Mugahi Ministry of Health Uganda	None declared.

Name and affiliation	Declared interest(s)
Angela Muriuki Independent expert Kenya	Consultant to the Concept Foundation on pre-eclampsia diagnostics. Also provides consultancy services to the Gates Foundation on sexually transmitted infections and gynaecology, with no involvement in its pre-eclampsia programme or diagnostics work.
Angela Nguku White Ribbon Alliance Kenya Kenya	None declared.
Duncan Shikuku UNFPA Headquarters Kenya	None declared.
Sunita Tandulwadkar Federation of Obstetric and Gynaecological Societies of India (FOGSI) India	None declared.
Kadidiatou Toure Partnership for Maternal, Newborn and Child Health (PMNCH) Switzerland	None declared.
Eleni Tsigas Preeclampsia Foundation United States of America	None declared.
Scientific Committee members	
Azadeh Baghaki Health Impact Group Switzerland	None declared.
Joyce Browne University Medical Center Utrecht Kingdom of the Netherlands	Received funding from the Dutch Research Council (NWO), Gates Foundation and The Research Council of Norway for pre-eclampsia-related research—SPOT (Severe Pre-eclampsia adverse Outcome Triage) study; PRESHA (PREventing Severe Hypertensive Adverse events) study. Scientific advisory member of Action on Preeclampsia Ghana.
Virginia Diaz Centro Rosarino de Estudios Perinatales (CREP) Argentina	None declared.
Celina Gialdini CREP Argentina	None declared.
Annie McDougall Burnet Institute Australia	Received funding from the Gates Foundation for pre-eclampsia research, including the PEARLS (Preventing Pre-eclampsia: Evaluating AspiRin Low-dose regimens following risk Screening) and MATRIX (Maternal Health Advancement Through Rapid Innovation and eXploration) studies; from Global Grand Challenges for the MOSAIC (Model for OptimiSing Assessment of risk and Care for Pre-Eclampsia Prevention) study; and from Unitaid for a pre-eclampsia-related study under the SUPREME (Sustained Uptake of Products for Pre-Eclampsia and Maternal Anemia) initiative.
Uzma Syed Acing Health Canada	None declared.

Name and affiliation	Declared interest(s)
Joshua Vogel Burnet Institute Australia	Receives research fellowship support from the Government of Australia through the National Health and Medical Research Council (NHMRC), provided to employer, the Burnet Institute, supporting salary and research activities including the PEARLS (Preventing pre-eclampsia: Evaluating AspiRin Low-dose regimens following risk Screening) Trial and MATRIX (Maternal health Advancement Through Rapid Innovation and eXploration research) platform.
Caitlin R. Williams Mirae Insights United States of America	None declared.
Other participants	
Edgardo Abalos Centro de Estudios de Estado y Sociedad (CEDES) Argentina	None declared.
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Moufalilou Aboubakar Ministry of Health Benin	None declared.
Abiodun Aboyeji Society of Gynaecology and Obstetrics of Nigeria (SOGON) Nigeria	None declared.
Hisseine Adanao Ministry of Public Health and Prevention Chad	None declared.
Adeniyi Aderoba WHO Regional Office for Africa Congo	None declared.
James Agada National Agency for Food and Drug Administration and Control (NAFDAC) Nigeria	None declared.
Asif Ahmed MirZyme Therapeutics Ltd United Kingdom	Founder, CEO and majority shareholder (>75%) of MirZyme Therapeutics Ltd, a company developing diagnostics and therapeutics for pre-eclampsia and vascular disease. Recipient of research funding from public and grant bodies supporting the development of pre-eclampsia diagnostics and therapeutics. Declared potential indirect benefit to the company from advances in maternal health policy and innovation. Participated in this meeting in an expert capacity.
Qurratul Ain Federal Government Polyclinic Pakistan	None declared.
Harriet Andrews PATH Kenya	None declared.

Name and affiliation	Declared interest(s)
Shabina Ariff The Aga Khan University Pakistan	None declared.
Diogo Ayres de Campos European Board and College of Obstetrics and Gynaecology (EBCOG) Portugal	None declared.
Charlotte Bakker European Medicines Agency (EMA) Kingdom of the Netherlands	Previously employed as a researcher by the Centre for Human Drug Research, a clinical research organization. No current financial interests or ongoing involvement with the organization.
Kelsey Barrett* Unitaid Switzerland	None declared.
Ferdousi Begum Ibrahim Medical College Bangladesh	None declared.
Rachid Bezaoui University Hospital Center Ibn Sina Rabat Morocco	None declared.
Titus K. Beyuo Government of Ghana Ghana	Travel support received from the Parliament of Ghana in relation to participation in this meeting. The individual is a Member of Parliament of Ghana.
Frehiwot Birhanu Clinton Health Access Initiative (CHAI) United States of America	None declared.
Kara Boeldt EndPreeclampsia.org United States of America	Paid patient consultant and Patient Advisory Working Group member for Comanche Biopharma on an investigational pre-eclampsia therapeutic (current). Founder of EndPreeclampsia.org, recipient of a Patient-Centred Outcomes Research Institute (PCORI) engagement award (completed December 2025) to support patient-centred outcomes research capacity in hypertensive disorders of pregnancy.
Solomon Bosa Ministry of Health and Medical Services Solomon Islands	None declared.
Lian Chen Peking University Third Hospital China	None declared.
Doris Chou WHO Headquarters Switzerland	None declared.
Robyn Churchill Pact United States of America	Provided pro bono support to CHAI in 2025. No financial remuneration was received.
Catherine Cluver Stellenbosch University South Africa	Receives consultancy support from companies involved in the development of novel therapeutics for pre-eclampsia (DiaMedica Therapeutics, Beech Biotech, Araka Therapeutics Inc., GondolaBio and Avilar Therapeutics). Investigator-sponsored research is being conducted to evaluate DM199 as a potential treatment for pregnancy complications, including pre-eclampsia (DiaMedica Therapeutics). Investigator-sponsored research is being conducted to evaluate metformin to treat and prevent pre-eclampsia (Merck KGaA Darmstadt).

Name and affiliation	Declared interest(s)
Arri Coomarasamy University of Oxford United Kingdom	None declared.
Maria Laura Costa Universidade Estadual de Campinas (Unicamp) Brazil	Received research support from QuidelOrtho for a biomarker study related to pre-eclampsia.
Fabricio da Silva Costa Griffith University Australia	Research support from Thermo Fisher Scientific through provision of materials for ongoing studies evaluating sFlt-1/PlGF biomarkers.
Rohan D'Souza McMaster University Canada	None declared.
Manjula Danansuriya WHO Regional Office for South-East Asia India	None declared.
Djima Patrice Dangbemey Ministry of Health Benin	None declared.
Indranil Das Ministry of Health and Family Welfare India	None declared.
Leandro de Oliveira Universidade Estadual Paulista (Unesp) Brazil	Received funding from QuidelOrtho Brazil for a single invited presentation on biomarkers in pre-eclampsia on Pre-eclampsia Day 2025. No current involvement with the company.
Seydou Diallo Ministry of Health and Social Development Mali	None declared.
Saidu Abdulhadi Diyo Federal Ministry of Health Nigeria	None declared.
Tony Duan Shanghai First Maternity and Infant Hospital, Tongji University School of Medicine China	None declared.
George Eleje Nnamdi Azikwe University Nigeria	None declared.
Esmahan Elkheir Federal Ministry of Health Sudan	Participates in technical activities and consultations with the Federal Ministry of Health, Sudan. No separate financial remuneration for speaking engagements declared.
Nasser El-Kholy Eve Health Care Centre Egypt	None declared.
Jayne Ellis JEMMDx United Kingdom	Independent consultant to Lepzi Ltd, providing clinical, regulatory and scientific support for development and evaluation of point-of-care placental growth factor (PlGF) diagnostic tests (current; supported by the Gates Foundation).
María Fernanda Escobar Vidarte Fundación Valle del Lili Colombia	None declared.
Sheila Juliet Eshiwani Roche Diagnostics Kenya	Works for Roche Diagnostics, a manufacturer of sFlt/PlGF biomarkers used to predict or rule out pre-eclampsia.

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Avelino García García Ministry of Public Health Cuba	None declared.
Karima Gholbzouri WHO Regional Office for the Eastern Mediterranean Egypt	None declared.
Shivaprasad Goudar KLE Academy of Higher Education and Research India	None declared.
Yahya Gulzar WHO Pakistan	None declared.
Joseph Haddad International Pediatric Association (IPA) Switzerland	None declared.
Jon Hyett Western Sydney University Australia	Current research support from Revvity through loan of analysers for a point-of-care PIGF measurement research project. Received past travel support from Thermo Fisher Scientific (2025) for a pre-eclampsia-related meeting.
Jeffrey Jacobs MSD for Mothers United States of America	Holds a current full-time employment position with MSD for Mothers, a programme of Merck, and receives salary remuneration.
Catherine Kakolo Mongella Thrive Beyond Preeclampsia Foundation United Republic of Tanzania	Chair of Thrive Beyond Preeclampsia Foundation, a patient-led local organization co-founded by pre-eclampsia survivors. Represents and advocates for the foundation during scientific conferences. Previously received support from Beyond Birth Consortium (ceased) and WACI Health (ceased). Current non-monetary involvement with the PRESHA (PREventing Severe Hypertensive Adverse events) study.
Richard Kalisa WHO Rwanda	None declared.
Theopista Kabuteni WHO Rwanda	None declared.
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Tina Lavin WHO Headquarters Switzerland	None declared.
Qi Liu SEEK Development Germany	None declared.
Frank Louwen FIGO United Kingdom	None declared.
Laura A. Magee King's College London United Kingdom	Past President of ISSHP and lead of ISSHP guideline development (2021; 2026 update ongoing). Research support received from the National Institute for Health and Care Research (NIHR) for timing-of-birth research and from the Fetal Medicine Foundation for pre-eclampsia research. Received expert opinion fees from the Canadian Medical Protective Association. Indirect research support received from QuidelOrtho (PIGF testing kits) and educational support through the Fetal Medicine Foundation World Congress.
Hadil Yousif Masri Rozana Occupied Palestinian territory, including east Jerusalem	None declared.
Elhadji Thierno Mbengue Ministry of Health and Social Action Senegal	None declared.
Shireen Meher University of Sydney Australia	Chief Investigator of a randomized controlled trial of calcium supplementation for the prevention of pre-eclampsia funded by the National Institute for Health and Care Research (NIHR) (completion scheduled for July 2026). Chief Investigator of a randomized controlled trial evaluating a β 3-adrenergic agonist for treatment of severe pre-eclampsia, funded by Ramsay Hospital Research Foundation (RHRF) and Heart Foundation, Australia (commencing mid-2026).
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Sonia Muliyl The Lancet Obstetrics, Gynaecology, and Women's Health United Kingdom	None declared.
Angel Mwiche Ministry of Health Zambia	None declared.
Sidrah Nausheen The Aga Khan University Pakistan	None declared.
Victor Ndicunguye Jhpiego Rwanda	None declared.
Norbert-Richard Ngbale Ministry of Public Health and Population Central African Republic	None declared.

Name and affiliation	Declared interest(s)
Marijuzca Nicolas Department of Health Philippines	Currently, Programme Manager of the National Safe Motherhood Program, Department of Health, Philippines. Role includes work related to the prevention and management of maternal complications, including pre-eclampsia; participation in the Summit is in an official capacity.
Lisa Noguchi Align: United States of America	Receives salary remuneration from Johns Hopkins University/Jhpiego. Employer receives funding from Unitaidd related to pre-eclampsia work.
Emma Nordenstedt Swedish Preeclampsia Association Sweden	Has received payments or honoraria for public speaking on topics related to the subject of this WHO meeting. Has also held positions involving representation of interests or advocacy related to the subject matter of the meeting.
Loise Nyanjau Ministry of Health Kenya	Holds a salaried position with the Ministry of Health.
Hiromi Obara Japan Institute for Health Security Japan	None declared.
Idyoro Joseph Ojukwu Juba Teaching Hospital South Sudan	None declared.
Pius Okong Ministry of Health Uganda	None declared.
Nan Okun Society of Obstetricians and Gynaecologists of Canada (SOGC) Canada	Member of SOGC and attending the meeting in an official capacity to support knowledge exchange and guideline development. Medical Co-Director for BORN Ontario/ Prenatal Screening Ontario, received payment for consultancy related to prenatal screening and policy/ guideline development. No commercial interests or investments declared.
Abisola Oladapo-Asher CoreLoop United States of America	None declared.
Olufemi Oladapo WHO Headquarters Switzerland	None declared.
Aris Papageorgiou University of Oxford United Kingdom	None declared.
Donald Vianney Pathe Mo-Ndang-Nenso Ministry of Health and Population Central African Republic	None declared.
Liona Poon FIGO China, Hong Kong SAR	Declared financial and non-financial interests related to pre-eclampsia diagnostics and research, including speaker fees (GE HealthCare), consultancy (Samsung Healthcare), research funding (Ferring Pharmaceuticals), in-kind support including ultrasound equipment, PLGF reagents and software licences (GE HealthCare, Samsung Healthcare, Revvity, Thermo Fisher Scientific, Roche Diagnostics, Ningbo Aucher Biological Technology Co., Ltd., Astraia GmbH), and leadership of PregnaSense Co. Limited (CEO; no remuneration).

Name and affiliation	Declared interest(s)
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Yogesh Rajkotia ThinkWell United States of America	None declared.
Sarosh Rana International Society for the Study of Hypertension in Pregnancy (ISSHP) United States of America	President of ISSHP and leading the development of ISSHP 2026 Guidelines. Current and recent consultancy relationships with diagnostic companies, including Thermo Fisher Scientific (2024–2026), Roche Diagnostics (2025–2026), and Siemens Healthineers (2023).
Musarrat Rani Midwifery Association of Pakistan Pakistan	None declared.
Stephen Rulisa Eagle Research Centre Rwanda	None declared.
Elvis Safary FIND Switzerland	None declared.
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Elaine Scudder International Rescue Committee United States of America	None declared.
Hailemariam Segni Abawollo Ethiopian Society of Obstetricians and Gynaecologists (ESOG) Ethiopia	Travel costs for participation in this WHO meeting covered by the Ethiopian Society of Obstetricians and Gynecologists.
Mohammad Shahidullah Projahnmo Research Foundation Bangladesh	None declared.
Apoorva Sharan CIFF India	None declared.
Phineas Sospeter Ministry of Health and Social Welfare United Republic of Tanzania	None declared.
Anne Cathrine Staff University of Oslo Norway	Vice-President of ISSHP. Received in-kind support of sFlt-1 and PlGF analytes from Roche Diagnostics.
Deveree Stewart Caribbean Regional Midwives Association Jamaica	None declared.
Andrew Storey Impact Nexus Africa South Africa	None declared.
Sabo Umar Suleiman Murtala Muhammad Specialist Hospital Nigeria	None declared.
Musarrat Sultana Ministry of Health and Family Welfare Bangladesh	None declared.
Lydia Sung SEEK Development Germany	None declared.

Name and affiliation	Declared interest(s)
Samar Taha Ministry of Health Occupied Palestinian territory, including east Jerusalem	None declared.
Catharine Taylor Independent expert United Kingdom	Consultancy support received from UNFPA for maternal, newborn and child health activities, including travel support for participation in the Summit while representing UNFPA. Previous consultancy relationship with MSD for Mothers (ended December 2024).
Romane Théoleyre* Unitaid Switzerland	None declared.
Patricia Titulaer Laerdal Global Health Norway	None declared.
Julia Tuttle CHAI United States of America	Has stock in Thermo Fisher Scientific ceasing June 2026.
Lisine Tuyisenge IPA Rwanda	None declared.
Udamage Don Puspananda Ratnasiri Asia and Oceania Federation of Obstetrics and Gynaecology (AOFOG) Sri Lanka	None declared.
Manu Vatish Gates Foundation United States of America	Received financial support from Thermo Fisher Scientific (ceased) prior to joining the Gates Foundation.
Marleen Vellekoop Every Pregnancy United Kingdom	None declared.
Peter Waiswa Makerere University School of Public Health Uganda	None declared.
Holly Warner SEEK Development Germany	None declared.
Charlotte E. Warren Independent expert United Kingdom	Provided consultancy/advisory services to organizations with interests related to the subject of the meeting or work within the past four years.
Sarah Webb Reproductive Health Supplies Coalition United States of America	Employed by an organization with an interest related to the subject of the meeting or work within the past four years.
Blair Wylie Society for Maternal-Fetal Medicine (SMFM) United States of America	Received partial travel support from the Society for Maternal-Fetal Medicine.
Emily Wymer SEEK Development Germany	None declared.
Mike Young Comanche Biopharma United States of America	Founder, employee and shareholder of Comanche Biopharma, a pharmaceutical company developing assets related to pre-eclampsia. Holds equity interests in the company.
Ebongo Zacheus Nanje Ministry of Public Health Cameroon	None declared.

* Unable to attend the Summit in person

For more information, please contact:

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