From the Womb to the Ward: Protecting Newborns and Infants through Maternal Immunization

Findings from the Maternal Immunization Readiness Network in Africa and Asia (MIRNA) Partner Session

ICM Triennial Congress

Lisbon, 16 June 2026

About the Session

On 16 June 2026, Maternal Immunization Readiness Network in Africa and Asia (MIRNA) hosted an interactive partner session at the International Confederation of Midwives (ICM) Triennial Congress. The aim of this session was to seek counsel from midwives in preparing for the introduction of new maternal vaccines, including RSV vaccines and future Group B Streptococcus (GBS) vaccines. Around 50 midwives, clinicians, researchers, and maternal health leaders from around the world participated in the discussion. The session combined expert presentations on the disease burden and vaccine landscape with facilitated small-group discussions on safety and efficacy, ANC scheduling, co-morbidities, and vaccine counseling. This document synthesizes what participants shared across those discussions.

At the heart of our discussion were the following best practices for vaccine counseling, according to midwives:

- Begin with open-ended questions: "What have you heard about this vaccine?" or "What concerns do you have?", before providing any information
- Listen first, with an open mind and without judgment
- Present a complete picture: discuss both the benefits of vaccination and the risks of the diseases themselves; conversations that focus only on vaccine risks, without discussing disease burden, leave women with an incomplete basis for decision-making
- Position vaccination within the broader maternal and child health journey—as one of many interventions intended to support healthy pregnancies and healthy infants
- Treat women as active participants in decision-making, not passive recipients of clinical recommendations

Key Themes

(1) Trust is foundational. Trust is not about information alone—it is about relationships.

The most consistent thread across every discussion was trust. ICM President Sandra Oyarzo Torres opened the meeting with this framing: trust is built when midwives listen carefully, communicate clearly, respect women's autonomy, and provide care that reflects each woman's values and circumstances. It is not a product of information delivery.

Several participants noted that women often arrive at antenatal visits having already been exposed to information about vaccination in pregnancy (accurate and otherwise) and they depend on their midwives to receive their questions with an open mind and heart. The success of these conversations depends on a careful balance of clinical information and evidence and compassionate, neutral framing and engagement. Shame and judgment, participants emphasized, actively undermine vaccine confidence, while respect and open inquiry build it.

The following can build trust:

- Listening before speaking
- Open-ended questions that invite women to share what they already know and what concerns them
- Clear communication, free of jargon
- Respect for women's autonomy and the contexts in which they make decisions
- Privacy and confidentiality in consultations
- Checking for understanding, not just providing information
- Welcoming questions rather than deflecting

(2) Trust takes time. Counseling is a process, not a single conversation.

Participants were clear that a single antenatal visit is rarely sufficient to support confident decision-making about vaccination in pregnancy. Conversations should begin early in pregnancy – at the first antenatal visit – and continue throughout each ANC contact; each conversation lays groundwork for the next. Midwives spoke of the need to openly and neutrally invite women to share their own questions or reflections about vaccines, to assess previous and current vaccination history, and to use the conversation to shape how new vaccines are introduced into counseling. The contrast

between ANC contexts was striking: some participants described women receiving hour-long consultations at each ANC touchpoint; others received no more than fifteen minutes. Yet there was broad agreement: creating space to discuss, query, and counsel for vaccination in pregnancy – even within busy, overburdened ANC programs – is critical.

Family influence and shared decision-making was identified as another significant factor when counseling for vaccination in pregnancy. Women receive advice from partners, mothers, grandmothers, and others whose views will shape their decisions about which interventions to accept in pregnancy. One participant offered a useful analogy to engage with family members who may not recognize new vaccines as necessary simply because they are unfamiliar: previous generations did not use car seats the way we do today, but that does not make car safety any less important. New knowledge brings new tools to protect women and babies, vaccines among them.

(3) Midwives need practical, experiential, disease-specific knowledge.

Knowledge domains participants identified as essential:

- Disease burden and how these illnesses present in neonates and infants
- The consequences of severe RSV and GBS disease, including long-term outcomes (e.g., neurological impairment, RV, asthma)
- Tools to support clear and neutral information sharing regarding vaccine safety and efficacy, potential side effects, and those who may be contraindicated for receipt of vaccination in pregnancy
- Guidance for eligibility criteria and accurate gestational age assessment
- Identification of who is authorized to administer vaccines in a given country or setting (this will vary significantly by context)

Where participants said they get—or would like to get—this information:

- Professional midwifery associations
- Conferences and cross-country learning opportunities
- National guidelines
- Online webinars and peer networks
- Direct participation in research

Confident vaccine counseling depends on understanding not only vaccines but the diseases they prevent. Many midwives have never seen a baby with severe RSV disease, neonatal tetanus, or GBS sepsis. When the consequences of vaccine-preventable diseases are invisible, it becomes even more important that midwives are equipped with the knowledge and evidence to communicate why maternal vaccines are so important and what they are protecting a mother's baby against.

The patient stories shown during the session, from a family affected by RSV in South Africa and a family affected by GBS in Kenya, were described as among the most powerful elements of the day. Stories make abstract risk real in a way that data alone does not.

Notably, participants also expressed that engaging midwives directly in research activities is incredibly valuable. When midwives participate in research, they build a deeper understanding of the evidence, develop confidence in the findings, and become stronger advocates and educators within their own settings.

(4) Fully integrating maternal immunization into routine ANC is challenging but critical.

Antenatal care visits are already dense. There was consensus across multiple groups that maternal immunization cannot be bolted on as a separate, standalone programme; it needs to be woven into the existing care continuum so that women expect it as part of a comprehensive package. In settings where tetanus toxoid has historically been the only

Practical adaptations discussed:

- Flexible scheduling and drop-in opportunities to reduce barriers to additional visits
- Gestational age assessment: some settings have early ultrasound; others rely on last menstrual period; point-of-care ultrasound is improving access in some contexts and may support more accurate timing
- Peer-to-peer approaches: women hearing from other women who have been vaccinated and can speak to their experience
- Integrating vaccine information and documentation into existing ANC tools and registers
- Clarifying referral pathways where vaccination is not delivered by the primary ANC provider

maternal vaccine, introducing RSV—and eventually GBS—will require policy development, provider education, community engagement, and updated materials from the outset.

(5) Women's voices, lived experience, and respectful care must remain central.

Participants emphasized that vaccine counseling should feel like a dialogue, not a clinical transaction. Lessons can be applied from family planning counseling, where the field has invested years in developing frameworks for respectful, autonomy-supporting conversations.

Participants also highlighted that the value of sharing lived experiences with vaccine-preventable diseases extends beyond individual counseling. Stories from families affected by RSV and GBS were described as essential not only for communicating with women and families, but for engaging the workforce, policymakers, and the broader community.

Implications for MIRNA

The discussion generated clear signals for MIRNA's readiness work and future engagement with midwives.

- **Training and resource development** should integrate disease-specific knowledge with vaccine information, not as separate curricula but as connected content that helps midwives understand what they are preventing, not only what they are administering. Patient stories and family testimonies should be developed as tools for both counseling and advocacy.
- **Counseling frameworks** that midwives can adapt for constrained ANC programs are needed. Practical guidance should draw from what has worked in the past – for example existing World Health Organization and family planning frameworks – to develop brief, structured counseling approaches that are usable across visits and grounded in respectful, patient-centered care.
- **Integration into ANC systems and materials** requires working within country programmes, not alongside them. Stakeholder engagement should prioritize connecting with those responsible for ANC protocols and training to embed maternal immunization into the routine package from the outset.
- **Midwife engagement in research and implementation** is both a readiness strategy and a trust-building exercise. Expanding pathways for midwives to participate—not only as subjects of readiness assessments but as active contributors—will strengthen the readiness network and its reach.
- **What participants said they still need.** Closing feedback from the session pointed to three recurring gaps: tools and resources to help midwives respond confidently and respectfully when women bring misinformation into consultations; disease-specific educational content that makes conditions like RSV and GBS concrete and meaningful in their local contexts; and ongoing connection with a peer community working on the same challenges.
- **The motivation for action is already there.** Participants came with clear purpose. Many sought to strengthen vaccine confidence and counter misinformation; others were focused on the urgent need to access and use maternal vaccines to prevent diseases, especially in low- and middle-income countries where the burden is greatest. Both reflect a shared conviction that midwives have a critical role to play, and that the time to prepare is now.

Acknowledgements

We are grateful to Sandra Oyarzo Torres, President of the International Confederation of Midwives, for opening this session and setting its tone, reminding us that trust is built through relationship, and that midwives must be present from the beginning as maternal immunization programs expand.

Thank you to our speakers: Lisa Noguchi, Director of Maternal and Newborn Health and Co-Director of Nursing and Midwifery at Jhpiego, for grounding the session in the history and evidence of maternal immunization and the centrality

of counseling; and Amy Wise, Senior Lecturer at the University of the Witwatersrand, for bringing us up to date on new RSV and GBS vaccines and equipping participants with the clinical evidence—safety, efficacy, and disease burden data—they need to confidently introduce and support these maternal vaccines in their settings. We also thank the facilitators who guided and captured the small-group discussions: Amy Wise and Lisa Noguchi joined by Julie Nyanchama, midwife and MIRNA Study Manager, and Olive Tengera, midwife and ICM Regional Board Member for Africa, whose leadership shaped the discussion and reporting throughout the session.

We would also, and especially, like to thank Dr. Judy van Aart and Hellen Odhiambo for their courage and their generosity. Sharing deeply personal experiences – caring for a newborn with severe disease, losing a baby before birth – brings immense meaning to our work. We honor the families – and the mothers – whose experiences remain at the heart of this work.

Finally, we thank the approximately 50 midwives and maternal health professionals who joined us from across Africa, Asia, Europe, and the Americas.