PMNCH 2021-2025 STRATEGY
First Full Draft for Consultation

18th May 2020
EXECUTIVE SUMMARY

[To be drafted for June 30th Board draft. Probably a Foreword from the Board Chair + a 1 page schematic summarising the Strategy (as per Section 4 Theory of Change)]
1. CONTEXT

Global burden of Women’s, Children’s & Adolescents’ Health & Well-Being

Major gains have been made in Women’s, Children’s & Adolescents’ Health and Well-Being (WCAH) over the last three decades. Life expectancy has dramatically increased and mortality rates of children under five have more than halved. This has been driven by better access to health services and improved health service delivery; and also by improvements in other sectors such as economic development, education, social protection, water and sanitation. Partnerships have been central to this progress – aligning old and new actors behind shared goals, strong political leadership, increased resources, better delivery and a sustained drive for results.

Yet there are very large inequities in health coverage and outcomes, and a growing double burden of ill-health: not only communicable diseases, but also non-communicable diseases (NCDs), injuries, violence and mental health. In some areas, the global health response is clearly inadequate, and will be further compounded by the impact of COVID-19. These areas include:

(i) the ‘unfinished business’ of the Millennium Development Goals (MDGs) – amenable Maternal and Child Mortality, including Newborn deaths and Stillbirths – particularly in sub-Saharan Africa, South Asia and almost everywhere in humanitarian and fragile settings;

(ii) orchestrated political challenges to Sexual and Reproductive Health & Rights (SRHR);

(iii) a growing and largely unaddressed burden relating to Adolescent Health and Well-being.

It is these three challenges in particular that will frame PMNCH’s engagement over the coming years.

Challenges in MNCH, SRHR & Adolescents

- the Maternal Mortality Rate in least developed countries is more than 40 times higher than in Europe. In 2018 it was estimated that almost half of Under 5 deaths were occurring in the neonatal period and that only half of small and sick newborns have access to quality care. That mothers and children continue to die is the true marker of the inequalities in health systems.

- As a result of COVID-19, some partners are estimating a decline of 80% in SRHR services. The Guttmacher Institute estimates that even a 10% decline in use of short- and long-acting reversible contraceptive methods would result in an additional 49 million women with an unmet need for modern contraceptives and an additional 15 million unintended pregnancies over just one year.

- Adolescent death rates globally are not declining as fast as deaths among children aged between one month and four years, partly because of the rise in AIDS-related adolescent deaths. Among adolescents and young adults, mental health and substance use issues, such as anxiety, depression, and alcohol and drug abuse, are the leading causes of ‘Years Living with Disability’.

At the time of writing, the world also faces a global health pandemic without historical precedent. COVID-19 presents a massive shock to an already struggling global health system and world economy. The Sustainable Development Goals (SDGs) ushered in an ambitious agenda to “Ensure healthy lives and promote well-being for all at all ages”, including both the unfinished MDG agenda and a renewed focus on Universal Health Coverage (UHC) and on NCDs. Not only has progress on the SDGs been slow and uneven, but COVID-19 has magnified social and economic inequalities, as well as deep inequities in health coverage and outcomes. It further threatens the achievement of the SDGs, both health-related and also SDGs in those sectors that are determinants of health outcomes such as economic development, education, water and sanitation and early childhood development.
The response and aftermath to this pandemic will change the global economy and will change public health. This pandemic may be time-bound but the issue is systemic, as must be the world’s response. Looking forward, we should accept nothing less than a radical, broad, well-resourced and sustained focus on public health, on health systems and on public health professionals; particularly the health of the most vulnerable women, children and adolescents. Partnerships in global health have never been more important; and nor has the voice of PMNCH and its 1,000 members.

“We are as strong as the weakest of our health systems... There is an opportunity to rebuild differently, but this will require much more effective international cooperation.” UN Secretary General António Guterres (31/4/20)

PMNCH in the global health landscape

The global health landscape has proliferated over the decade and a half of PMNCH’s existence. With governments at its centre, supported by a range of actors playing roles in research, normative guidance, advocacy, financing and the delivery of services. WHO and the UN Funds and Programmes are providing normative and technical leadership and the International Financial Institutions and the thematic funds providing international funding complementary to domestic budgets. An increasing number of partnerships cover different areas of thematic interest.

It is a landscape in many ways not built for 21st Century challenges: new economic, social and health challenges, foremost of which is climate change and now the COVID-19 pandemic; sustained structural inequalities, worsening in many regions; a weakening of traditional institutions, and, in many countries, democratic and civic space. In this landscape – fragmented and with multiple competing aims and interests – PMNCH plays a unique role as a partnership: aligning diverse partners around the importance of women’s, children’s and adolescents’ health, and supporting evidence-based advocacy for change and accountability for outcomes. The next Section seeks to define PMNCH’s distinct value proposition in this complex world of new threats, and, indeed, opportunities.

2. PMNCH VALUE PROPOSITION

Value Proposition

PMNCH is the world’s largest alliance for women’s, children’s and adolescents’ health and well-being. It provides a platform for organisations to align objectives, strategies and resources, and to advocate for and deliver interventions to improve maternal, newborn, child and adolescent health. PMNCH’s core value proposition is three-fold:

- **thematic focus:** PMNCH is the only global health partnership focusing on women’s, children’s and adolescents’ health and well-being and on the continuum of care;
- **breadth of the Partnership:** PMNCH, as of 2020, has more than 1,000 partners, organised into ten constituencies (see opposite), across 192 countries; no other partnership has the breadth, diversity and penetration of PMNCH;
➢ **convening power**: PMNCH has the power to convene at the highest level and execute with pace and urgency through a global network of partners (country, regional, global levels); hosted by the World Health Organisation (WHO) but with independent governance and with the richness and breadth of its large, diverse Constituency membership.

**Shaping the global response to women’s, children’s and adolescents’ health (2021-2025)**

There are huge opportunities to shape a more effective global response to women’s, children’s and adolescents’ health and well-being over the coming five years: significant global progress in core indicators relating to maternal and child mortality; rapid advancements in science and technologies for prevention and treatment of health conditions; an increasingly connected and digitally-enabled world reducing distance and increasing cooperation. And a collective appreciation, as the world navigates in and a way out of the COVID-19 pandemic, of the importance and value of strong health systems, of well-resourced health care professionals, and of economic safety nets for the most vulnerable.

It will be critical for the next five years to line up behind an agreed and common agenda for accelerated action for women’s, children’s and adolescents’ health, and to use that agenda to drive measurable progress, with a particular focus on the most vulnerable populations. In moving forward, we will also learn from the past. Over 2019/20, an External Evaluation was conducted of PMNCH. The textbox below lists selected findings and recommendations of the Evaluation, together with how they have been addressed in this Strategy.

<table>
<thead>
<tr>
<th>PMNCH’s achievements over the last decade</th>
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<tr>
<td>➢ giving voice to over 7,000 organizations worldwide by facilitating consultations on the SDGs for Health and on the ‘Every Woman Every Child’ Global Strategy for Women’s, Children’s and Adolescents’ Health</td>
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<tr>
<td>➢ building the ‘Every Women Every Child’ movement to orchestrate US$88 billion in concrete, measurable commitments for the Global Strategy since 2010, and tracking their progress</td>
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<td>➢ helping to secure global agreements between the 192 Member States of the United Nations through the UN General Assembly and the World Health Assembly (e.g. the SDGs and the ‘Every Newborn Action Plan’)</td>
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<td>➢ ensuring visibility of MNCH and the inclusion of SRHR in Member State Resolutions on Universal Health Coverage (UHC)</td>
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<td>➢ developing broad-based partner initiatives and agreements (e.g. ‘Ending Preventable Maternal Mortality; ‘Nurturing Care for Early Childhood Development’ Framework)</td>
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<td>➢ development of the Global Consensus Statement on Meaningful Adolescent &amp; Youth Engagement endorsed by over 250 organizations in 2018, and building youth capacity through grants to develop coalitions and undertake joint advocacy and accountability work</td>
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<td>➢ securing resolutions in support of women’s and children’s health by the 140 parliaments of the Inter-Parliamentary Union (IPU)</td>
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<tr>
<th>Lessons learnt from the PMNCH External Evaluation (2019/20)</th>
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<tr>
<td>Evaluation findings / recommendations (selected)</td>
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<tr>
<td>PMNCH’s vision and mission remain relevant, valid and urgent</td>
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<td>PMNCH has been pulled in too many directions</td>
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<td>PMNCH’s main value addition is its Advocacy function and convening power</td>
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<td>PMNCH’s Governance is heavy and time-intensive</td>
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</table>
PMNCH should strengthen its partner engagement processes

Operationalize Digital Strategy and put in place effective and innovative partner engagement mechanisms; priority focus for Strategy implementation

PMNCH should clarify its approach to country engagement

PMNCH role in country and regional engagement processes rationalized and clarified; priority focus for Strategy implementation

PMNCH should develop a new Strategy, with a clear Theory of Change and Results Framework

PMNCH 20021-2025 Strategy produced, with clear Theory of Change and Results Framework, and clearer description of Partnership roles and accountabilities

We anticipate that the changes outlined above, together with additional reforms to PMNCH’s business model detailed in this Strategy, will result in a more focussed and dynamic partnership over the coming five years. We are on a ‘campaign footing’, equipped to mobilise our 1,000 plus partners behind the needs and demands of women, children and adolescents worldwide.

3. VISION & MISSION

The vision of PMNCH is ‘A world in which every woman, child and adolescent realizes their right to health and well-being, leaving no one behind’.

This is the world to which PMNCH wishes to make a distinct and measurable contribution.

The mission of PMNCH is ‘To mobilize, align and amplify the voice of partners to advocate for women’s, children’s and adolescents’ health and well-being, particularly the most vulnerable’.

This is the distinct functional contribution that PMNCH seeks to make to that vision, leveraging the power of partnerships to drive results for women’s, children’s and adolescents’ health and well-being.
4. THEORY OF CHANGE

The Theory of Change (see Annex 1) that underpins this Strategy has five components that together propose how PMNCH will contribute to the SDGs and to sustainable improvements in women’s, children’s and adolescents’ health and well-being, especially for the most vulnerable.

i. Problem Statement (the problems that PMNCH is trying to address)

- **Maternal, Newborn & Child Health (MNCH)**: the unfinished agenda of the MDGs (preventable maternal and child mortality, including newborns & stillbirths); particular focus on humanitarian & fragile settings
- **Sexual, Reproductive Health & Rights (SRHR)**: morbidity and mortality relating to SRHR; politicization of SRHR and threats to rights
- **Adolescents**: a growing and largely unaddressed burden relating to Adolescent Health and Well-being

ii. Objectives (the corresponding Objectives PMNCH will pursue for the Strategy period)

- **Maternal, Newborn & Child Health (MNCH)**: amplifying action to reduce preventable MNC mortality and morbidity, including stillbirths, by stimulating the integration of essential WCAH interventions in UHC and enhancing high-quality services
- **Sexual, Reproductive Health & Rights (SRHR)**: enhancing and aligning advocacy to uphold essential SRHR interventions and ensure continuous progress on financing and equitable access to comprehensive SRHR packages
- **Adolescents**: advancing the health and well-being of adolescents by engaging, aligning and capacitating partners around the Adolescent Health and Well-Being Framework and related policy and action

iii. Functions (how PMNCH will deliver these Objectives)

- **Advocacy** as PMNCH’s core function, supported by three main approaches:
  - **knowledge synthesis & application**: synthesising and packaging data and evidence to identify and illustrate gaps in progress; inform advocacy ‘asks’; and support consensus building in joint messaging for advocacy goals
  - **partner engagement, alignment & empowerment**: connecting and aligning partners through digital methods and convening, and building their capacity to hold duty bearers to account and to be more effective advocates for WCAH
  - **execution of campaigns & accountability for outcomes**: designing and conducting targeted advocacy campaigns engaging all partners and high-level champions to amplify evidence-based messages and achieve impact, holding all stakeholders to account
iv. **Outcomes** *(the high-level Outcomes that PMNCH’s activities will contribute to)*

- **Policy**: better policies and legislation for women’s, children’s and adolescents’ health
- **Financing**: more and better financing for women’s, children’s and adolescents’ health
- **Services**: increased & more equitable coverage and uptake of quality services

v. **Impact** *(the impact associated with those Outcomes)*

**Other SDGs (strong determinants of health outcomes) that PMNCH will contribute to and track:**

**Priority SDG 3 targets and indicators for WCAH** most linked to PMNCH’s three objectives of MNCH, SRHR & Adolescents, with a particular focus on equity:

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<tr>
<td>SDG 3.1: reduction of maternal mortality; % births attended by skilled health personnel</td>
<td>SDG 3.2: under-5 mortality; neo-natal mortality</td>
<td>SDG 3.3: reduction in communicable diseases, including HIV, TB and Malaria</td>
<td>SDG 3.7: access to sexual and reproductive health-care services; adolescent birth rates</td>
<td>SDG 3.8: universal health coverage</td>
<td>SDG 3.c: increased health financing; increased health worker density and distribution</td>
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With this Theory of Change and systematic way of working, PMNCH should be able to contribute to even stronger impact by being more focused, and, through a more distinct functional focus on Advocacy, play its role in the global health landscape. **Objectives, Functions and Outcomes** are further detailed in the Sections that follow. Section 5 focuses on PMNCH **Objectives** relating to the three focus areas of MNCH, SRHR and Adolescents: what are the issues; what PMNCH will do; and how it will build on PMNCH work to date. The COVID-19 situation has and will continue to influence more or less all aspects of PMNCH’s work but PMNCH’s focus and role remains even more valid.
5. **PMNCH OBJECTIVES**

PMNCH’s three focus areas and corresponding Objectives are described separately below, but they are inextricably linked. They will be addressed as part of a Continuum of Care within a Life Course Approach (see figure below).

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<tr>
<th>GOALS</th>
<th>Enable all people to live healthy and long lives and contribute to sustainable development</th>
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<tr>
<td>LIFE PHASES</td>
<td>Pregnancy, childbirth and neonatal</td>
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<tr>
<td>DETERMINANTS</td>
<td>Universal health coverage, primary health care and multisectoral services</td>
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<td>FRAMEWORK</td>
<td>Right to the highest attainable standard of health</td>
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**PMNCH will adopt a Life Course Approach to WCAH [may adopt this graphic]**

1. **Maternal, newborn and child health (MNCH):** amplifying action to reduce preventable MNC mortality and morbidity, including stillbirths, by stimulating the integration of essential WCAH interventions in UHC and enhancing high-quality services

While significant progress has been achieved in bringing down under-5 child mortality rates1 (from 93 to 39 per 1,000 live births between 1990 and 2018), progress around newborn mortality and stillbirths has lagged behind. In 2018 it was estimated that almost half of under 5 deaths were occurring in the neonatal period2, and that only half of small and sick newborns have access to quality care3. While the global maternal mortality rate (MMR) is estimated to have fallen by 38% in 2017 compared to 2000, there are wide variations between countries. Sub-Saharan Africa is estimated to account for two thirds of the global maternal deaths in 2017. MMR in least developed countries is more than 40 times higher than in Europe4.

The movement for Universal Health Coverage (UHC) provides an unprecedented opportunity to accelerate progress towards ending preventable deaths and improving the health and well-being of women, children and adolescents around the world. However, as the UNSG’s Independent Accountability Panel notes, to achieve this goal, governments need to include essential health services for women, children and adolescents throughout the life course in their national UHC packages.5 Additionally, based on the Ebola experience, it is clear that maternal, newborn and child mortality trends will be further compounded by COVID-19’s impact on essential services.

Therefore, given the urgent need to ensure that there continues to be a sustained and equitable focus on MNCH, including stillbirths, PMNCH will drive advocacy and attempt to forge consensus around the integration of essential WCAH interventions in UHC benefits packages. This effort will be underpinned by the development of knowledge translation products around the essential interventions packages that will help support our advocacy efforts – globally, nationally and locally.

PMNCH will build on recent work on MNCH, including: strategy briefs on issues (e.g. ‘Women’s empowerment and gender Equality’); and evidence summaries and strategy briefs in support of regional meetings (e.g. briefs in support of the International Conference on Maternal, Newborn and Child Health in Johannesburg, and the Inter-Ministerial Conference in Post ICDP and MDGs in Beijing).
2. **Sexual and Reproductive Health and Rights (SRHR):** enhancing and aligning advocacy to uphold essential SRHR interventions and ensure continuous progress on financing and equitable access to comprehensive SRHR packages

The Guttmacher-Lancet Commission found in 2017 that meeting the unmet need for contraception for 214 million women in developing regions would avert an additional 67 million unintended pregnancies annually. It would result in an estimated 76,000 fewer maternal deaths each year. Women are also more likely to have their demand for modern contraception met in countries where gender equality and their educational opportunities improve. Although there are substantial benefits to investing in SRHR, and while many countries are including common elements of SRHR (primarily family planning, maternal, and newborn health) in their UHC packages and plans, inclusion of a comprehensive package of SRHR interventions is rare, and by no means guaranteed.

Previous public health emergencies have shown that the impact of an epidemic on SRH often goes unrecognized, because of the indirect consequences of strained health care systems, disruptions in care and redirected resources. As a result of COVID-19, some partners are estimating a decline of 80% in SRHR services. The Guttmacher Institute estimates that even a 10% decline in use of short- and long-acting reversible contraceptive methods would result in an additional 49 million women with an unmet need for modern contraceptives and an additional 15 million unintended pregnancies over just one year.

Under Objective 2 (SRHR), PMNCH will align and organise its partners around evidence-based advocacy and communication campaigns, championed by political leaders and thought leaders to amplify the need for uninterrupted access to comprehensive SRHR services, sustained financing for SRHR, and an enabling environment for women and girls to be their own agents of change.

PMNCH will build its advocacy on recent work on SRHR including: analytical/campaign work on SRHR financing (‘Funding for Sexual & Reproductive Health and Rights in low- and middle-income countries: threats, outlook and opportunities’); and case study research on SRHR within UHC (‘New case studies: prioritizing essential packages of health services in six sub-Saharan countries’).

3. **Adolescent’s health and wellbeing:** advancing the health and well-being of adolescents by engaging, aligning and capacitating partners around the Adolescent Health and Well-Being Framework and related policy and action

Adolescent death rates globally are not declining as fast as deaths among children aged between one month and four years, partly because of the rise in AIDS-related adolescent deaths. As more children survive their early years and progress to adolescence, it is essential to understand and address conditions that threaten their ability to lead a healthy life. Among adolescents and young adults, mental health and substance use issues, such as anxiety, depression, and alcohol and drug abuse, are the leading causes of ‘Years Living with Disability’. Depressive disorders are leading non-fatal health issues in female adolescents aged 15-19 years (2016), and suicide is a key public health concern among all adolescents. Furthermore, a thriving adolescent population fuels economic growth by contributing to increased productivity, reduced health expenditure, and ensuring reducing inequities across generations. For every dollar invested in selected adolescent health interventions, there is an estimated ten-fold health, social and economic return.

Under Objective 3 (Adolescents), PMNCH will seek to maximize the triple dividend of adolescent health & well-being – improving health and well-being now; enhancing it throughout the life-course; contributing to the health and well-being of future generations – by developing and implementing the
Adolescent Health and Well-Being Framework. Partners, specifically Adolescent and Youth partner coalitions at country level, will also be capacitated (e.g. through small grants and digital toolkits of resources) to implement the Framework and other related policies and actions to advance the health and well-being of adolescents.

PMNCH will build on recent work on Adolescents, including: knowledge synthesis on adolescent mental health (‘Adolescent Mental Health: Time for Action’); and campaign resources for PMNCH partners (‘Rolling out the advocating for change for adolescents toolkit’).

6. **FUNCTIONS & PARTNER ENGAGEMENT**

Functions

PMNCH will focus on enabling partners to do more together than alone and will leverage the power of partnerships. PMNCH will position Advocacy as its core function and will continue to work on the other functional areas specified in the previous PMNCH Strategic Plan and Business Plan (Analysis, Accountability and Alignment), but as integrated efforts to drive forward Advocacy, rather than acting as parallel functions. This represents much greater focus and a shift in emphasis from PMNCH’s 2016-2020 Strategic Plan when the four ‘A’ functions were equally prioritized.

Advocacy will be supported by three main approaches (with examples of existing activities and products listed below in italics):

- **Knowledge synthesis & application**: synthesising and packaging data and evidence to identify and illustrate gaps in progress; inform advocacy ‘asks’; and support consensus building in joint messaging for advocacy goals (e.g. Adolescent Well-Being Framework; Essential Interventions, Medicines and Commodities in Universal Health Coverage).

- **Partner engagement, alignment & empowerment**: connecting and aligning partners through digital methods and convening, and building their capacity to hold duty bearers to account and to be more effective advocates for WCAH (e.g. support to Multi-Stakeholder Platforms; Parliamentary hearings; small grants for Adolescent and Youth organisations).

- **Execution of campaigns & accountability for outcomes**: designing and conducting targeted advocacy campaigns engaging all partners and high-level champions to amplify evidence-based messages and achieve impact, holding all stakeholders to account (e.g. COVID-19 campaign, Network of Leaders, media, celebrity engagement).
The Partnership will orchestrate and support multi-pronged advocacy efforts, engaging partners and constituencies from grassroots to the highest political level, using these three main approaches.

Historically, the most effective PMNCH-supported campaigns, such as the Every Woman Every Child campaign or the Every Newborn Action Plan, have relied on a combination of clear goals and measurable targets, effective leadership, strong partner alignment, effective use of high level champions, crisp messaging, and strong media engagement. Campaigns will be time-bound by nature; precise targets, strategies and tactics shift over time in relation to need and opportunity. In this new 2021-2025 Strategy, PMNCH will place a renewed emphasis on campaigns as a vehicle for progress towards long-standing advocacy goals.

PMNCH Advocacy and COVID-19

In relation to the COVID-19 pandemic, PMNCH is gathering all partners to advocate together for investments and policies to protect access to essential services for women, children and adolescents. This campaign seeks to mitigate the very real risks of increased mortality and morbidity as a result of fraying health systems, as well as a primary risk for those vulnerable to infection. PMNCH is supporting high-level national, regional and global champions to elevate and amplify campaign asks, including through ‘virtual’ events, social media, the press, parliamentarians, and networks of other high-level influencers. PMNCH is coordinating across constituency groups and through social media partnerships to amplify messages, and to surface up ‘ground-level’ realities, needs, stories and solutions to better target advocacy efforts. PMNCH is grounding its messages in high quality evidence about the effects of the pandemic on women, children and adolescents, and communicating through powerful frames – including the need for future pandemic preparedness to safeguard global security. These different levers and resources for action – champions, media, messages, country partnerships – are being deployed simultaneously, in a coordinated fashion in this campaign approach.

‘Accountability’: re-describing PMNCH’s role in the new Strategy period

Accountability has traditionally been a strong focus of PMNCH’s work. For the coming Strategy period, PMNCH will pivot its work on Accountability, reducing its focus on global accountability processes – where others have comparative advantage and a clearer mandate – and shifting more to empowering partners to hold governments, donors and others to account, linked to PMNCH’s core advocacy function.

To reduce PMNCH’s role in global accountability processes, PMNCH will: no longer host the Independent Accountability Panel (as it appears to move towards a UHC mandate broader than WCAH); no longer co-chair the Finance Tracking Working Group with Countdown, nor provide funds to conduct health financing analysis and tracking (others such as the World Bank, WHO and GFF are better suited to this role); no longer support estimates for ODA (others such as OECD DAC and OECD member countries should take on this role); no longer conduct annual EWEC Commitment Progress Tracking (EOSG/EWEC Secretariat will continue to record commitments, which is key for advocacy). PMNCH will continue to work with some global accountability processes, including working with Countdown to 2030, UNICEF and WHO on progress monitoring and reporting.

PMNCH will increase its focus on: making resources such as guidance tools, data visualization tools and case studies available to strengthen partner capacity for accountability; social accountability to support the capacity of traditional accountability actors like media and parliamentarians to hold governments and others to account; and strengthening mutual accountability between partners and countries.
Partner Engagement

PMNCH’s value proposition lies in the Partnership being the world’s largest alliance for women’s, children’s and adolescents’ health and well-being. It provides a platform for organisations to align objectives, strategies and resources, and to advocate for and deliver interventions to improve women’s, children’s and adolescents’ health and well-being.

PMNCH partner engagement – including support to partners engaging directly at the country level – will be mainly through the mutually reinforcing mechanisms listed below. PMNCH will particularly accelerate the implementation of the digital strategy as the key enabler of PMNCH partner engagement.

i. **Maximising the full engagement of all members through the Constituency structure**: we will leverage our Constituency structure, which enables us to: (i) maximise the aggregating power of Constituency groupings, (ii) bring different Constituencies together with each other, including those under-represented in global health governance (e.g. Health Care Professionals; Adolescent & Youth Organisations), and (iii) provide a platform for different Constituency groupings in our Governance and leadership.

ii. **Leveraging global partnerships & alliances**: we will leverage PMNCH’s formal engagement in number of global health partnerships and alliances, including: EWEC High Level Steering Group; Global Financing Facility Investors’ Group; FP2020 Reference Group. We will seek to leverage the resources and capabilities of the large global health alliances including GAVI and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

iii. **Working through and with other sectors**: given the importance of broader determinants of health, we will also seek closer alliances – whether structural or issue- and campaign-based – with global partnerships in areas such as Nutrition, Education and Water & Sanitation, including the Scaling up Nutrition (SUN) movement, the Global Partnership for Education and the Global Partnership to End Violence Against Children. As part of increasing our work with other sectors that contribute to health outcomes, PMNCH will contribute to and track, as part of our Results Framework (see Annex 2), SDG progress in other sectors, including: Poverty reduction (SDG 1), Nutrition (SDG 2), Girls’ Education (SDG 4), Early Childhood Development (SDG 4), Gender Equality (SDG 5), WASH (SDG 6), Violence Against Children (SDG 16); Partnerships (SDG 17).

iv. **Digitally-enabled communication, knowledge exchange, and joint action**: we will align, resource and amplify the voices of partners through digitally-enabled communication among partners, across constituencies and sectors. This will enable exchange of knowledge, including sharing of global public goods, as well as global convening and mutual support. This will be supported by products such as evidence syntheses, toolkits and advocacy briefs. It will enable all PMNCH partners everywhere – including those with extensive country presence (e.g. UN agencies, NGOs), those with aggregating power (e.g. Inter-Parliamentary Union) and small grass-roots organisations based in partner countries – to be more aligned and effective advocates for women’s, children’s and adolescent health. We will act globally to impact locally, and we will enable local experiences to inform and influence global action.

v. **Engagement through regional and sub-regional fora**: we will increase PMNCH’s engagement in regional and sub-regional fora, both health-related and economic and political (e.g. African
Union; the Association of South East Asian Nations). We will challenge ourselves over the Strategy period to better engage with and leverage these regional / sub-regional mechanisms.

vi. **Country multi-stakeholder grants**: we will shift from our current models of providing multiple grants at country level to a single ‘country multi-stakeholder grants’ model; designed to align, mobilise and resource under-represented organisations in partner countries advocating for women’s, children’s and adolescent health (including civil society organisations and adolescent and youth organisations).

vii. **PMNCH Partners’ Forum**: we will experiment with new models of the PMNCH Partners’ Forum, including annual virtual formats.

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**PMNCH Partners’ Forum 2018, India**

The Partners’ Forum 2018 was convened by PMNCH and the Government of India in New Delhi on 12-13 December 2018. Among the 1,600 participants were 33 country delegations, including 22 Ministers of Health and Finance and 23 Parliamentarians, 195 speakers & moderators and over 400 young people. The objective of the Partners’ Forum was to achieve greater consensus and alignment among PMNCH’s partners on priorities, strategies and technical approaches to accelerate implementation of the Global Strategy for Women’s, Children’s and Adolescents’ Health and progress towards Universal Health Coverage and the SDGs. A number of partners made specific commitments, including: (i) 19 country commitments, including the Indian Prime Minister Narendra Modi pledging $100 billion by 2025 for health services, (ii) India also launched its Strategy for Women’s, Children’s and Adolescent’s Health 2018-2030, (iii) World Vision International pledged $7 billion for WCAH, (iv) Laerdal Medical Foundation pledged an additional $65 million to the Every Woman Every Child movement. The Forum generated 85 published stories in 20 countries as well as 464 million unique impressions on social media. The Government of India has been a donor to PMNCH since 2014, recently doubling its annual commitment.

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7. **OUTCOMES**

PMNCH will advocate for and track our contribution to three sets of outcomes related to women’s, children’s and adolescents’ health, with a focus on our three priority areas of Maternal, Newborn and Child Health, SRHR and Adolescents. Within our Theory of Change (see Annex 1), it is anticipated that these outcomes will in turn contribute to the SDG 3 targets and indicators for women’s, children’s and adolescents’ health (see Annex 4). Tracking of these outcomes – how indicators will be selected; frequency of measurement; means of verification – is further described in the outlined Results Framework for this Strategy (see Annex 2). Finally, the outcomes below are largely related to the health sector. Given the multiple determinants of health outcomes outside of the health sector, we will also identify outcomes in sectors such as Education, WASH and Economic development that PMNCH can contribute to during the Strategy period.

A. **POLICY: better policies & legislation for WCAH (focus on MNCH, SRHR, Adolescents)**

Good policies and legislation are the foundations for effective, fair and equitable investments in women’s, children’s and adolescents’ health, as well as protective instruments in their own right. In turn, policies and legislation must translate into concrete plans for delivery against these commitments. PMNCH will advocate for, and track, better policies and plans in three areas (with a focus on MNCH, SRHR and Adolescents).
➢ WCAH present in national plans and laws
➢ WCAH present in international agency goals, plans and agreements
➢ Rights relating to WCAH upheld

B. FINANCING: more and better financing for WCAH (focus on MNCH, SRHR, Adolescents)

More financing, including domestic financing, overseas development aid (ODA) and private flows – better aligned to need and to government priorities and more equitably allocated – will be critical to delivering better health outcomes for women, children and adolescents. PMNCH has considerable experience in advocating for, raising and tracking additional financing. This will continue to be a strong theme for the coming Strategy period. We will advocate for, and track, PMNCH’s contribution in three areas (with a focus on MNCH, SRHR and Adolescents).

➢ Increased domestic financing to WCAH
➢ Increased ODA to WCAH
➢ Increased & aligned private sector investment

C. SERVICES: increased and more equitable coverage and uptake of quality services for WCAH (focus on MNCH, SRHR, Adolescents)

Policies and legislation (Outcome A) and financing (Outcome B) must be translated into increased quality and more equitable coverage and uptake of services (Outcome C), in order to translate into better health outcomes. PMNCH will particularly focus on the coverage of essential interventions for women, children and adolescents in Primary Health Care, as part of Universal Health Coverage. We will also advocate for and track the number and equitable distribution of health care professionals, with a particular focus on midwives and nurses.

➢ Increased coverage of essential interventions for WCAH in Primary Health Care and Universal Health Coverage
➢ Increased number of midwives and nurses
➢ Increased access to essential medicines and commodities
➢ Improved quality and uptake of services

8. GOVERNANCE & MANAGEMENT

Governance

PMNCH’s core asset is the breadth and diversity of its partners. However, the 2019/20 external evaluation found that PMNCH’s governance has become heavy and time-intensive, with structures poorly understood by its partners. The governance structures will be streamlined and restructured while retaining the core strength of the partnership.

PMNCH will adapt our governance reforms looking at the functions, size, Constituency structure and Committee structure of the Board, as well as the frequency and type of meetings, especially taking advantage of the opportunities presented by a digital and virtual environment. For the future, meetings of the PMNCH Board will be a mix of virtual and in-person, capitalizing on the ongoing digitalisation of the membership and partner engagement. There will also be a revision of the Board manual once the optimal governance structure is agreed on by the PMNCH Board.
Secretariat

The new Strategy period will be an opportunity to build on what has worked to date in terms of Secretariat structure and operational principles, whilst orienting the team towards new and more effective ways of supporting the work of partners, including more virtual working. This will include, among other things, embracing and capitalizing on the Partnership's emerging digital platform and implementation approaches, and consequently reshaping the staff profiles to match expected future ways of working – not least, as shaped by the COVID-19 pandemic.

An important finding of the 2019/20 PMNCH External Evaluation was that PMNCH has spread itself too thinly over recent years, failing to prioritise sufficiently and undertaking too many activities. As outlined below, the Partnership will use an annual work-planning process to prioritize and reduce the number of activities it undertakes, focusing efforts on where impact can be best achieved. Activities will be undertaken through PMNCH’s partnership-centric approach – with Partners leading activities through Working Group and other structures, supported by the Secretariat – rather than the Secretariat leading on the execution of activities itself.

Budgets & Annual Workplans

Annual workplans and budgets will be developed and updated on a rolling basis throughout the annual work planning process. The workplan and budgets will be updated at the end of each year and presented to PMNCH’s governance bodies. When assessing which specific activities to take on each year in annual workplan, the following principles for prioritization will apply:

- what are the needs for action, using an equity lens?
- where are the evidence-based gaps opportunities for intervention?
- what are others doing that PMNCH should build on and not duplicate?
- what is PMNCH’s comparative advantage and explicit added value?
- what is the partner demand, both to generate and to utilize PMNCH products?

The management of the PMNCH budget will be guided by a set of principles agreed by the Partnership’s governance structures, and in alignment with WHO rules and regulations. As part of its hosting arrangement at WHO, the Partnership is subject to the audit and financial management processes required by its host for all departments and hosted partnerships. In addition, the Partnership will actively disseminate information about its activities and performance, with all reports and information available on its website, regularly updated. This will include, for example, (i) annual financial and narrative reports; (ii) ongoing donor reporting, subject to the specific donor agreement; (iii) presentations and regular reporting on progress to governance bodies; (v) any evaluations and/ or reviews.
ANNEX 1. Theory of Change

### Problem statement

The problems that PMNCH is trying to address...

- **Womens’, Children’s & Adolescents’ Health & Well-Being (WCAH)**
  1. Maternal, Newborn & Child Health (MNCH) - unfinished agenda of the MDGs: preventable maternal & child mortality (including newborns & stillbirths); particular focus on, humanitarian & fragile settings
  2. Sexual and Reproductive Health & Rights (SRHR) - morbidity and mortality relating to SRHR; politicization of SRHR and threats to rights
  3. Adolescents’ Health & Well-Being - a growing and largely unaddressed burden relating to adolescent health and well-being

### PMNCH Objectives

The objectives PMNCH will pursue (3 priority focus areas for the Strategy period)...

1. **MNCH** - amplifying action to reduce preventable MNC mortality and morbidity, including stillbirths, by stimulating the integration of essential WCAH interventions in UHC and enhancing high-quality services
2. **SRHR** - enhancing and aligning advocacy to uphold essential SRHR interventions and ensure continuous progress on financing and equitable access to comprehensive SRHR packages
3. **Adolescents** - advancing the health and well-being of adolescents by engaging, aligning and capacitating partners around the Adolescent Health and Well-Being Framework and related policy and action

### PMNCH Functions & Activities

How PMNCH delivers these objectives...

**ADVOCACY:** advocating and amplifying for WCAH (focus on MNCH, SRHR, Stillbirths, Adolescents); supported by three main approaches:

- **Knowledge synthesis & application:** synthesising and packaging data and evidence to identify and illustrate gaps in progress; inform advocacy 'asks'; and support consensus building in joint messaging for advocacy goals
- **Partner engagement, alignment & empowerment:** connecting and aligning partners through digital methods and convening, and building their capacity to hold duty bearers to account and to be more effective advocates for WCAH
- **Execution of campaigns & accountability for outcomes:** designing and conducting targeted advocacy campaigns led by high level champions and supported by all partners to hold stakeholders to account

### Outcomes

The high level outcomes that PMNCH’s activities will contribute to (PMNCH contribution to 2030 targets)

A. **POLICY**
   - Better policies & legislation for WCAH - WCAH present in national plans and laws
   - Rights relating to WCAH upheld

B. **FINANCING**
   - More and better financing for WCAH - increased domestic financing to WCAH
   - Increased ODA to WCAH
   - Increased & aligned private investment

C. **SERVICES**
   - Increased & more equitable coverage and uptake of quality services for WCAH - increased coverage of essential interventions in PHC & UHC - increased number of midwives and nurses
   - Increased access to essential medicines and commodities - improved quality and uptake of services

### Impact

Health outcomes (PMNCH contribution to WCAH)

**SDGs for WCAH**

**ASSUMPTIONS / RISKS:** INTERNAL FACTORS: (i) PMNCH is able to define, negotiate and communicate a unique value proposition in the global health architecture, (ii) PMNCH has the convening power to attract, retain and support the mobilisation of partners (partner-centric model), (iii) PMNCH has a model of country engagement (working through partners + country grants) that is effective and sustainable, (iv) PMNCH has adequate financial resources to execute activities, (v) PMNCH Board & Secretariat prioritise a manageable number of focus areas & deliverables for the Strategy period (focussing on actions critical for the WCAH SDGs, not done by others). EXTERNAL FACTORS: (vi) Major and accelerated external shocks such as pandemics, global economic recessions and climate change fundamentally re-describe global health challenges and ways of working, and threaten gains made in WCAH, (vii) Reduced multilateralism and new norms of reduced international cooperation weaken global health institutions and an effective response to WCAH
ANNEX 2. Results Framework

The Results Framework below is derived from the Theory of Change. Baselines and targets will be established in 2020. Where relevant and possible, baselines and results reporting will be disaggregated by: priority focus area (MNCH; SRHR; Adolescents); population group (e.g. women; income distributions, disability, migrants); by region; by country type (e.g. humanitarian & fragile settings). Progress on the execution of these activities against Strategy goals will be conducted on an annual basis by the Board through annual work planning and review; this process will also determine what additional activities are undertaken. In addition to yearly monitoring as described below, PMNCH will undergo an external evaluation in 2024, to review Strategy 2021 – 2025 progress and to plan for the next Strategy period (assumed to be 2026 – 2030, to coincide with SDG completion).

<table>
<thead>
<tr>
<th>IMPACT</th>
<th>PMNCH Accountability*</th>
<th>Frequency</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDG targets &amp; indicators (selected) for WCAH and for other sectors</td>
<td>Contribution</td>
<td>2030 (with annual progress checks)</td>
<td>UN High-level Political Forum; GHO/WHO</td>
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<tr>
<td>and for other sectors (determinants of health outcomes)</td>
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<thead>
<tr>
<th>OUTCOMES</th>
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<tbody>
<tr>
<td>A. POLICY: better policies &amp; legislation for WCAH</td>
<td>Contribution</td>
<td>Annual</td>
<td>Relevant national, regional, global documents; national health plans; human rights reporting</td>
</tr>
<tr>
<td>- WCAH present in national plans and laws</td>
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<td></td>
<td></td>
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<tr>
<td>- WCAH present in international agency goals, plans and agreements</td>
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<tr>
<td>- rights relating to WCAH upheld</td>
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<tr>
<td>B. FINANCING: more and better financing for WCAH</td>
<td>Contribution</td>
<td>Annual</td>
<td>World Bank / WHO; GFF; OECD DAC</td>
</tr>
<tr>
<td>- increased domestic financing to WCAH</td>
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<tr>
<td>- increased ODA to WCAH</td>
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<tr>
<td>- increased &amp; aligned private sector investment</td>
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<tr>
<td>C. SERVICES: Increased coverage and uptake of quality services</td>
<td>Contribution</td>
<td>Annual</td>
<td>WHO; Countdown to 2030; UNFPA</td>
</tr>
<tr>
<td>- increased coverage of essential interventions for WCAH in PHC &amp; UHC</td>
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<td></td>
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<tr>
<td>- increased number of midwives and nurses</td>
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<tr>
<td>- increased access to essential medicines and commodities</td>
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<tr>
<td>- improved quality and uptake of services</td>
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</table>

| OUTPUTS                                                               |                        |                          |                                            |
| Outputs of Activities to be specified in Annual Workplan              | Attribution (Partners & Secretariat) | Annual | PMNCH Annual Workplan & Review; tracking digital engagement; Audit |

| INPUTS                                                                |                        |                          |                                            |
| Financial & human resources to be specified in Annual Workplan        | Attribution (Secretariat) | Annual | PMNCH Annual Workplan & Review; Audit |

* ‘Attribution’ applies to things within PMNCH’s control (i.e. management of inputs; execution of activities to deliver outputs). ‘Contribution’ applies to things outside of PMNCH’s full control (i.e. higher order outcomes and impact). This distinction is important for establishing PMNCH’s accountabilities, including for future evaluations.
### ANNEX 3. Risks & Risk Management

Risks listed below are derived from the ‘Assumptions / Risks’ listed in the Theory of Change (See Annex 1). They are divided into two categories: (i) internal factors, and (ii) external factors. They are headline risks and not exhaustive. Risk management will also be addressed on an ongoing basis by the Secretariat and the Board, including through the Risk Register formally overseen by the Board.

<table>
<thead>
<tr>
<th>RISKS</th>
<th>RISK MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTERNAL FACTORS</strong></td>
<td></td>
</tr>
</tbody>
</table>
| 1. PMNCH is not able to define, negotiate and communicate a unique **value proposition** in the global health architecture | ➢ PMNCH Strategy 2021 – 2025 and subsequent communications lay out a clear & compelling PMNCH value proposition  
➢ Board, PMNCH Partners, Secretariat all act as champions for PMNCH’s mission & value |
| 2. PMNCH does not have the **convening power** to attract, retain and support the mobilisation of partners | ➢ Board members work to effectively engage their constituencies, supported by the Secretariat  
➢ ‘Partner-centric model’ has the buy-in of the Partnership and is well-resourced and well-supported by the Secretariat |
| 3. PMNCH does not have a model of **country engagement** (working through partners + country grants) that is effective and sustainable | ➢ PMMCH implements the recommendations of the Country Engagement Working Group  
➢ Results reporting reaches to country level (distinguishing between PMNCH attribution and contribution) |
| 4. PMNCH has inadequate **financial resources** to execute activities | ➢ Executive Director prioritises fundraising (ideally multi-year and unrestricted) for Strategy in short-term  
➢ Board and Executive Committee supports fundraising goals |
| 5. PMNCH Board & Secretariat fail to **prioritise** a manageable number of focus areas & deliverables for the Strategy period (focussing on actions critical for the WCAH SDGs, not done by others) | ➢ Board & Secretariat maintain discipline in adhering to Strategy priorities  
➢ Annual work planning process provides an opportunity for annual review & planning  
➢ Funders only allocate funds for activities in the Strategy / workplan |
| **EXTERNAL FACTORS**                                                 |                                                                                 |
| 6. Major and accelerated external shocks such as **pandemics, global economic recessions and climate change** fundamentally re-describe global health challenges and ways of working, and threaten gains made in WCAH | ➢ PMNCH should advocate through the Strategy period for sustained access to WCAH services; mitigation of effects of major external shocks on WCA, and; greater pandemic / disaster preparedness, including investments in health systems and in health care professionals  
➢ PMNCH and Secretariat must have the agility to adjust workplans / activities / delivery with speed and urgency |
| 7. **Reduced multilateralism and new norms of reduced international cooperation** weaken global health institutions and an effective response to WCAH | ➢ PMNCH should advocate for the importance of multilateralism and a joined-up international response to challenges in WCAH  
➢ work with and through UN agencies, government partners and others on the Board (and within the broader membership) to advocate for and support a joined-up international system |
ANNEX 4. SDG targets & indicators (PMNCH Impact measures)

Targets and indicators most linked to PMNCH’s objectives for the Strategy period are shaded. These will be given greatest prioritisation in PMNCH’s work and in how we measure our contribution to women’s, children’s and adolescents’ health.

<table>
<thead>
<tr>
<th>Targets</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SDG 3: ‘Ensure healthy lives and promote well-being for all at all ages’</strong></td>
<td></td>
</tr>
<tr>
<td>3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births</td>
<td>3.1.1 Maternal mortality ratio 3.1.2 Proportion of births attended by skilled health personnel</td>
</tr>
<tr>
<td>3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births</td>
<td>3.2.1 Under-5 mortality rate 3.2.2 Neonatal mortality rate</td>
</tr>
<tr>
<td>3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases</td>
<td>3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations 3.3.2 Tuberculosis incidence per 100,000 population 3.3.3 Malaria incidence per 1,000 population 3.3.4 Hepatitis B incidence per 100,000 population 3.3.5 Number of people requiring interventions against neglected tropical diseases</td>
</tr>
<tr>
<td>3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being</td>
<td>3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease 3.4.2 Suicide mortality rate</td>
</tr>
<tr>
<td>3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol</td>
<td>3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders 3.5.2 Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol</td>
</tr>
<tr>
<td>3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents</td>
<td>3.6.1 Death rate due to road traffic injuries</td>
</tr>
<tr>
<td>3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes</td>
<td>3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods 3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group</td>
</tr>
<tr>
<td>3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all</td>
<td>3.8.1 Coverage of essential health services 3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income</td>
</tr>
<tr>
<td>3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination</td>
<td>3.9.1 Mortality rate attributed to household and ambient air pollution 3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services) 3.9.3 Mortality rate attributed to unintentional poisoning</td>
</tr>
<tr>
<td>3.a Strengthen the implementation of the World Health Organization Framework</td>
<td>3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older</td>
</tr>
<tr>
<td>Convention on Tobacco Control in all countries, as appropriate</td>
<td>3.1 Proportion of the target population covered by all vaccines included in their national programme</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all</td>
<td>3.b.1 Total net official development assistance to medical research and basic health sectors</td>
</tr>
<tr>
<td>3.3 Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all</td>
<td>3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis</td>
</tr>
<tr>
<td>3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States</td>
<td>3.c.1 Health worker density and distribution</td>
</tr>
<tr>
<td>3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks</td>
<td>3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness</td>
</tr>
<tr>
<td></td>
<td>3.d.2 Percentage of bloodstream infections due to selected antimicrobial-resistant organisms</td>
</tr>
<tr>
<td>Other SDGs (strong determinants of health outcomes) that PMNCH will contribute to and track</td>
<td></td>
</tr>
<tr>
<td><strong>Poverty reduction</strong>: SDG 1.1 By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than $1.25 a day</td>
<td>1.1.1 Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)</td>
</tr>
<tr>
<td><strong>Nutrition</strong>: SDG 2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons</td>
<td>2.2.1 Prevalence of stunting (height for age &lt;= -2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age</td>
</tr>
<tr>
<td></td>
<td>2.2.2 Prevalence of malnutrition (weight for height &gt;=+2 or &lt;= -2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)</td>
</tr>
<tr>
<td><strong>Girls’ Education</strong>: SDG 4.1 By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes</td>
<td>4.1.1 Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex</td>
</tr>
<tr>
<td><strong>Early Childhood Development</strong>: SDG 4.2 By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education</td>
<td>4.2.1 Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex</td>
</tr>
<tr>
<td><strong>Gender Equality</strong>: SDG 5.1 End all forms of discrimination against all women and girls everywhere; SDG 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation</td>
<td>5.1.1 Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex</td>
</tr>
<tr>
<td></td>
<td>5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate</td>
</tr>
<tr>
<td><strong>Partnership</strong></td>
<td><strong>SDG</strong></td>
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<tr>
<td><strong>WASH:</strong> SDG 6.1</td>
<td>By 2030, achieve universal and equitable access to safe and affordable drinking water for all; SDG 6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations</td>
</tr>
<tr>
<td><strong>Violence Against Children:</strong> SDG 16.2</td>
<td>End abuse, exploitation, trafficking and all forms of violence against and torture of children</td>
</tr>
<tr>
<td><strong>Partnerships:</strong> SDG 17.1 (Finance)</td>
<td>Strengthen domestic resource mobilization, including through international support to developing countries, to improve domestic capacity for tax and other revenue collection; SDG 17.16 (Multi-stakeholder partnerships) Enhance the global partnership for sustainable development, complemented by multi-stakeholder partnerships that mobilize and share knowledge, expertise, technology and financial resources, to support the achievement of the sustainable development goals in all countries, in particular developing countries</td>
</tr>
</tbody>
</table>

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1 Levels & Trends in Child Mortality. UNICEF. 2019  
2 Ibid.  
3 Survive and thrive: Transforming care for every sick newborn. WHO. 2018.  
4 Maternal mortality: Levels and trends. WHO. 2019  
10 Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries. Guttmacher. 2020  