PMNCH 25th Board Meeting

Tuesday, 30 June, 2020

Document Title: Draft PMNCH 2021 to 2025 Strategy

Document Number: PMNCH-B25-2020; 4a

Summary: The Strategy document was developed under the guidance of the Strategy Committee. It proposes a five-year strategy for PMNCH, paying particular attention to the findings of the External Evaluation. The draft of the Strategy was developed through a comprehensive consultative process, including the PMNCH's diverse partner base. It suggests a considered way forward, by focusing on three main areas and by using advocacy as the main function.

Actions Required: *The PMNCH Board is asked to review the Strategy and decide on next steps for its finalization.*

- *The Board may wish to reflect on the following questions:*
  - *Do you feel that the changes made to the draft Strategy from the original Strategy Outline capture views and suggestions emerging from the consultations?*
  - *Do you think that we now have a sufficiently agile and sharp strategy that will enable PMNCH with all its members to really make a difference for WCAH?*
  - *What is the optimum timing for completion and launch?*
  - *What will be the next steps for engaging with PMNCH members across the world?*

PMNCH 2021-2025 STRATEGY

Second Full Draft for Board

12th June 2020

FOREWORD

[Foreword from the Board Chair, to be drafted later in the process as the last input pre-publication, in order for the Foreword to be current.]

SUMMARY

At the time of writing, the world faces a global health pandemic without historical precedent. **COVID-19** presents a massive shock to an already struggling global health system and world economy. Major gains have been made in **Women's, Children's & Adolescents' Health and Well-Being** (WCAH) over the last three decades. But these gains are severely threatened.

PMNCH is the **world's largest alliance** for women's, children's and adolescents' health and well-being, with over 1,000 partners. Our **vision** is a world in which every woman, child and adolescent is able to realize their right to health and well-being, leaving no one behind. Our **mission** 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. Our time is now.

We will drive forward three inter-connected objectives over the period of this Strategy:

- **Maternal, Newborn & Child Health (MNCH)**: to advocate vigorously for the inclusion of essential services for MNCH in costed country benefits packages that drive down preventable morbidity and mortality, including stillbirths;
- **Sexual, Reproductive Health & Rights (SRHR)**: to uphold essential SRHR interventions and ensure continuous progress on financing and equitable access to comprehensive SRHR packages;
- **Adolescents**: to advance 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.

With **Advocacy** as our core function – supported by knowledge synthesis, partner engagement, campaigns and outreach – we will mobilise and resource our partners to seek changes in **policy**, **financing** and **services** for women, children and adolescents. We will work not only in the **health** sector, but also seek to contribute to and track outcomes in other sectors that are major **determinants of health outcomes**, such as education, WASH and economic development.

To deliver this Strategy, we will work through a **partner-centric approach**, engaging and aligning our partners through a **digital**-led strategy of partner engagement. We will streamline our **governance** and **Secretariat** support functions over the Strategy period to deliver with more efficiency and to drive value-for-money and results.

For PMNCH, this new Strategy period will be marked in particular by three **strategic shifts**: a tighter thematic focus (MNCH; SRHR; Adolescents); greater functional specialisation, with Advocacy as our core function; and greater efficiency and reach through the acceleration of our digital strategy. We will act with pace and urgency, and with an unswerving commitment to the health and well-being of women, children and adolescents worldwide.

1. CONTEXT

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

At the time of writing, the world 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 agenda of the Millennium Development Goals (MDGs) and a renewed focus on Universal Health Coverage (UHC) and on non-communicable diseases (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. The indirect impact of the pandemic will likely be far greater than the direct impact, due to reduced health services or fear of seeking medical care, unemployment and food insecurity, worsened mental health, intimate partner violence, and worldwide economic recession. COVID-19 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)

Major gains have been made in Women's, Children's & Adolescents' Health and Well-Being[i] (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 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) – **preventable 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 and Rights**[ii] (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'.

PMNCH in the global health landscape

The global landscape for health is 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 – 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.

PMNCH plays a unique role as a partnership: aligning diverse partners around the importance of women's, children's and adolescents' health and well-being, and supporting evidence-based advocacy for change and accountability for outcomes. With governments at its centre, supported by a range of actors playing roles in research, normative guidance, advocacy, financing and the delivery of services.

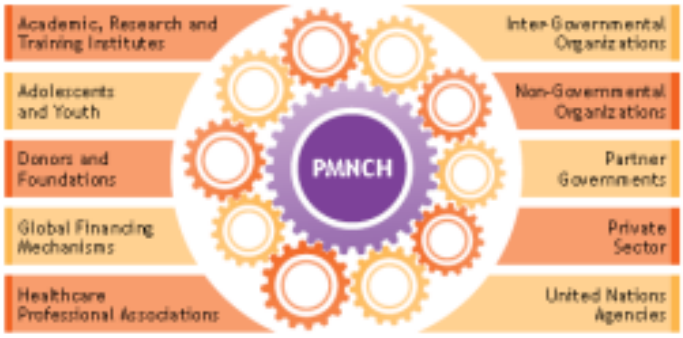
The next Section seeks to define PMNCH's distinct value proposition in this complex world of new threats, and, indeed, opportunities.

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 and well-being. It provides a unique partnership platform – stimulating, coordinating and resourcing action for the world's most disadvantaged and disenfranchised communities. PMNCH's core value proposition is three-fold:

- thematic focus: PMNCH is the only global multi-stakeholder 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 and well-being (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 its 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.

PMNCH's achievements over the last decade

- 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
- 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
- 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')
- ensuring visibility of MNCH and the inclusion of SRHR in Member State Resolutions on Universal Health Coverage (UHC)
- developing broad-based partner initiatives and agreements (e.g. 'Ending Preventable Maternal Mortality'; 'Nurturing Care for Early Childhood Development' Framework)
- development of the Global Consensus Statement on Meaningful Adolescent & 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
- securing resolutions in support of women's and children's health by the 140 parliaments of the Inter-Parliamentary Union (IPU)

It will be critical for the next five years to align behind an agreed and common agenda for accelerated action for women's, children's and adolescents' health and well-being, 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.

Lessons learnt from the PMNCH External Evaluation (2019/20)	
Evaluation findings / recommendations (selected)	**PMNCH Strategy 2021-2025 response**
PMNCH's vision and mission remain relevant, valid and urgent	Retain essence of vision and mission (WCAH; Equity; Partnership), but make them more focused
PMMCH has been pulled in too many directions	Adopt greater focus: from 6 focus areas of 2018-2020 Business Plan to 3 focus areas and corresponding smart/measurable objectives
PMNCH's main value addition is its Advocacy function and convening power	Make Advocacy the primary function of PMNCH, with other functions re-described and in service of the core Advocacy function
PMNCH's Governance is heavy and time-intensive	Streamline governance: reduce structures and face-to-face meetings, as well as digitalize operations more
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 (attribution versus contribution)

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 is able to realize 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 other targets, and to sustainable improvements in women's, children's and adolescents' health and well-being, especially for the most vulnerable. Components of the Theory of Change are further described in the Sections of this Strategy document that follow: Problem Statement (Section 5); Objectives (Section 6); Functions & Partner Engagement (Section 7); Outcomes (Section 8); Impact (Section 9).

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 equity and 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)**: to advocate vigorously for the inclusion of essential services for MNCH in costed country benefits packages that drive down preventable morbidity and mortality, including stillbirths
- **Sexual, Reproductive Health & Rights (SRHR)**: to uphold essential SRHR interventions and ensure continuous progress on financing and equitable access to comprehensive SRHR packages
- **Adolescents**: to advance 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
  - partner engagement
  - campaigns and outreach

iv. **Outcomes** *(the high-level Outcomes that PMNCH's activities will contribute to)*

- **Policy**: better policies and legislation for MNCH, SRHR and Adolescents
- **Financing**: more and better financing for MNCH, SRHR and Adolescents
- **Services**: increased & more equitable coverage and uptake of quality services

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

- **SDG 3 (Health Outcomes) & EWEC Global Strategy**: SDG 3 and EWEC Global Stratgey targets and indicators relating to MNCH, SRHR & Adolescents
- **Other SDGs (determinants of Health Outcomes)**: SDG 1 (Poverty Reduction); SDG 2 (Nutrition); SDG 4 (Education & Early Childhood Development); SDG 5 (Gender Equality); SDG 6 (WASH); SDG 13 (Climate Change); SDG 16 (Violence Against Children); SDH 17 (Partnerships)

5. PROBLEM STATEMENT

The role of PMNCH is to contribute to further progress for children's, women's and adolescent's health across the world. The following summary of the main challenges facing WCAH form the base for defining the specific objectives and expected results for PMNCH.

Maternal, Newborn and Child Health (MNCH)

While significant progress has been achieved in bringing down under-5 child mortality rates[iii] (from 93 to 39 per 1,000 live births between 1990 and 2018), progress on newborn mortality and stillbirths has lagged behind. In 2018, it was estimated that almost half of under 5 deaths were occurring in the neonatal period[iv], and that only half of small and sick newborns have access to quality care[v]. 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 Europe[vi].

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.[vii] 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.

Sexual and Reproductive Health and Rights (SRHR)

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 also result in an estimated 76,000 fewer maternal deaths each year[viii]. Women are also more likely to have their demand for modern contraception met in countries where gender equality and their educational opportunities improve[ix]. 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 SRHR often goes unrecognized, because of the indirect consequences of strained health care systems, disruptions in care and redirected resources.[x] As a result of COVID-19, some partners are estimating a decline of 80% in SRHR services[xi]. 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[xii].

Adolescent Health and Well-Being

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 the 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[xiii]. Yet the health and well-being of adolescents receives significantly less investment and attention than warranted – both in the health sector and in those sectors that are determinants of adolescent health outcomes. Without greater political prioritisation and investment, adolescent mortality and morbidity will increase, particularly in low- and low-middle income countries with rapidly rising youth populations.

6. OBJECTIVES

This Strategy adopts three focus areas – MNCH; SRHR; Adolescents – with corresponding Objectives described below. These three Objectives, representing a sharpened focus relative to PMNCH's previous Strategy, have been chosen on the basis of the burden of mortality and morbidity for women's', children's and adolescents' health and well-being (see previous Section), as well as PMNCH's comparative advantage and opportunities to build on PMNCH and partner investments to date.

These three Objectives are described separately below, but they are inextricably linked – for example, SRHR is a critical issue for maternal health and for adolescent health and well-being – and in many areas will be supported through the same interventions. They will be addressed as part of a Continuum of Care (meaning the provisioning of health services across primary, secondary and tertiary levels), within a Life Course Approach (ensuring linkages across all life phases), and working also beyond the health sector to address broader determinants of health.

PMNCH will adopt a Life Course Approach to WCAH

1. **Maternal, newborn and child health (MNCH):** to advocate vigorously for the inclusion of essential services for MNCH in costed country benefits packages that drive down preventable morbidity and mortality, including stillbirths

Given the urgent need to ensure a sustained and equitable focus on MNCH, including stillbirths, PMNCH will undertake evidence-based advocacy for the integration of essential MNCH interventions in Primary Health Care and UHC schemes. This effort will be underpinned by: (i) the development of inter-related global public goods including: Global Action Plan to Accelerate Progress for Every Mother and Child in Humanitarian and Fragile Settings; Advocacy Toolkit for Stillbirths and MNH policymaking;

Global Investment Framework for WCAH in Preparedness and Response Plans; Resources to support parliamentarians, youth and civil society to support global, regional and national efforts around the integration of essential SRMNCAH interventions in UHC, including financial protection schemes; and (ii) the implementation of advocacy campaigns to ensure adequate coverage of quality MNCH interventions.

2. **Sexual and Reproductive Health and Rights (SRHR)**: to uphold essential SRHR interventions and ensure continuous progress on financing and equitable access to comprehensive SRHR packages

PMNCH will work through its partners to drive effective evidence-based advocacy to uphold essential SRHR interventions and rights. This will be done by undertaking coordinated and integrated advocacy campaigns to strengthen political commitment and policies, and increase funding for the full spectrum of SRHR interventions and services, including safe abortion services. PMNCH will put special attention on human rights dimensions of the SRHR agenda. Further analysis and evidence synthesis work around ODA and domestic resources for SRHR, and impact of COVID-19 on SRHR issues will be undertaken to inform the advocacy campaigns.

3. **Adolescent's health and wellbeing**: to advance 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

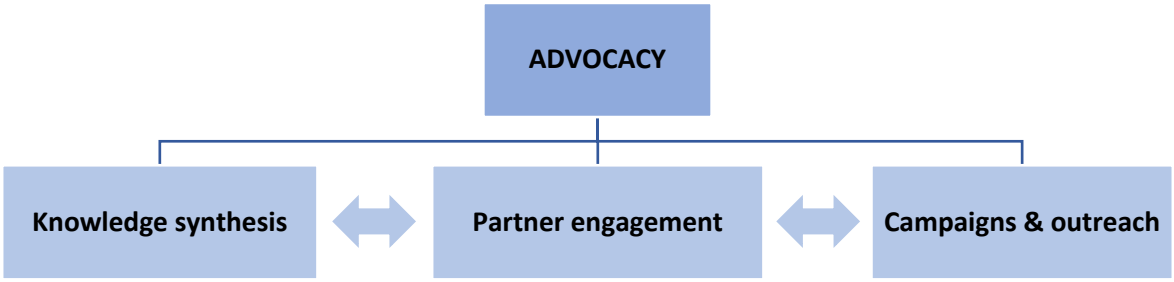
PMNCH will seek to maximize the triple dividend of adolescent health and well-being – improving health and well-being now; enhancing it throughout the life-course; contributing to the health and well-being of future generations. This will be done through a three pronged approach by: developing an Adolescent Health and Well-Being Framework (AWF) for adolescent-responsive multisectoral action; organising a Global Adolescents Summit to align efforts around adolescent health and well-being, increase financing including domestic financing, and solicit political endorsement of the AWF for integration into national policy national plans; and strengthening capacities of youth networks to undertake meaningful engagement and contribute to national policy and programme development processes.

7. 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):



i. **Knowledge synthesis**: translating and packaging evidence to highlight gaps in progress, support consensus building on advocacy asks, and equip partners with evidence for action and greater accountability *(e.g. Adolescent Well-Being Framework; Essential Interventions, Medicines and Commodities in Universal Health Coverage)*.

ii. **Partner engagement**: supporting the development of partner knowledge, skills and capacity for joint advocacy, meaningful inclusion, and greater accountability of multi-stakeholder policy dialogue *(e.g. support to Multi-Stakeholder Platforms; small grants for coalition building of Adolescent and Youth advocacy organisations; development of digital platform for partner knowledge-sharing and collaboration)*.

iii. **Campaigns and outreach**: mobilizing all partners in a coordinated approach to reaching common advocacy and accountability goals, amplifying messages through champions, parliaments, media, and other influential channels *(e.g. Call to Action on COVID-19; national, regional and global political engagement; social media campaigns)*.

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 partners are advocating together for political commitment, investments and policies to protect and promote the health and rights of women, children and adolescents. The PMNCH Call to Action on COVID-19 urges greater support for sexual, reproductive, maternal, newborn, child and adolescent health services, supplies, information, and demand generation campaigns, including for contraception, immunization, safe delivery, prevention of stillbirths and mental health support.

Other PMNCH COVID-19 advocacy asks focus on the need to advance SRHR and gender equality; improve quality care, including respectful and dignified care; improve recruitment, pay and working conditions of frontline health workers, including midwives and nurses; social protection, including food and nutrition security, for marginalized and vulnerable groups, guided by enhanced data to better understand disparities; improved access to functional, safe and clean toilet and handwashing facilities and quality potable drinking water; and prevention of violence against women, children and adolescents through education and protection programmes.

Backed by this Call to Action, PMNCH will support all constituencies to plan together for action through national multi-stakeholder platforms. PMNCH will also support integrated 'all of government' COVID-19 response plans that bring together different sectors – finance, health, gender, security, education and others. PMNCH will partner strategically with the private sector to augment government capacity and bring forward innovations to deliver quality services safely. PMNCH will also support the uptake of its action call by other advocacy communities, including those related to WASH, gender-based violence, education and Universal Health Coverage.

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. PMNCH will continue to work with Countdown to 2030, UNICEF and WHO on progress monitoring and reporting. However, PMNCH will no longer host the Independent Accountability Panel (IAP), as the IAP moves towards a UHC mandate broader than WCAH. As part of empowering partners in their accountability functions, 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.

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 outcomes, 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); Climate Change (SDG 13); 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 adolescents' health and well-being. We will act globally to impact locally, and we will enable local experiences to inform and influence global action.

PMMCH Digital Strategy

PMNCH will accelerate the implementation of the digital strategy as the key enabler of PMNCH partner engagement. PMNCH's digital platform will:

- foster meaningful partner information-sharing and collaboration within and between constituencies, countries, regions and thematic concerns;
- enable partner access to high quality digital packages of knowledge tools, resources and information to scale up advocacy and accountability;
- facilitate and incentivize co-production of shared deliverables among partners in line with the PMNCH 2021-2025 Strategy;
- measure reach/impact of PMNCH efforts, assessing progress towards common goals;
- achieve greater efficiency and impact in PMNCH Governance and Secretariat operations.

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 and well-being (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.

PMMCH 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 Adolescents' 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.

8. OUTCOMES

In advocating, PMNCH's core function, for MNCH, SRHR and Adolescents, PMNCH will contribute to Outcomes in three areas:

A. **POLICY**: better policies & legislation for MNCH, SRHR, Adolescents
B. **FINANCING**: more and better financing for MNCH, SRHR, Adolescents
C. **SERVICES**: increased and more equitable coverage and uptake of quality services for MNCH, SRHR, Adolescents

Our Theory of Change proposes that changes in these three sets of Outcomes will in turn contribute to changes at the Impact level, i.e. principally SDG and Global Strategy targets and indicators (see Section 9 below). The Results Framework at Annex 2 details specific Outcomes in polices, financing and services that PMNCH will seek to contribute to. These are explained in broad terms below.

A. POLICY: better policies & legislation for MNCH, SRHR, Adolescents

Good policies and legislation are the foundations for effective, fair and equitable investments in women's, children's and adolescents' health and well-being, 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):

- **essential SRMNCH interventions in national and sub-national plans & policies**
- **supportive legislation**
- **upholding of rights relating to WCAH**

B. FINANCING: more and better financing for 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 four areas (with a focus on MNCH, SRHR and Adolescents).

- **financial protection schemes for WCA**
- **increased domestic financing and ODA for WCAH**
- **increased & aligned private sector investment**
- **better use of existing resources for WCA (waste and corruption)**

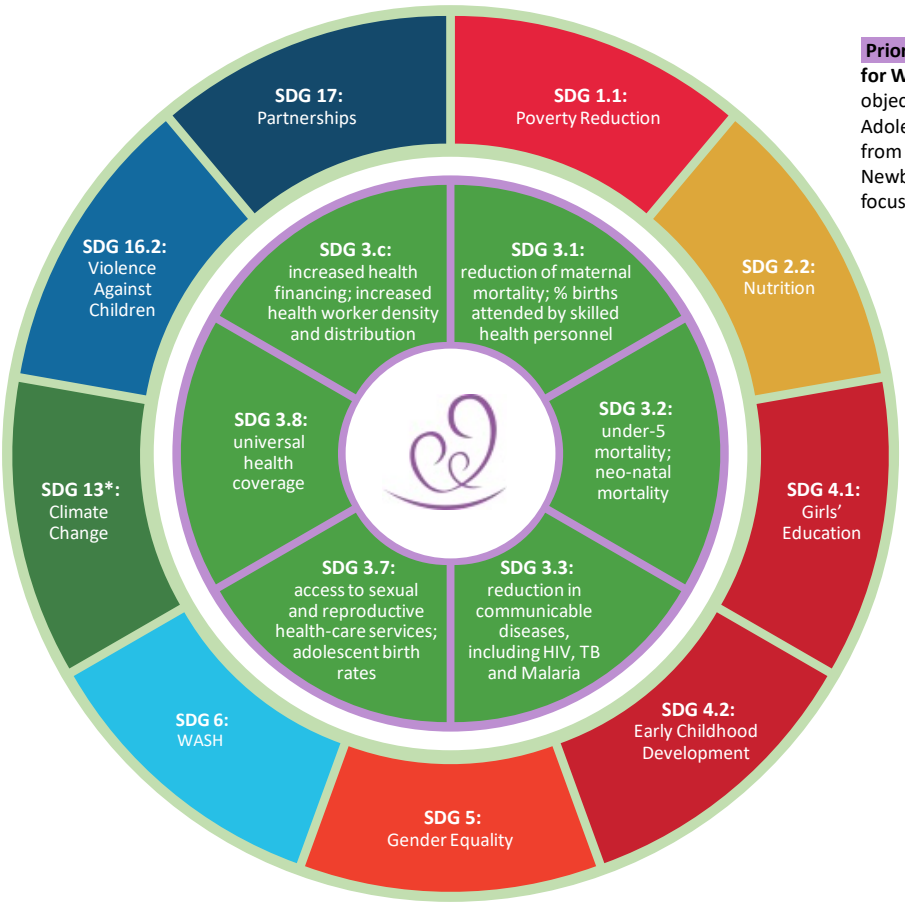
C. SERVICES: increased and more equitable coverage and uptake of quality services for MNCH, SRHR, Adolescents

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 effective coverage of quality -WCAH interventions**
- **strengthened health systems (e.g. HRH, supply chains) for better delivery of services**
- **increased recruitment, pay and working conditions of midwives & nurses**
- **improved demand and uptake of services**

9. IMPACT

Changes in the Outcomes listed in Section 8 will in turn contribute to Impact-level changes. Our Results Framework in Annex 2 lists PMNCH's desired Impact – as measured by changes principally in SDG and Global Strategy targets and indicators – in two areas: (i) targets and indicators relating directly to health outcomes (SDG 3 and Global Strategy targets), and (ii) those SDG targets and indicators relating to other SDGs that are major determinants of health outcomes (e.g. Early Childhood Development, Girls' Education, Poverty Reduction).



Priority SDG 3 targets and indicators for WCAH most linked to PMNCH's three objectives of MNCH, SRHR & Adolescents (plus Stillbirths indicator* from EWEC Global Strategy / Every Newborn Action Plan), with a particular focus on equity

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

10. GOVERNANCE & MANAGEMENT

Governance *[to be revised, subject to Board decisions on Governance restructuring options]*

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.

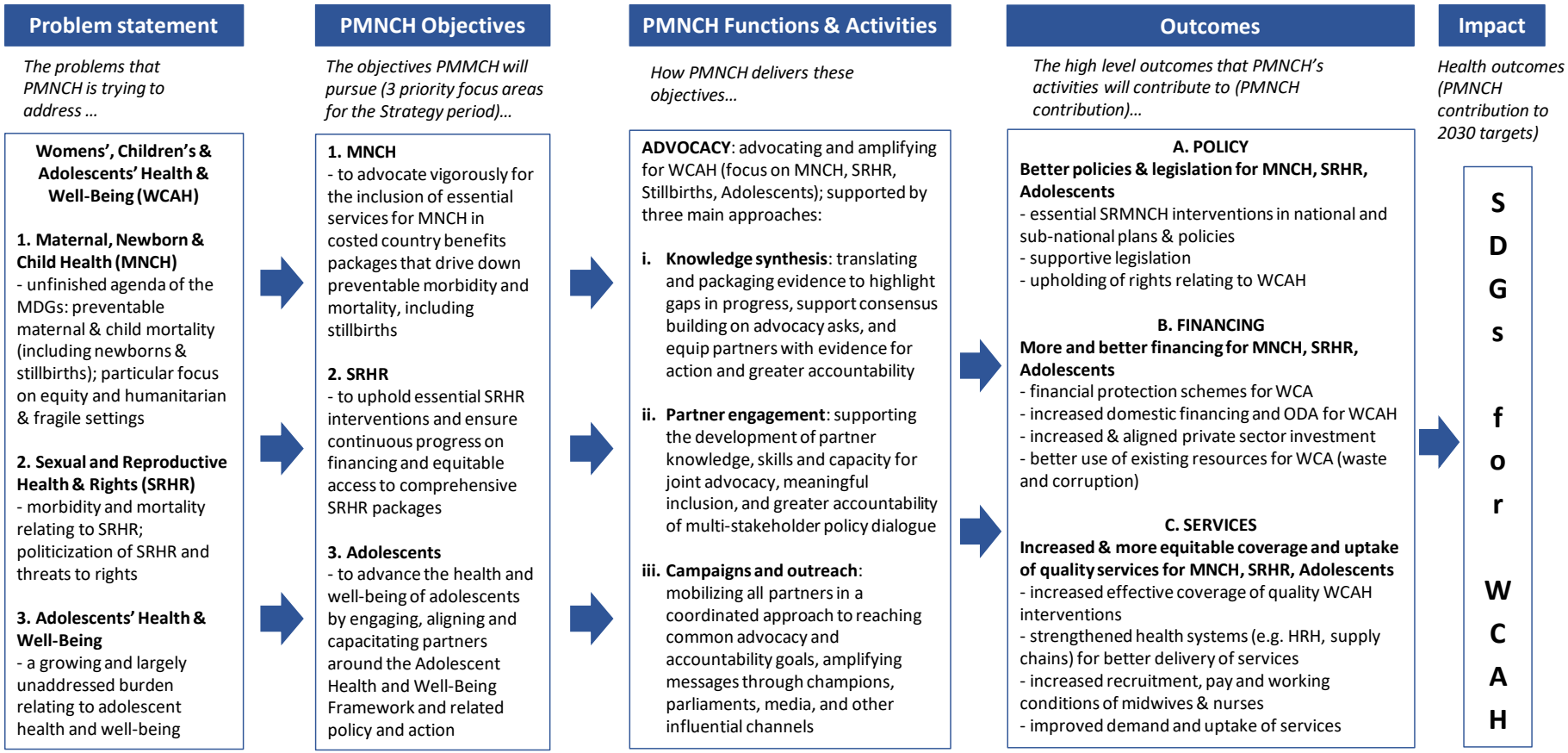
Budgets & Annual Workplans

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



ANNEX 2. Results Framework

The Results Framework below is derived from the PMNCH Theory of Change. All Impact and Outcomes indicators have existing means of verification. Impact level indicators are drawn principally from the SDGs and the EWEC Global Strategy; both SDG 3 (Health) and SDGs for those sectors outside of Health that are significant determinants of health outcomes. Outcome indicators are drawn principally from four sources: SDGs; EWEC Global Strategy; Countdown to 2030; Global Action for Measurement of Adolescent Health. For both Impact and Outcomes, PMNCH's accountability is one of *contribution* and not *attribution* for the achievement of results. Outputs and Inputs are described in the Results Framework in broad terms only, and will be further detailed in PMMCH Annual Workplans. In addition to annual Work Planning and Review, 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).

Results	MNCH	SRHR	Adolescents
IMPACT (PMNCH contribution)			
Indicators selected from: (i) SDG indicators, (ii) EWEC Global Strategy targets & indicators, (iii) Global Action for Measurement of Adolescent Health (GAMA) indicators	**SDG 3 (Health) & EWEC Global Strategy indicators** ➢ Maternal mortality ratio (3.1.1) ➢ Under-5 mortality rate (3.2.1) ➢ Neonatal mortality rate (3.2.2) ➢ Stillbirth rate (GS 3.2) ➢ Adolescent mortality rate (GS 3.4) ➢ Suicide mortality rate by age (3.4.2) ➢ Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group (3.7.2) ➢ Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations (3.3.1), Tuberculosis incidence per 100,000 population (3.3.2), Malaria incidence per 1,000 population (3.3.3) ➢ Adolescent fertility rate (Global Action for Measurement of Adolescent Health (GAMA) indicator) ➢ Adolescent (10–19 years) injury-related mortality rate, and by age category, sex and type or injury (per 100 000 population) (GAMA) ➢ Prevalence of intimate partner violence among adolescents (GAMA) **Other SDGs (determinants of Health outcomes)** ➢ Poverty Reduction 1.1.1); Nutrition (2.2.1); Girls' Education (4.1.1); Early Childhood Development (4.2.1); Gender Equality (5.1.1; 5.2.1; 5.2.2); WASH (6.1.1; 6.2.1); Climate Change (13.1.1; 13.1.2); Violence Against Children (16.2.1; 16.2.2; 16.2.3); Partnerships (17.1.1; 17.1.2; 17.16.1)		

OUTCOME (PMNCH contribution)			
A. POLICY: better policies & legislation for WCAH - essential SRMNCH interventions in national and sub-national plans & policies - supportive legislation - upholding of rights relating to WCAH	➢ National policy on: ANC (CD 5462), access to skilled care at childbirth (CD5528), free access to health services for pregnant women and newborns (CD 5410 & CD 5414), postnatal care for mothers and newborns (CD 5466), universal access to health services for children (CD 5433) ➢ National policy/law to review maternal deaths, stillbirths, and neonatal deaths (CD 5492, CD 5496 & CD 5498) ➢ National policy and standards on management of low birth weight, preterm and newborns with severe illness (CD 5467 & 5468)	➢ National policy on Quality of Care includes sexual and reproductive health (Countdown 5405)	➢ National policy specifically addressing adolescent health issues (Countdown 5374) ➢ Policy/legislation on free access to health services for adolescents (Countdown 5413)
B. FINANCING: more and better financing for WCAH - financial protection schemes for WCA - increased domestic financing and ODA for WCAH - increased & aligned private sector investment - better use of existing resources for WCA (waste and corruption)	➢ Current country health expenditure per capita (including specifically on MNCH) financed from domestic (3.8.2) ➢ Proportion of population with large household expenditures on health as a share of total household expenditure or income sources (GS3.8) ➢ Percentage of total health expenditure spent on reproductive, maternal, newborn, and child health (EPMM Phase 2 core indicator) ➢ Total net official development assistance for MNCH (within 3.b.2)	➢ Current country health expenditure per capita (including specifically on SRH) financed from domestic sources (3.8.2) ➢ Percentage of total health expenditure spent on reproductive, maternal, newborn, and child health (EPMM Phase 2 core indicator) ➢ Total net official development assistance for SRHR (within 3.b.2)	➢ Current country health expenditure per capita (including specifically on AH) financed from domestic sources (3.8.2) ➢ Total net official development assistance for AH (within 3.b.2)
C. SERVICES: Increased coverage and uptake of high-quality services - increased effective coverage of quality -WCAH interventions - strengthened health systems (i.e. HRH, supply	➢ Proportion of births attended by skilled health personnel (3.1.2) ➢ Coverage of essential MNCH services (3.8.1) ➢ Percentage of infants < 6 months who are exclusively fed breast milk (GS 3.2); ➢ Percentage of children fully immunized (GS3.2)	➢ Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods (3.7.1) ➢ Coverage of essential SRH services (3.8.1)	➢ Adolescent health indicators are included in the existing national household surveys (GAMA) ➢ Coverage of essential AH services (3.8.1) ➢ Proportion of men and women aged 15-24 with basic knowledge about SRHR (GS3.7 & 5.6);

chains) for better delivery of services - increased recruitment, pay and working conditions of midwives & nurses - Improved demand and uptake of services	➢ Proportion of the target population covered by all vaccines included in national programme (3.b.1) ➢ Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis (3.b.3) ➢ Health worker density and distribution (3.c.1) ➢ Proportion of coverage of early postnatal care (ENAP Target 3 2020-2025)	➢ Proportion of men and women aged 15-24 with basic knowledge about SRHR (GS3.7 & 5.6) ➢ Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis (3.b.3)	➢ Proportion of the target population covered by all vaccines included in their national programme (3.b.1) ➢ Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis (3.b.3) ➢ Adolescents covered by all vaccines included in their national programme [HPV] (GAMA)
OUTPUTS (PMMCH attribution)			
Outputs related to activities to be specified in Annual Workplan	➢ Coordinated and integrated advocacy campaigns to strengthen political commitment, policies and domestic resource mobilization/ODA for MNCH and stillbirths, SRHR and Adolescents; ➢ Knowledge synthesis and harmonized progress tracking facilitated to inform advocacy campaigns and champion messaging (including investment case and ODA and domestic financing for MNCH, SRHR and AHWB). ➢ Digital platform, resources development and capacity building in place to enable and enhance joint advocacy and coordinated action by policy makers, parliamentarians, media, champions and at global, regional and national levels ➢ Community monitoring and advocacy designed to drive improved quality and coverage of services, including through efforts to stimulate community empowerment and demand for the right to quality care ➢ Cross constituency and PMNCH member collaboration and actions at global, regional and country level		
INPUTS (PMNCH attribution)			
Financial & human resources to be specified in Annual Workplan	➢ Engaged PMNCH partners using their time and resources to drive change, including high-level champions ➢ Digital solutions in place to facilitate collaboration and action by partners ➢ Small grants to strengthen Multi-Stakeholder Platforms at national level for joint advocacy and accountability for WCAH budget, policies & plans, including support to civil society, parliamentarians, media & youth groups participate in national and global policy dialogue; ➢ Effective governance to facilitate increased engagement and advocacy ➢ Fit-for-purpose Secretariat to support partner engagement and implementation of Strategy and relating workplans		

ANNEX 3. Risks & Risk Management

Risks listed below are derived from the 'Assumptions / Risks' listed in the Theory of Change. 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.

RISKS	RISK MANAGEMENT
INTERNAL FACTORS	
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

Endnotes

[i] PMNCH defines Women's, Children's and Adolescents' Health (WCAH) to include Newborns and Stillbirths.
[ii] PMNCH uses the Lancet / Guttmacher 2019 definition of SRHR, which expands on the original definition of SRHR agreed at the International Conference on Population and Development in 1994 by explicitly stating that sexual and reproductive health is not possible without sexual and reproductive rights: "the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so."
[iii] Levels & Trends in Child Mortality. UNICEF. 2019
[iv] Ibid.
[v] Survive and thrive: Transforming care for every sick newborn. WHO. 2018.
[vi] Maternal mortality: Levels and trends. WHO. 2019
[vii] Mason E, Sen G, Yamin E. Universal health coverage provisions for women, children and adolescents. Bulletin of the World Health Organization 2020;98:79-79A. doi: http://dx.doi.org/10.2471/BLT.19.249474
[viii] Adding It Up: Investing in Contraception and Maternal and Newborn Health. Guttmacher Institute. 2017
[ix] Trends in sexual activity and demand for and use of modern contraceptive methods in 74 countries: a retrospective analysis of nationally representative surveys. Lancet Global Health. 2020
[x] World Health Organization, COVID-19: operational guidance for maintaining essential health services during an outbreak, 2020, https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak.
[xi] Marie Stopes International, Methodology for calculating impact of COVID-19, 2020, https://www.mariestopes.org/resources/methodology-for-calculating-impact-of-covid-19.
[xii] Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries. Guttmacher. 2020
[xiii] Sheehan P, Sweeny K, Rasmussen B, Wils A, et al. Building the foundations for sustainable development: a case for global investment in the capabilities of adolescents. Lancet, 2017; 390: 1792–806.