PMNCH for Women's, Children's and Adolescents' Health
Hosted by the World Health Organization

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Proposed indicator definitions

Table of Contents

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1. Outputs

1.1 Partners' advocacy efforts aligned and amplified

Indicator	**% of Collaborative Advocacy Action Plans (CAAPs) implemented as intended**
Definition	• CAAPs are defined as PMNCH-supported national-level partner-led plans aimed at holding governments accountable for their commitments to women's, children's, and adolescents' health and wellbeing (WCAHW). • Implemented as intended is defined as achieving at least 80% of the milestones outlined in the CAAP within the reporting period.
Rationale for use	CAAPs are a core instrument for PMNCH's country-level advocacy efforts.
How it is measured	**Numerator**: Number of CAAPs implemented as intended **Denominator**: Total number of CAAPs planned Assessment is based on self-reporting against predefined activities and timelines in the CAAP.
Target(s)	At least 70% of CAAPs implemented as intended within the defined implementation period.
Data source and reporting frequency	CAAP coordinating partner progress reports; reported annually.
Limitation	Relies on self-reported data, which may be subject to bias. External factors at the national level may affect implementation timelines. Does not assess the quality of implementation.

Indicator	**Number of the Global Leaders Network (GLN) countries**
Definition	Increase is defined as a growing number of countries that are part of the GLN, a global South-lead global health diplomacy initiative supported by PMNCH to advance the attainment of SDGs related to WCAHW.
Rationale for use	GWL is a core advocacy mechanism of PMNCH that leverages the visibility, influence, and convening power of high-profile political leaders.
Target(s)	At least two new GLN countries per reporting year.
How it is measured	Count of GLN countries during the reporting period compared to the count from the previous year.
Data source and reporting frequency	GLN meeting reports; reported annually.
Limitation	Does not capture depth or quality of engagement within the GLN.

1.2 Political actors committed to WCAHW

Indicator	**Sustained engagement of Heads of States and/or their delegates in the GLN**
Definition	• Sustained engagement is defined as participation in GLN events, technical meetings, or other GLN convenings as a speaker, panelist, host, or participant contributing to discussion or outcomes.

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	• Heads of States and/or their delegates are defined as Ministers of Health or Finance, Deputy Ministers, First Ladies, Ambassadors, or Permanent Representatives.
Rationale for use	This indicator tracks high-level political engagement, which is critical for advancing policy commitments and mobilizing resources for WCAHW. Engagement signals growing political will and visibility for PMMCH's focus areas. GNL is a global health diplomacy initiative core to the PMNCH's work.
How it is measured	**Numerator**: Number of Heads of State or their delegates with active engagement in the GLN during the current reporting year. **Denominator:** Number of active Heads of State or delegates recorded in the previous reporting year.
Target(s)	Value of 1 or above to reflect sustained engagement.
Data source and reporting frequency	Meeting reports and attendance lists; reported annually.
Limitation	Verifying sustained engagement may vary across contexts, and political turnover can impact consistency. Additionally, the indicator measures frequency and not necessarily the depth or quality of engagement. Attribution to PMNCH efforts may be indirect.

1.3 Sustained financial investment for WCAHW

Indicator	**% of countries (CAAP and GLN) with cases for financing and/or rights**
Definition	A "case" is defined as a publicly accessible document developed in a CAAP or a GLN country, that presents a clear ask for investment in and commitment to improve financing and/or rights for WCAHW.
Rationale for use	A case for investment and rights signals the commitment of the country to improve WCAHW.
How it is measured	**Numerator**: Number of CAAP and GLN countries with at least one case (rights or investment or both) **Denominator**: Total number of CAAP and GLN countries Followed by comparison between reporting years.
Target(s)	At least 70% of CAAP and GLN countries with a case for investment and/or rights.
Data source and reporting frequency	Implementing partner and CAAP coordinating partner progress reports and GLN reports; reported annually.
Limitation	Does not reflect the influence or outcomes of the cases. Relies on self-reporting across CAAP and GLN countries. Cases themselves and their reporting may vary across the countries.

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1.4 Accountability enhanced

Indicator	**% of countries (CAAP and GLN) with a functioning WCAHW commitment tracking mechanism**
Definition	• A commitment tracking mechanism is defined as a publicly accessible system or activity to monitor commitments in CAAP and GLN countries (e.g., digital platform, reporting framework, dedicated monitoring system, or regular annual meeting to review progress). • Functioning is defined as publicly available and updated at least annually.
Rationale for use	This indicator assesses the extent to which CAAPs and GLN countries include systems to track progress on WCAHW-related commitments, which is essential for accountability and informed advocacy. A functioning tracking mechanism increases the likelihood of follow-through on commitments.
How it is measured	**Numerator**: Number of CAAPs and GLN countries with a functioning WCAHW commitment tracking mechanism **Denominator**: Total number of CAAPs and GLN countries
Target(s)	100% of CAAPs and GLN countries include and maintain a functioning commitment tracking mechanism.
Data source and reporting frequency	CAAP coordinating partner and GLN country progress reports; reported annually.
Limitation	The functionality and quality of tracking mechanisms may vary across contexts and may be influenced by external factors and dependent on political will.

1.5 Community voices, stories, and lived experiences inform policies and programs

Indicator	**Community voices and lived experiences, including those of adolescents and youth, positively shape policy or program design**
Definition	• Community voices are defined as perspectives and views of women, mothers, children, adolescents, and youth from the Global South, who are affected by national WCAHW policies and programs. • Lived experience is defined as personal knowledge and understanding gained through direct experience. • Adolescents are defined as individuals aged 10-19 years, and youth as those aged 15-24 years. • Positively shape means that policies and programs are evidence-based and respond to the above-mentioned populations' needs.
Rationale for use	This qualitative indicator captures in-depth examples of how community voices and lived experiences influence the design or development of policies or programs for WCAHW. It reflects PMNCH's commitment to foster inclusive partnerships.
How it is measured	This indicator is assessed through structured case studies, highlighting the processes, actors, and outcomes of community engagement, which can be

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	drawn from a country with a national CAAP coordinating partner or a relevant PMNCH member. For detailed guidance, see Appendix A.
Target(s)	At least 2 case studies documented per year.
Data source and reporting frequency	Case studies collected and written by the focal point at the PMNCH Secretariat, with input from relevant PMNCH partner, and the CAAP coordinating partner; reported annually.
Limitation	The sample size is small, and the findings are not representative. The quality of the insights depends on the interviewer's skills and level of trust established with the interviewees. Because case studies are internally written, they may also be subject to positive reporting bias.

1.6 Grassroots movements, youth, and adolescents equipped and empowered

Indicator	**Adolescent, youth, and grassroots movement representatives positively engage in CAAP or GLN processes**
Definition	• Adolescents are defined as individuals aged 10-19 years, and youth as those aged 15-24 years. • Grassroots organizations are defined as community-driven organizations that consist of a group of people pursuing common interests, largely on a volunteer and not-for-profit basis. • Positive engagement is occurring in policy-related spaces (e.g., policy dialogues) that allows for open discussion and where participants feel valued and experience impact. • CAAP or GLN processes are defined as convenings, consultations, coordination or planning meetings held as part of PMNCH's CAAPs or GLN activities.
Rationale for use	This indicator provides insight into the inclusiveness and quality of engagement between community actors and CAAPs and GLNs. It reflects on PMNCH's focus on meaningful participation and helps identify strengths and gaps in how engagement is experienced and valued by those closest to the issues.
How it is measured	Data collected through semi-structured interviews. For detailed guidance, see Appendix B.
Target(s)	At least one case study conducted annually.
Data source and reporting frequency	The Secretariat, CAAP implementation partners, or GLN focal points identify suitable individuals, conduct, and document the interviews; reported annually.
Limitation	The sample size is small, and the findings are not representative. The quality of the insights depends on the interviewer's skills and level of trust established with the interviewees. Because case studies are internally written they may also be subject to positive reporting bias.

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2. Intermediate Outcomes

Outcomes are mostly standard indicators, with data collected externally.

2.1 Commitments implemented

Indicator	**Health expenditures on the less than five-year-old population, reproductive health, and maternal health conditions, as % of current health expenditure**
Definition	Current health expenditure is defined as financing budgeted for health, including costs related to service delivery, supplies, and human resources targeting five-year-old population, reproductive health, and maternal health conditions.
Rationale for use	Without proper financing, progress towards WCAHW stagnates. This standard indicator assesses how countries prioritize key areas of WCAHW within overall health spending. It reflects the contribution of PMNCH's advocacy for implementing financial commitments made in these areas.
How it is measured	For details, see here for less than 5-year old population, here for reproductive health, and here for maternal conditions.
Target(s)	Stability or increase in the level of annual health expenditure.
Data source and reporting frequency	WHO Global Health Observatory. Indicator Data Registry; data is reported annually.
Limitation	Data on age-specific, reproductive, and maternal health expenditure are often incomplete or inconsistently reported across countries. Estimates may rely on proxies, modelling, or assumptions, affecting accuracy, comparability, and reliability.

2.2 Impact-oriented partnerships and multi-sectoral coalitions in place and sustained

Indicator	**% of planned regional coalitions initiated**
Definition	• A regional coalition is defined as a collaborative network of PMNCH partners that convenes to work towards shared objectives at the regional level, aligning with PMNCH's goals and mission. • Initiated is defined as the public launch of the coalition.
Rationale for use	PMNCH supports coalition building at the regional level to encourage South-South learning and positive "peer" pressure. Regional coalitions enable cross-country collaboration and strengthen the collective voice of partners in influencing regional institutions and intergovernmental processes, allowing for responses that are more contextually relevant than global or national efforts alone.
How it is measured	**Numerator**: Number of regional coalition initiatives initiated **Denominator**: Total number of regional coalition initiatives planned during the reporting period
Target(s)	100%
Data source and reporting frequency	Public documentation of launch; reported annually.

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Limitation	The indicator measures coalition formation but not their functionality, inclusiveness, or impact.

Indicator	**National coordinating body in country (CAAP and GLN) that is responsible for developing, implementing, or overseeing SRMNCAH strategy, policy, and/or plan**
Definition	A national coordinating body is defined as a national-level committee or working group, led by the Ministry of Health. It is responsible for developing, implementing, or overseeing the national strategy, policy or plan related to sexual, reproductive, maternal, newborn, child, and adolescent health (SRMNCAH).
Rationale for use	A national coordinating body promotes multi-sectoral planning required for an implementation of commitments made. It helps generate and maintain political will and prioritization of WCAHW in national decision-making. This standard indicator reflects a country's commitment to leadership and accountability in advancing WCAHW, with a focus on CAAP and GLN countries.
How it is measured	National policy surveys completed by WHO country offices and focal points at the respective Ministries of Health in CAAP and GLN countries, for more details, see here.
Target(s)	100 %.
Data source and reporting frequency	WHO Data Portal, SRMNCAH policy survey; data is reported every 4-5 years. More frequent reporting likely available internally from WHO.
Limitation	The existence of a national coordinating body does not guarantee its effectiveness, regular functioning, or meaningful stakeholder participation. Reporting may also rely on self-assessment, which can lead to overstatement of coordination capacity.

2.3 Anti-rights movements combated

Indicator	**% of countries (CAAP and GLN) where anti-gender laws are absent**
Definition	• Anti-gender laws refer to laws or policies that restrict, undermine, or criminalize gender equality, SRH, or the rights of women and LGBTQ+ individuals and reject international standards on gender and human rights. • Absence means the non-existence of such laws within a country's legal framework
Rationale for use	Absence of anti-gender laws signals whether countries provide an enabling legal and policy environment for advancing SRHR and gender equality, reflecting a country's commitment to uphold international human rights standards. This indicator supports PMNCH's commitment to counter anti-rights movements by demonstrating the share of CAAP and GLN countries where such movements have not succeeded in shaping restrictive legal and policy outcomes.

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How it is measured	**Numerator**: Number of CAAP and GLN countries where no anti-gender laws are present **Denominator**: Total number of CAAP and GLN countries
Target(s)	At least 70%
Data source and reporting frequency	CAAP coordinating partner or GLN progress reports; reported annually.
Limitation	This indicator does not account for enforcement of the law, nor informal practices, including spread of dis- or misinformation, that may undermine rights. It also does not reflect positive legal protections for SRHR and gender equality.

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3. Sustained Outcomes

3.1 Policies, services, and financing in place in support of unmet commitments to and unfinished agenda for WCAHW

Indicator	**Improved coverage of reproductive, maternal, newborn, and child health (in CAAP and GLN countries)**
Definition	This is a composite index that is part of SDG 3.8.1 and measures average coverage of essential health services for reproductive, maternal, newborn and child health (RMNCH) and includes tracer indicators for: • Family planning coverage • Antenatal care coverage • Child immunization coverage • Care-seeking for pneumonia
Rationale for use	Unfinished agenda for WCAHW is one of the three key focus areas of PMNCH. This standard indicator tracks RMNCH health service coverage and helps identify access gaps, aligned with PMNCH's vision for improved WCAHW. It reflects country progress in translating policy and financing commitments into tangible health service improvements for women, mothers, children, and adolescents.
How it is measured	Indicators are tracked through national survey and administrative data and the values are normalized on a scale from 0 to 100, where a higher score indicates better coverage. **Numerator**: Number of CAAP and GLN countries with a score of 60 or above **Denominator**: Total number of CAAP and GLN countries
Target(s)	At least 70% of CAAP and GLN countries with a score of 80 or above.
Data source and reporting frequency	WHO Global Health Observatory. Indicator Data Registry, data is reported every 2-3 years.
Limitation	The indicator focuses on a few RMNCH areas and does not track WCAHW and related services more broadly. It does not capture the quality, equity, or timeliness of services provided, and by relying on national averages, it may mask in-country disparities (e.g., by income, age, geography).

3.2 Policies, services, and financing in place in support of sexual and reproductive health and rights

Indicator	**% of countries (CAAP and GLN) with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information, and education**
Definition	SDG Indicator 5.6.2 measures the extent to which countries have national laws and regulations that guarantee full and equal access to women and men aged 15 years and older to SRHR. Laws and regulations cover maternity care, contraception services, sexuality education, HIV, and HPV.

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	The indicator is a percentage scale of 0 to 100, indicating a country's status and progress in the existence of such national laws and regulations.
Rationale for use	SRHR is one of the three key focus areas of PMNCH. This indicator aligns with PMNCH's commitment to SRHR, assessing the existence of legal and policy frameworks that guarantee access to these rights. It reflects progress towards influencing policy change for WCAWH as a critical step towards access to services.
How it is measured	**Numerator**: Number of CAAP and GLN countries with a score of 75 or above **Denominator**: Total number of CAAP and GLN countries Data from 2022 will serve as the baseline.
Target(s)	At least 70% of PMNCH's CAAP and GLN countries with a score of 75% or above
Data source and reporting frequency	Sustainable Development Goals. WHO Data Portal; data is reported every 4 years.
Limitation	The indicator exclusively measures the existence of policies and legal frameworks but not their implementation, including financing, coverage and quality of SRHR services.

3.3 Policies, services, and financing in place in support of adolescent health and well-being

Indicator	**% of countries (CAAP and GLN) with a national strategic plans for adolescent health and well-being**
Definition	A national strategic plan is defined as a publicly available national-level policy document that outlines a desired future, key interventions, and how to address political, social, economic, and technical factors and constraints, while engaging other sectors as needed.
Rationale for use	Improving adolescent health and well-being is one of the three key focus areas of PMNCH. The presence of a national strategic plan reflects a country's commitment to adolescent health and well-being, providing an opportunity also for further advocacy and partner mobilization for implementation.
How it is measured	**Numerator**: Number of countries (CAAP and GLN) with a national strategic plan **Denominator**: Total number of CAAP and GLN countries National policy surveys are completed by WHO country offices and focal points at the respective Ministries of Health, for more detail see here.
Target(s)	At least 70%.
Data source and reporting frequency	WHO Data Portal, SRMNCAH policy survey, data is reported every 4-5 years.
Limitation	With a focus on policy, the indicator does not track services and their financing for adolescent health and wellbeing. The existence of a strategic plan does not reflect the quality or implementation status. Plans may vary

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	significantly in scope and content across countries, and self-reported data may overstate actual commitment or progress.

4. Impact

A world where every woman, child, and adolescent can realize their right to health and wellbeing; where no woman, mother, child, or adolescent dies of preventable causes; and where universal access to sexual and reproductive health and rights is upheld.

Indicator	**Mortality (maternal, under -five, adolescent)**
Definition	• Maternal mortality is defined as the number of maternal deaths during a given time period per 100,000 live births during the same time period. • Under five mortality is defined as the probability of a child born in a specific time period dying before reaching the age of 5 years, if subject to age-specific mortality rates of that period, expressed as deaths per 1,000 live births. • Adolescent mortality is defined as the number of deaths among adolescents (10-19 years old) per 100,000 adolescent population.
Rationale for use	These standard mortality indicators align with PMNCH's vision of a world where no mother, newborn, child or adolescent dies from preventable causes and where they can realize their right to health and wellbeing. **Maternal mortality (SDG Indicator 3.1.1)** is a core public health measure of women's health and a central marker of progress in reducing preventable deaths during pregnancy and childbirth. **Under-five mortality (SDG Indicator 3.2.1)** is a core public health measure of tracking the country progress toward health and survival of young children. **Adolescent mortality** reflects the country progress in addressing health and survival of adolescents 10-19 years. Together, these indicators help assess whether policy commitments, services, and financing for WCAWH are translating into improved health outcomes, informing the need to strengthen responsive health and protection systems.
How it is measured	**Maternal:** Numerator: Recorded (or estimated) maternal deaths Denominator: Total recorded (or estimated) live births Expressed per 100,000 live births. Mathematical modelling is used to ensure the MMR estimation approach is consistent across context. **Under five:** Probability of death derived from a life table and expressed as rate per 1,000 live births. **Adolescent:** Civil or sample registration: Mortality by age and sex is used to calculate age-specific rates. Census: Mortality by age and sex tabulated from

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	questions on recent deaths that occurred in the household during a given period preceding the census (usually 12 months). Census or surveys: Direct or indirect methods provide adult mortality rates based on information on the survival of parents or siblings.
Target(s)	**Maternal:** Reduction to less than 70 per 100,000 live births. **Under five:** Reduction to equal or less than 25 per 1,000 live births. **Adolescent:** Reduction in mortality.
Data source and reporting frequency	**Maternal:** Sustainable Development Goals. WHO Data Portal; data reported every 2-3 years. **Under five:** Sustainable Development Goals. WHO Data Portal; data reported annually. **Adolescent:** WHO Global Health Observatory. Indicator Data Registry; data reported every 2-3 years.
Limitation	While these are global indicators, PMNCH operates in only a subset of countries. Progress on mortality indicators is often slow and may lag behind recent changes in policy, services, or financing. Mortality among women, children, and adolescents is often underreported due to weak data systems, incomplete death recording, limitations in survey methods, or may rely on proxy indicators or modelling. National averages mask in-country health disparities (e.g., by income, age, geography), particularly among marginalized groups, where mortality rates tend to be higher.

Indicator	**Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care**
Definition	Proportion of women aged 15-49 years (married or in union) who make their own decision on all three selected areas, i.e., decide on their own health care, decide on the use of contraception, and can say no to sexual intercourse with their husband or partner if they do not want. Only women who provide a "yes" answer to all three components are considered women who make their own decisions regarding sexual and reproductive health. A union involves a man and a woman regularly cohabiting in a marriage-like relationship.
Rationale for use	SDG Indicator 5.6.1 tracks women's autonomy in SRH decision-making, which is central to enhancing SRHR. It aligns with PMNCH's vision of realizing women's and adolescents' right to health and well-being, reflecting improvements in agency and rights.
How it is measured	**Numerator**: Number of married or in union women and girls aged 15-49 years who said yes to all three abovementioned areas of sexual and reproductive decision-making **Denominator**: Total number of women and girls aged 15-49, who are married or in union

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	Data is collected through existing country-specific surveys such as Multiple Indicator Cluster Surveys (MICS), Demographic Health Surveys (DHS), and Generation and Gender Surveys.
Target(s)	Ensure universal access to SRHR as agreed in accordance with the Programme of Action of the International Conference on Population and Development, the Beijing Platform for Action, and the outcome documents of their review conferences.
Data source and reporting frequency	Sustainable Development Goals. WHO Data Portal; data is reported annually.
Limitation	PMNCH's contribution to policies, services, and financing may not translate directly into individual decision-making ability that is also shaped by complex and intersecting socio-cultural factors. While this is a global indicator, PMNCH operates in only a subset of countries. The indicator excludes women and girls who are not married or in union and therefore does not capture the full picture, especially for adolescent girls and young women. As household surveys are the main data source, certain populations, such as unhoused or other minority groups are often underreported. The United States' defunding of the DHS may impact the availability of data.

Indicator	**Number of countries reporting progress in multi-stakeholder development effectiveness monitoring frameworks that support the achievement of the sustainable development goals**
Definition	Multi-stakeholder development effectiveness monitoring frameworks are defined as country-led, voluntary frameworks with agreed indicators that assess the strength of cooperation among development actors. They involve data collection and review with participation from the public sector, private sector, and civil society.
Rationale for use	SDG Indicator 17.16.1 reflects the extent to which countries are engaging in inclusive, country-led monitoring of development effectiveness, involving stakeholders across sectors. It aligns with PMNCH's mission to foster and support multi-sectoral coalitions and partnerships and helps assess whether PMNCH's efforts to convene at global, regional, and national levels are contributing to strengthened collaboration and progress toward the SDGs.
How it is measured	Unit of measure: Number of countries Method of computation: A country is considered to be reporting progress if, since the last reporting cycle, the number of indicators within the framework(s) showing a positive trend exceeds those showing a negative trend.
Target(s)	Increase in the number of countries reporting progress in multi-stakeholder development effectiveness monitoring frameworks.
Data source and reporting frequency	Sustainable Development Goals. SDG Global Data Portal; data is reported every 2-3 years.

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Limitation	This indicator depends on voluntary and country-led reporting, and thus, the type of frameworks, the depth of stakeholder engagement, and methodological consistency may differ between countries. While this is a global indicator aggregated by OECD and UNDP, PMNCH operates in only a subset of countries. The scope is broad (SDGs), limiting PMNCH's contribution to the progress overall and WCAHW in particular.

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Appendix A. Case study design: *Community voices and lived experiences, including those of adolescents and youth, positively shape policy or program design*

Methodology

Select at least two case studies per year from CAAPs, GLN, or suitable PMNCH partner initiatives where community voices and lived experiences directly shaped a policy or program related to WCAHW. Work with the CAAP coordinating partner, GLN, or country focal point to document the case using the template below as guidance. Collect information through conversations, meeting notes, and other relevant materials. Clearly describe the context, engagement process, and specific ways community input influenced outcomes. Highlight enablers, challenges, and key lessons learned to inform future advocacy and programming.

The case studies should focus on different cases in each study to allow for drawing diverse approaches, experiences, and lessons from a range of contexts.

Case study outline

Context

- Brief overview of current situation of WCAHW in the context
- Introduction of the policy or program that was influenced

Community engagement process

- How were the communities and people, including adolescents and youth, with lived experience engaged?
- Who was involved?
- What methods or tools were used?

Translating voices into action

- Concrete examples of how community voices shaped the policy or program
- Quotes or short narratives from community members and stakeholders

Enablers and challenges

- What worked well and what key factors supported meaningful engagement?
- What were main challenges or limitations faced during the process?

Reflections and lessons learned

- What was learned?
- What would be done differently next time?

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Appendix B. Case study design: *Adolescent, youth, and grassroots movement representatives positively engage in CAAP and GLN processes*

Methodology

Conduct semi-structured interviews with at least one interviewee per case with representatives from grassroots movements, youth-led or adolescent-led organizations, and civil society organizations. To capture diverse views and experiences, avoid interviewing the same representatives from year to another. While not meaningful to define the exact minimum number of interviews, the sample should be sufficient to generate relevant insights. Use the interview guide below as a flexible tool to explore participants' experiences engaging with government actors on WCAHW issues. Record the conversations (with consent) or take detailed notes to ensure accurate documentation. Create a safe and respectful environment for open dialogue. Focus on capturing perspectives on influence, challenges, and what made the engagement meaningful or not.

Interview questions

1. Please describe a recent experience where you or your organization engaged with CAAP/GLN processes on WCAHW?
   Prompt: What was the purpose of the engagement? How were you invited/ included?
2. How would you describe the level of influence you had in that engagement?
   Prompt: Were your views taken seriously? Did anything change based on your input?
3. In your view, what made the engagement meaningful—or not meaningful—for you?
   Prompt: Think about who was present, how decisions were made, how you were treated.
4. What kind of support (e.g., information, resources, safe space) helped or could have helped you participate more fully?
   Prompt: What was missing that would have made a difference?
5. Have you received any feedback from CAAP/GLN partners after your participation? If so, what was it, and how did you perceive it?
   Prompt: Did they explain how your input was used—or not?

Case study outline

Context

- Brief overview of the current situation for adolescent, youth, and grassroots engagement in the case study context.
- Introduction of the interview partners and the goals of the engagement.

Engagement process

- How were representatives invited or involved in engaging with CAAP/GLN partners?
- What were the types of stakeholders involved, and the methods used for engagement?

Quality of engagement

- How did interview partners experience the engagement process (e.g., inclusive, respectful, tokenistic)?

Enablers and challenges

- What worked well and what key factors supported meaningful engagement?
- What were main challenges or limitations faced during the process?

Reflections and lessons learned

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- What was learned?
- What would be done differently next time?

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Appendix C. Case study design: *Country initiative*

This template provides an outline for PMNCH to describe its advocacy work and related results. It supports the documentation of a selected PMNCH-supported initiative, helping to communicate PMNCH's work and capture learnings that can inform future efforts. Intended as a flexible tool, the template can be adapted to suit the specific context and purpose of each initiative.

Selecting a case that demonstrates PMNCH's added value, tangible results, and transferable lessons contributes to a compelling narrative.

Overview
Project name:
Country/region:
Intervention period:
Lead organization:
Partners and stakeholders involved:
Issue and context (1-2 paragraphs)
• **What problem or issue did the initiative aim to address?** *Describe the objective/purpose of the initiative.* • **Why was this issue important in this context?** *Describe the political, economic, social, legal, or other relevance of the issue.* • **What was the existing political, system, or financial landscape before the intervention?** *Provide more details on the context in which the initiative was implemented.*
Strategy and activities (2-3 paragraphs)
• **What strategies were used to influence decision-making and systems?** *Explain how the initiative attempted to bring about change, and how it was expected to lead to results.* • **What activities were carried out?** *Describe the specific actions taken (e.g., coordination, convenings, joint action planning)* • **How did coordination, engagement, and participation shape the initiative?** *Describe how different actors worked together and how stakeholders and communities, including youth, adolescents, and grassroots organizations, were involved in planning and implementation.*
Results (2-3 paragraphs)
• **What are the immediate outcomes of the initiative?** *Describe what changed (particularly regarding outputs of the PMNCH Theory of Change). Describe also unexpected outcomes or reactions, if applicable.* • **How does the initiative contribute to longer-term change?** *Elaborate on the extent to which the initiative helped lay the groundwork for future results (regarding intermediate and sustained outcomes of the PMNCH Theory of Change).*
Key takeaways (1-2 paragraphs)
• **What enabled the change?** *Describe the success factors.* • **What were the challenges?** *Describe factors hindering implementation or achieving results.* • **What learnings could inform similar efforts in other contexts?** *Describe what you would recommend others do or avoid (or PMNCH in the future); what worked well and what did not; and what you would do differently next time.*

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Annex 3. Illustrative template for a learning agenda

Learning Questions	Learning Activities	Resources and Timing
What does PMNCH need to know to deliver its Strategy 2026-2030 effectively? For example, • Are there gaps in the technical evidence base? • Are there gaps in the partner base and engagement? • Are there gaps in knowledge of and preparedness for external shocks and game-changers?	What actions will PMNCH take to answer the learning questions? • Has the PMNCH Secretariat or partners already investigated the question (eg, through evaluations, research)? • If not, with whom with a similar question to collaborate?	Who will be responsible for implementing learning activities and when? What resources are needed, and to what extent are they available?
Q1		
Q2		
Q3		
Q4		
Q5		