Methods guide for country case studies on successful collaboration across sectors for health and sustainable development¹

March 2018

Countries are implementing the Every Woman Every Child Global Strategy (EWEC Global Strategy)², and collaboration across sectors is key to success and progress towards health and Sustainable Development Goals (SDGs). This guide supports the development of 12 country case studies selected through a PMNCH global call for proposals to find out: How is collaboration across sectors taking place in countries? What innovative practices are emerging? What conditions lead to success? What are the results of collaboration across sectors and impacts for people’s health and sustainable development? What can we learn? The case studies selected from low-, middle-, and high-income countries will provide inspiration, insight, and ideas into what worked and why, as well as the challenges addressed. Six priority themes of the EWEC partners’ framework will be covered:

- Early Childhood Development
- Adolescent Health and Well-Being
- Quality, Equity and Dignity in Services
- Sexual and Reproductive Health and Rights
- Empowerment of Women, Girls and Communities
- Humanitarian and Fragile Settings

These twelve case studies will be published as a special issue in the BMJ and launched at the 2018 Partners’ Forum in New Delhi India on 5th to 6th December. They will be widely profiled, promoted and also disseminated through traditional and digital media channels. The case studies will facilitate sharing lessons across countries to inform action.
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Summary of the process to develop a country case study

Each country case study has 3 key deliverables:

- Working report developed using Table 1 in this methods guide, including on the collaborative process, planning and implementation, and results achieved at different levels including ultimately for health and sustainable development;
- Multi-stakeholder review meeting to review and finalize the working report;
- 3000-word journal article submitted to the BMJ, based on the finalized working report. Authorship would be agreed in advance, based on the criteria set out in this guide, and other partners’ contributions would be acknowledged.

The case studies will be launched at the Partners’ Forum on 5-6 December 2018 in India, New Delhi.

<table>
<thead>
<tr>
<th>KEY MILESTONES 2018</th>
<th>KEY TASKS FOR DEVELOPING THE CASE STUDY</th>
<th>RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>By early April</td>
<td>• Lead organization (i.e. successful applicants) identifies an operational lead(s)/ lead author(s) (no more than 2) for the case study and brings together a country working group to review the case study process and timelines (and agree dates for key deliverables and events), develop the plan and budget, secure national consultancy support if required and coordinate with the international consultant to set up and support the process, including to organize the multistakeholder review meeting • The country working group should be made up of different stakeholders from different constituencies, for example, government; non-government organizations; academic, research and training institutes; health care professional associations; multilateral organizations; private sector; donors and foundations; global financing mechanisms; adolescents and youth, programme beneficiaries and other relevant stakeholders • Contact the H6 focal point in the country, where relevant, who can help support the process, and for non-government led case studies, help coordinate with relevant government colleagues for engagement with the case study process • Use the guiding questions (Table 1) to start collating relevant programme data, reports and evaluations and other peer-reviewed and grey literature, as well as identifying further information and key informant interviews required, to draft the working report • Lead organization / international consultants to brief the Global Steering Committee and PMNCH on the formation of the country working group, and to flag any challenges at this initial stage</td>
<td>Lead organization and operational lead(s)/ lead author(s) Country working group Supported by consultants and coordinating with Global Steering Committee and PMNCH secretariat</td>
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</tbody>
</table>
### DEVELOP THE WORKING REPORT USING THE GUIDING QUESTIONS TO COLLATE DATA

| By end-June (to be shared 2 weeks in advance with multistakeholder review meeting participants and Global Steering Committee) | • Finalize the working report using the guiding questions and a synthesis of relevant programme data, reports and evaluations and other peer-reviewed and grey literature and develop the working report  
• Country visit by international consultant  
• Lead organization / international consultants to brief Global Steering Committee on country process to date | Lead organization and operational lead(s)/ lead author(s)  
Country working group  
Supported by consultants and coordinating with Global Steering Committee and PMNCH secretariat |

### CONDUCT MULTISTAKEHOLDER REVIEW MEETING

| By mid-July | • Follow the guide for organizing a multistakeholder review meeting, including the preparation, planning, participants and process  
• Undertake the multistakeholder review meeting to review and update the working report and resolve any remaining issues  
• Country visit by international consultant for the multistakeholder review  
• Draft journal article based on the working report developed for internal editing | Lead organization and operational lead(s)/ lead author(s)  
Country working group  
Supported by consultants and PMNCH secretariat |

### DEVELOP JOURNAL ARTICLE BASED ON THE WORKING REPORT AND MULTISTAKEHOLDER REVIEW

| By mid-August | • Submit the 3000-word paper to the BMJ with sign off from authors. Authorship will be agreed as per the authorship guidelines included in this guide | Lead organization and operational lead(s)/ lead author(s)  
Supported by consultants and PMNCH Secretariat |

| By end-November | • Revise and finalize manuscript in response to comments from peer-reviewers and the BMJ Editorial Committee  
• Work with BMJ technical editors on copyedited manuscript and checking pdf proofs | Lead organization and operational lead(s)/ lead author(s)  
Supported by consultants and PMNCH Secretariat |

### ACTIVITIES LEADING UP TO THE PARTNERS’ FORUM

| By early December | • Publication of journal articles - contingent on successfully going through the BMJ peer review, editorial and publication process  
• Contribute to the Partners’ Forum programme, especially the communications materials and learning sessions as will be agreed between the lead organization and Forum Organizing Committee as the agenda develops | The BMJ  
Lead organization and operational lead(s)/ lead author(s)  
Country working group  
Supported by consultants and coordinating with Global Steering Committee and PMNCH Secretariat |
Case study methods

Conceptual Framework

The conceptual framework for the case studies of successful collaboration across sectors is adapted from a framework on multisectoral action for nutrition, a guide on programme reporting standards, the Health in all Policies Training Manual, a model for public policy and administration decision-making and practice and an evidence synthesis of factors influencing successful collaboration across sectors. The framework comprises seven main components (Figure 1):

1) Programme description
2) Context, challenge and stakeholders
3) Framing the issue and planning action
4) Implementation architecture and mechanisms
5) Monitoring, accountability and learning
6) Evolution, scale and sustainability
7) Results of collaborating across sectors

Figure 1: Conceptual framework for the case studies on collaborating across sectors

Each country case study has 3 key deliverables:

- Working report developed using Table 1 in this methods guide, including on the collaborative process, planning and implementation, and results achieved at different levels including ultimately for health and sustainable development;
- Multi-stakeholder review meeting to review and finalize the working report;
• 3000-word journal article submitted to the BMJ, based on the finalized working report. Authorship would be agreed in advance, based on the criteria set out in this guide, and other partners’ contributions would be acknowledged.

The case studies will be launched at the Partners’ Forum on 5-6 December 2018 in India, New Delhi.

The process to develop the case study is as follows:

• The conceptual framework depicted in Figure 1 provides the basis for the guiding questions in Table 1.
• Country working group to use the guiding questions in Table 1 to identify and collate relevant documentation and data, and to agree on the main sources of evidence
• Address specific gaps in the data, to consult with key informants as required
• A multistakeholder review process would be used to finalize the working report. The working paper should be shared with the Global Steering Committee and multistakeholder review participants in advance of the multistakeholder review meeting
• The finalized working report would be used to develop the 3000-word journal article. The journal article will follow standard BMJ peer review and publication processes.
• The working report can also be used by the country team for other purposes. For example, after this case study process the working report could be developed as a separate advocacy document, briefing paper or country report e.g. see 2014 Success Factors series country reports http://www.who.int/pmnch/successfactors/en/ Please note this would not be considered as part of this current process.

The guiding questions presented in Table 1 should help structure the working report development—and standardize the process across the 12 country case studies. Specifically, they support organizing, analyzing and synthesising the documentation about how collaboration across sectors for women’s, children’s, and adolescents’ health evolved and progressed over time in a given context and what made the collaboration across sectors successful, as well as key lessons learned – for both the country and other countries interested in learning from the experience. The guiding questions and multistakeholder review process aim to ensure that the case studies are evidence-based, with triangulation of information and perspectives and are representative of a collaborative exercise.

In addition to the guiding questions, there are two additional columns to help the country working groups develop the working report. The first column helps to assess the available data and documentation and plan for additional information that would be required e.g. through key informant interviews. The second column will help the working groups to reflect on the nature and quality of evidence used to develop the case studies. This also would feed into lessons learned across the countries on the methods used to better understand collaboration across sectors and to inform future research and evaluation.
Guiding questions for case study development

Please note: The Programme description is required for all case studies. In each following main section of the table, there is one required question (identified as *required). Not all the other questions will be relevant to every programme. This is a semi-structured guide that can be adapted to the specifics of each case study and used to generate the content for the working paper. The format and length of the working report can be agreed by the country working group.

Table 1. Guiding questions and evidence considerations for the case study

<table>
<thead>
<tr>
<th>MAIN SECTIONS OF CASE STUDY WORKING REPORT</th>
<th>What data and documentation are: 1) available; and 2) required (e.g. interviews)</th>
<th>Reflections on the nature and quality of evidence by main section</th>
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<tbody>
<tr>
<td><strong>1. PROGRAMME DESCRIPTION</strong> <em>(required)</em></td>
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<tr>
<td>• What is the name of the programme?</td>
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<tr>
<td>• What is the start and end/planned end dates of the programme (incl. delays and/or unexpected end of the programme and an explanation of the reasons)</td>
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<tr>
<td>• What is the main content focus of the case study / objectives?</td>
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<td>• What are the sectors involved?</td>
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<tr>
<td>• What is the scope – target population (described using key sociodemographic characteristics) no. of people covered; national / sub-national etc?</td>
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<tr>
<td>• What is the context with respect to the country/state/province of the case study?</td>
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<tr>
<td>• Lead implementing organization(s) and contact details</td>
<td></td>
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<tr>
<td>• What is the budget overall and annual resources required for implementation (i.e. financial, physical and human resources)?</td>
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<tr>
<td>• What are the donor(s)/funding source(s)?</td>
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<tr>
<td><strong>2. CONTEXT, CHALLENGE AND STAKEHOLDERS</strong></td>
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Rationale for starting the programme
• What was the nature and significance of the issue or problem being addressed that necessitated the collaboration across sectors?
• What were the solutions, interventions or opportunities identified that drove the initiation of the programme?

Setting and context
• What is the policy/political context in which this collaboration started? – describe formal and informal processes.
• Overview of the contextual factors (i.e. policy/political, environmental, epidemiological, historical, sociocultural, socioeconomic, legal and/or health system). How did these contextual factors:
  - Trigger or spark conversations/dialogue about a collaborative approach? When did it start – informally and formally?
  - Influence, positively or negatively, the start of the collaboration
  - Affect the degree of convergence/type of collaboration that emerged across institutions operating in different sectors.

Stakeholders
Description of the involvement of different stakeholders in programme development.
3. FRAMING THE ISSUE AND PLANNING ACTION

- What is the theory of change, logical framework and summary timeline of the programme? In case you do not have these available please see the Annex to help develop this.* (required)
- What were the methods and rationale for selecting programme activities (e.g. based on results of a situational or stakeholder analysis, or needs assessment, and selection criteria such as evidence of impact or sustainability, or potential for scale-up)?
- How was location, i.e. country/place name(s), specific site(s), type of environment (e.g. urban or rural) decided upon?
- What information is there about whether or not gender, equity, rights and ethical considerations were integrated into the programme, and if so, how?
- Was a shared vision created for the collaboration across sectors? How? Were there opportunities for informal and formal trust-building? What were these?
- How was the appropriate architecture (e.g. the mechanisms, processes and structures) to support the collaboration across sectors decided upon?
- How did stakeholders decide upon the relative contribution of resources by different sectors, stakeholders, and levels? Was this decided jointly? If so, how?
- How were membership, roles, responsibilities, and incentives of sectors, stakeholders, and levels decided upon? Was it clear what their incentives for involvement were at the beginning or did these emerge as the collaboration developed?*
- How was the issue framed for the different audiences and sectors, and by whom?
- What strategies were used at different levels to generate support across sectors? What was the involvement of champions and leaders at all levels?
- Was there piloting of the programme activities elsewhere or within the programme done as part of programme implementation; how, when, where and by whom this was done and with what results for the collaboration?

4. IMPLEMENTATION ARCHITECTURE AND MECHANISMS

- In which areas was the collaboration across the sectors strongest? Score each from 1 to 10, with 10 being the highest* (required):
  1. Leadership
  2. Political strategy and policy negotiations
  3. Needs assessment
  4. Planning and design
5. Budget decisions  
6. Resource mobilisation  
7. Management and coordination  
8. Implementation  
9. Monitoring and evaluation  
10. Advocacy and communications

Implementation
Description of what was done and how
• Are the main implementation components/activities depicted in the log frame (see section above and Annex)? If not, please update this.
• Was the architecture (e.g. the mechanisms, processes and structures) to host the collaboration already in place?
• What policy, strategy, and legislative frameworks existed or were developed to support the collaboration?
• Did institutional restructuring have to take place to accommodate collaboration and what happened?

Description of what was done and how
• Are the main implementation components/activities depicted in the log frame (see section above and Annex)? If not, please update this.
• Was the architecture (e.g. the mechanisms, processes and structures) to host the collaboration already in place? If so, did institutional restructuring have to take place to accommodate collaboration and what happened?
• Alternately, did the mechanisms, processes and structures have to be custom built? What considerations had to be taken when building new architecture? How did this work?
• How did mobilization of resources—financial, human, infrastructural—take place?
• What incentives were put in place to sustain collaboration?
• Did any barriers to collaboration emerge? How were they overcome?
• Overall, was a culture of collaboration established across sectors and levels? If so, how? Was collaboration institutionalised, or was it dependent on specific individuals who helped to drive the process?
• What mechanisms used to ensure fidelity of programme implementation and adherence to appropriate standards of quality (e.g. supervision and support of personnel, refresher training, product quality checks)

Factors affecting collaboration
Description of key barriers and facilitators to the collaboration, including contextual factors (e.g. social, political, economic, health systems)
• What were the key barriers or obstacles encountered in the collaboration across sectors?
• Were any of the key barriers initially foreseen?
• What strategies were used to overcome these barriers, and how were these identified? What are the remaining challenges? What did not work? How was the problem identified and the collaboration adjusted? Were solutions identified jointly? If so, how.
• Was collaboration constant over time, or were there variations in level of engagement? How were these addressed?
• What environmental, political, social, economic, institutional and/or epidemiological contexts affected/influenced—either positively or negatively—the evolution of the collaboration across sectors during different phases of the collaboration? What contexts facilitated the roll out or further development / implementation of collaboration across sectors? What contexts impeded the
1. Collaboration across sectors?
• Did any of these contexts influence the level of working together across sectors in this stage of the collaboration?
• Were there key individuals who helped drive the process? Who were they and how did they influence the collaboration?
• Did mobilization and/or the relative contribution of resources—financial, human, infrastructural—change during programme? If so, why and how?
• Did membership, roles, responsibilities, and incentives of sectors, stakeholders, and levels change during the programme? If so, why and how?
• Did advocacy work continue during programme implementation? If so, what were the activities and who conducted them?

Financing, costing and cost-effectiveness
• Was the programme costed in advance, and if so, was this done in terms of the contribution of each sector, and if so, how? Were these costings validated as the programme was implemented?
• What were specific costs incurred in working across multiple sectors? Did these costings correspond to the resources each sector actually received or mobilized to undertake the programme?
• Was cost-effectiveness a factor in choosing to implement a multisectoral programme? In retrospect was the programme seen as being cost-effective?
• How does the perceived and actual cost-effectiveness of the programme impact on its sustainability and political viability?

5. Monitoring, Accountability and Learning

Monitoring and evaluation, including data collection and analysis of indicators, to identify problems/issues and potential solutions
• At the outset, what was envisaged as the main objectives or outcome(s) by which the success of the collaboration and programme was to be judged?
• Was there a process to develop joint monitoring and evaluation framework, based around the main outcome(s) or impact measure(s) by which the success of the programme, including the collaborative process, was to be assessed? If so, how did this process unfold and what was agreed upon? (i.e., How did stakeholders agree on what to measure for monitoring and evaluation?)
• Was agreement reached on transparency and sharing of data?
• Who was given responsibility for monitoring and evaluation and was this independent? And why were they selected for this role?
• Were explicit indicators or targets related to human rights, gender equality and or equity considered and or agreed upon? Does the monitoring framework include any mechanisms for social participation (e.g. by target population)?
• Were the monitoring & evaluation systems established for the collaboration across sectors adequate or was adaptation required and if so how was this identified?
• What capacities, processes, or tools needed to be built for monitoring and evaluation and how were these identified? How were they built?
• How were findings from monitoring and evaluation to be disseminated?
• What were the resources and timelines provided for monitoring and evaluation? Were these sufficient for planning, data collection, stakeholder engagement, and dissemination?

Accountability
• What were the accountability structures used or put in place? Please describe.
• Which sector or organization had ultimate accountability for results?
• How was accountability developed across sectors? What targets and indicators
were used to do this? Who ensured accountability across sectors?* (required)

- What structures and processes were used to mediate accountability between sectors?
- How successful was the programme in creating accountability across sectors, and what were the different sectors’ perception of how well this worked?
- Was there independent review and/or external evaluations of the programme and collaboration?
- How did the monitoring, evaluation and learning feed into remedial action and improvements throughout the collaboration?
- How was the evidence generated from monitoring and evaluation packaged and disseminated? Were stakeholders able to use this evidence for learning and adaptations to the collaboration and programme? If so, how?

6. RESULTS

- Description of the programme results (i.e. key process, output, outcome indicators), differentiating between short-, mid- and long-term effects (with or without any impact)
- What methods, including indicators, were used to assess results and attribute impact to the programme? Use results chain below to help describe the full range of impacts of collaborating across sectors *(required)

Results chain framework to help identify and describe the results of Collaborating Across Sectors* (not all results would be relevant to all case studies)

<table>
<thead>
<tr>
<th>Collaboration</th>
<th>Implementation</th>
<th>Knowledge</th>
<th>Policy</th>
<th>Service/coverage</th>
<th>Health, societal and sustainable development impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint vision and shared purpose</td>
<td>Time (prevention or reduction of duplicative activities or services)</td>
<td>Problem definition/understanding</td>
<td>Policy-making inputs at different levels</td>
<td>Types of services</td>
<td>Health outcomes (e.g. Global Strategy – Survive, Thrive &amp; Transform targets) <em>(required)</em></td>
</tr>
<tr>
<td>Shared resources and responsibilities</td>
<td>Value for money (cost-effectiveness)</td>
<td>Research or M&amp;E methods developed or used</td>
<td>Policy change results</td>
<td>Reach/coverage of services</td>
<td>Sustainable development outcomes (e.g. SDGs)</td>
</tr>
<tr>
<td>Cooperation and mutual support</td>
<td>Human resources (motivation, skills, retention of staff)</td>
<td>New evidence/findings generated</td>
<td>Policy networks</td>
<td>Quality of services</td>
<td>Community engagement</td>
</tr>
<tr>
<td>Achieve more together than separately</td>
<td>Capacity-strengthening of local community or government to manage across sectors</td>
<td>Publications and papers</td>
<td>Knowledge networks established</td>
<td>Efficiency and effectiveness of services</td>
<td>Knowledge, attitudes and behaviours</td>
</tr>
<tr>
<td>Collaboration mechanisms or networks set up or strengthened</td>
<td>Leadership and awards/recognition</td>
<td>Communication</td>
<td>Policy capital</td>
<td>Equity of services</td>
<td>Equity, gender equality and human rights</td>
</tr>
</tbody>
</table>

- What evidence exists to demonstrate the results of the collaboration?
- Analysis/reporting of programme effects stratified by key sociodemographic characteristics and/or geographical areas.
- Documentation of any unexpected effects (i.e. beyond what was anticipated in the design) on the target population, the communities and/or the health services
- What was the coverage/reach and opt out/dropout rate related to the programme?
- How has the collaboration across sectors contributed to progress towards the Global Strategy’s key indicators related to Survive (ending preventable deaths), Thrive (ensuring health and well-being), and Transform (expanding enabling environments)?
- How has the collaboration addressed the guiding principles of the Global Strategy including equity, gender equality
and human rights? What evidence exists to demonstrate this?
• Have political commitment and advocacy been sustained over the duration of the collaboration across sectors? If so, how? How did this contribute to the implementation and quality of the programme?
• What are stakeholder perceptions of the impacts of the collaboration across sectors, including the target/recipient populations where relevant? Are there elements of the collaboration that are valued by stakeholders that may not necessarily be reflected in quantitative data?
• Were there any unintended impacts (positive and/or challenging)?
• What surprises were there: What was unexpectedly good or bad—or simply unexpected—that shaped how events unfolded, relationships developed, and progress was achieved?

7. EVOLUTION, SCALE AND SUSTAINABILITY

Reflections on the evolution, scale and sustainability of the programme over time, e.g. the expected ability to maintain the programme activities, level of engagement of stakeholders, outcomes achieved, effects (intended or unintended), partnerships built; Description of the scale-up of all or some programme activities, or any plans for scale-up

Scale and sustainability
• Is the programme’s theory of change strong, with initial outcomes that are encouraging, and systems in place to track key performance data going forward?
• Is the programme’s operational model delivering results effectively and efficiently, that then could support scaling up, in terms of * (required):
  - People – selection and training level of personnel
  - Context – political and social environment for the programme
  - Financing – reliability of funding and funding model
  - Growth/scaling up – with identified interest/opportunities and commitments to scale up
  - Commitment to continued collaboration – meeting sectors’ interests, and advancing the collaboration overall
  - Recipients'/beneficiaries – supportive evaluation of programme
• What environmental, political, social, economic, institutional and/or epidemiological contexts have affected/influenced—either positively or negatively—the scale and sustainability of collaboration across sectors? What contexts are driving or facilitating scale and sustainability? What contexts are challenging or impeding?
• What capacity building efforts were put in place for working across sectors as a foundation for the collaboration and throughout the process?
• How have stakeholders, including champions, across sectors and levels remained or not remained committed to and able to be part of this to the collaboration across sectors? How does this affect the sustainability?
• How might the degree of convergence (e.g. extent to which stakeholders are aligned and work together) be characterized across sectors, stakeholders, and levels? Has this had to change to sustain the collaboration? If so, why and how? Were there any important variations or differences in the extent specific sectors, stakeholders, or levels work together?
• Have the resources and architecture for the collaboration across sectors been sufficient to sustain action? Has adaptation been required for sustainability and if so how was this identified? If so, was there enough flexibility to ensure sustainability?
• Has membership, roles, responsibilities, and incentives for sectors, stakeholders, and levels changed in order to ensure sustainability? If so, why and how?
• Was collaboration sustained if/when staff changes occurred?
• Has mobilization and/or relative contribution and management of resources—
<table>
<thead>
<tr>
<th>Lessons learned</th>
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<tbody>
<tr>
<td>Appraisal of the weaknesses and strengths of the programme; what worked well and what can be improved</td>
<td></td>
</tr>
<tr>
<td>• What key lessons were learned from this collaboration that can inform future collaboration across sectors in this and other countries?</td>
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</tr>
<tr>
<td>• Did information gathered during the monitoring and evaluation activities influence the evolution, scale and sustainability of the collaboration? If so, how?</td>
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<tr>
<td>• Thinking back to the beginning of the collaboration, how might you do things differently if this were to be repeated?</td>
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<tr>
<td>• This case study was identified as a story of success. Is the success a result of the collaboration across sectors which would not have happened otherwise and if so, in what way?</td>
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<tr>
<td>• What is regarded by different stakeholders as the most significant / important factor or driver about the collaboration that influenced the success of the project</td>
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<table>
<thead>
<tr>
<th>Adaptations and evolution</th>
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<tbody>
<tr>
<td>Information about whether or not the programme and collaboration was delivered as intended, including description of any discrepancies between programme design and actual implementation, and the degree of match between programme content and theory of change; Description of ongoing adaptation of programme activities to better fit the context and the fidelity of the activity plan</td>
<td></td>
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<tr>
<td>• Looking back, what was the timeline of key events and changes? (See the Annex for example of summary timeline of the programme)</td>
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<tr>
<td>• Once implementation was underway, was the architecture (e.g. the mechanisms, processes and institutions) for the collaboration across sectors adequate or was adaptation required and if so how was this identified? If adaptations were needed, was the architecture flexible enough to respond to learnings? How did this process of adaptation work?</td>
<td></td>
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<tr>
<td>• How was the monitoring and evaluation framework used for reflection and adaptation of the programme?</td>
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<thead>
<tr>
<th>CONCLUSION, CASE STUDY PROCESS AND ADDITIONAL INFORMATION</th>
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<tbody>
<tr>
<td>Conclusion and finalization</td>
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</tr>
<tr>
<td>• Has the story of the collaboration been told comprehensively? Are there gaps? Are all events accounted for? Have all voices been heard?</td>
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<tr>
<td>Reflections on case study methods and process <em>(required)</em></td>
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<tr>
<td>• Reflections on the methods guide and process to develop the case study.</td>
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</tr>
<tr>
<td>• What worked well and what did not?</td>
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<tr>
<td>• What adaptions or changes were made to the methods set out in this guide?</td>
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<table>
<thead>
<tr>
<th>Case study supplementary material</th>
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<tbody>
<tr>
<td>• Bibliography</td>
<td></td>
</tr>
<tr>
<td>• Methods</td>
<td></td>
</tr>
<tr>
<td>• Optional annexes: maps or key data; timeline of the collaboration across sectors; list of major actors or implementers</td>
<td></td>
</tr>
<tr>
<td>• Links to photos, videos and other communications materials</td>
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</table>
Roles and responsibilities for developing the case studies

For each case study, the composition of the country working group will vary and depend on the nature of the programme, stakeholders involved, policy and programme context, technical and other resources available and other considerations. The country working group will be supported by national consultancy support (as required) and closely coordinate with the international consultants, the BMJ the Global Steering Committee and the PMNCH Secretariat.

The following roles and responsibilities are just indicative of the kind of tasks that are required and can be adapted to context-specific needs. No matter the configuration and adaptations for context-specific terms of reference (ToR), the collective objective will be to deliver a timely, high quality product, specifically the journal article, in order to share lessons learned across countries at the Partners’ Forum in December 2018.

Summaries of roles and responsibilities are highlighted below, with more detailed terms of reference in the Annexes.

**LEAD ORGANIZATION AND OPERATIONAL LEAD(S)/ LEAD AUTHOR(S)**

The lead organization(s) is the applicant who submitted the proposal that was selected for development as a case study (See Table of 12 case studies in Annex). The lead organization should identify an operational lead(s)/ lead author(s) (no more than 2 leads) for the development of the case study as per the process outlined in this guide. This includes: convening and coordinating a country working group of key stakeholders related to the case study programme; developing the background working report and conducting the multistakeholder dialogue; ensuring the drafting and timely submission of a final, quality 3000-word journal article in English; and ensuring adequate arrangement of administrative support related to the case study. It is the responsibility of the lead organization to ensure all relevant stakeholders, including government stakeholders are informed of the case study and engaged in the country working group and/or multistakeholder dialogue process.

PMNCH will provide $15,000 to the lead organization for the development of the case study. The lead organization can decide how to use these funds in order to meet the three key deliverables, and assess the technical, analytical and writing that is available within the lead organization and the country working group for the development of the case study. Should there be capacity gaps within the lead organization and country working group, the lead organization has the option to engage external national consultancy support for case study development. For example some country working groups might identify that they need more analytical and writing support, while others may need additional support with the planning and facilitation of the multistakeholder dialogue process.

**COUNTRY WORKING GROUP**

The lead organization will put together a country working group of key stakeholders across sectors who are a) related to the case study programme; and b) can contribute to case study development, including: provide information to address the guiding questions below; support the multistakeholder review process; and contribute to development of the 3000-word journal article in English as per the authorship guidelines in this guide. The country working group should be made up of partners across the various constituencies for example: government; non-government organizations; academic, research and training institutes; health care professional associations; multilateral organizations; private sector; donors and foundations; global financing mechanisms; adolescents and youth, programme beneficiaries and other relevant stakeholders.
The country working group should undertake initial data collection prior to the international consultant’s first visit so that meetings can be organised with key partners as required to collect the relevant information and or meet with key informants to address specific gaps in the data. This means that logistics for these visits and follow-up inform an agenda for the international consultant’s first visit and less time is spent making appointments at the last minute.

**NATIONAL CONSULTANCY SUPPORT (adaptable/optional to be decided by countries)**
Should additional support be required, beyond the country working group (above) and international consultant (below), national consultancy support can be contracted by the lead organization to support in the development of the case study. *Indicative Terms of Reference (TORs)* for the national consultancy support are provided in Annex 1. These tasks reflect some of the broad areas of work that might be required, but the specifics can be adapted and agreed by the lead organization together with the country working group. The TORs can therefore be revised depending on what the needs are. While working closely with the country working group and the international consultant, they are responsible to the lead organization.

**INTERNATIONAL CONSULTANT**
The international consultants provided by the PMNCH Secretariat will facilitate a standard approach across all the country case studies. The international consultants will work closely with the lead organization, country working group and national consultancy support (if engaged) and are available to provide advisory, technical, analytical and writing support as needed for the development of high quality country case studies, including the multistakeholder dialogue process. As per the TORs for the national consultancy, the tasks of the international consultant may vary based on need.

**The BMJ**
The 3000-word articles submitted to the BMJ would follow the formal BMJ peer review and publication process. Aligned with standard practice, the BMJ would be responsible for coordinating the journal peer review and publication of the papers. (Please see timeline in summary table at the beginning of this guide).

**GLOBAL STEERING COMMITTEE**
The Global Steering Committee will provide overall guidance on the case study methods, and review and comment on working reports towards developing the 3000-word journal articles for each country case study for submission to the BMJ. The Global Steering Committee also will have a role in the development of synthesis papers, for example, an overarching synthesis paper, highlighting findings emerging across the case studies, and a methods paper which provides feedback on the process to develop the case studies, including challenges and adaptations made.
Organising the multistakeholder review: preparation, planning, participants, process

Multistakeholder review processes will be conducted as part of the process to develop the case study on the collaboration. It will draw on methods from the PMNCH guide for multistakeholder dialogues developed through the 2014 Success Factors studies process. Multistakeholder review processes will involve face-to-face meetings of health and development stakeholders to reflect upon questions such as how the case under study came to be, how it developed over time, obstacles overcome and remaining, and parameters for future sustainability and growth.

1. Preparing for the multistakeholder review
   - The country working group, together with relevant government ministries and other key stakeholders will convene a multistakeholder review meeting. Preferably, this review process would be part of a regular meeting, or planned event of such a group. See the PMNCH guide for multistakeholder dialogues to support the preparation and implementation of the multistakeholder review meeting and the article by Frost et al which describes the 2014 Success Factors multistakeholder review process.
   - Should it be required, the lead organization can contract national consultancy support for the development of the case study, including the planning and facilitation of a multistakeholder review meeting.
   - Logistics will be coordinated by the country working group and consultant/s, together with other partners as required. The review will ideally be conducted by convening a 1 day stakeholder meeting (logistics include the country working group, consultants and country partners: inviting participants, finalising the agenda, arranging the venue and materials. Key preparation tasks and an example agenda for a stakeholders meeting are summarized in Box 2 and Table 1 at the end of this section. The agenda should align allow for discussion of all key issues and leave room for active discussion and consensus-building around the main findings.

2. Participants for the multistakeholder review (consider around 25 people)
   - Participants will be identified from all stakeholder constituency groups and relevant sectors – ideally with representatives from multiple or all levels, where feasible – especially those involved in, benefiting from, or influencing, the specific collaboration. This includes representatives from civil society or community/target population groups consistent with the principle of social participation.

3. Time required for the multistakeholder review
   - Normally the time required for the multistakeholder review meeting will be one day in person
   - Additional time will be required to collect data, analyse the main findings and messages and develop the working report in advance of the multistakeholder review.
   - Any participants who are asked to present will need enough notice to prepare their presentation, and should be properly briefed by the country working group and consultants.
   - If participants include consumers/civil society, then time needs to be allowed to organise their participation and translation or other support might be needed (see next logistics note) e.g. where participants are not literate, or a community support worker is present with the participant.
4. Conducting the review

- The multistakeholder review will focus on the working report on collaboration across sectors. Participants of the multistakeholder review meeting should provide feedback on the content of the working report and make recommendations for edits and changes. If more data are needed, they should indicate where these data can be obtained or key informants who can provide further information. All stakeholders need time to review the working report, which will be shared two weeks in advance of the meeting but also come prepared including (a) having read the paper (b) identified feedback and (c) where possible come with additional information and or details of where additional information can be found. If there are conflicting perspectives, the following criteria could be used/adapted to resolve the issues:

**Criteria to help resolve conflicting perspectives on the success of the collaboration**

The guide is designed to support the development of an evidence-based case study, including triangulation of all available information and perspectives, using a collaborative approach. Differing perspectives however may arise. While resolving any such differences is a case by case basis, suggested criteria include:

- Potential impact (likely to have contributed to improvements based on impact framework and available data)
- Temporal association (had been implemented long enough to have had an impact)
- Types and quality of data and evidence – see Table 1.
- Scale (had reached a large enough target population to influence health and development outcomes) and
- Consensus (broad agreement between key stakeholders within and outside the health sector).
- Participants may agree on other relevant criteria.
- Please note: This process does not require an unrealistically consensual piece, and it is important to report/acknowledge differing perspectives. This could be an important finding of the case-studies.

**Outputs of the multistakeholder review meeting**

- Short meeting report
- Updated working report based on multistakeholder review inputs
Logistics note: Key Preparations tasks for multi-stakeholder review meeting

The country working group, consultants and lead H6 agency where relevant should help arrange:

• Invitations for all participants in the multi-stakeholder review meeting- usually 20-30 max to ensure good interaction. Participants for the meeting should receive an invitation and a draft agenda for the meeting. One week prior to the meeting participants should be sent working report.

• A meeting room large enough for all participants and break-out rooms if group work is to be conducted.

• Materials and supplies, including:
  – Paper and pencils for all participants;
  – A laptop computer and an overhead projector to use with the laptop computer;
  – Flipchart and markers.

• A budget for all proposed activities. This may include technical support staff and participants in the large group meeting; costs of transportation for the consultant (data gathering); venue costs; materials and supplies; document photocopying costs, translation as required

• Documents needed for the multi-stakeholder review, including:
  – Participant materials, including:
    ➢ Agenda
    ➢ Most recent draft of the working report
    ➢ Review tasks / Questions to review the working report
Example agenda: Multistakeholder review meeting (To be adapted by the country working groups)

<table>
<thead>
<tr>
<th>Time</th>
<th>Activities</th>
</tr>
</thead>
</table>
| 09:00 – 09:30 | Introduction  
  - Welcoming remarks  
  - Participants introduction  
  - Introduction of facilitators  
  - Background  
  - Current status of the document: methods, data used  
  - Overview: how the multistakeholder review meeting will be conducted |
| 09:30 – 10:30 | Plenary session:  
  Agreement on data sources and main findings; criteria to resolve conflicting perspectives etc |
| 10:30 – 10:45 | Tea break                                                                                                                                          |
| 10:45 – 12:30 | Small group work: xxx (e.g. by the guiding questions etc)  
  Break into 2-4 groups.  
  Agreement on data used; factors identified; edits as needed.  
  Groups summarise findings in plenary session – group discussion |
| 12:30 – 13:30 | Lunch                                                                                                                                            |
| 13:30 – 14:30 | Small group work: xxx (e.g. by the guiding questions etc)  
  Break into 2-4 groups to review xxx.  
  Agreement on data used; factors identified; edits as needed.  
  Groups summarise findings in plenary session – group discussion |
| 14:30 – 14:45 | Tea break                                                                                                                                          |
| 14:45 – 15:45 | Small group work: xxx (e.g. by the guiding questions etc)  
  Break into 3 groups to review xxx as being important.  
  Agreement on data used; factors identified; edits as needed.  
  Groups summarise findings in plenary session – group discussion |
| 15:45 – 16:45 | Plenary session: Review proposed next steps and priorities  
  Agreement on main findings; additions, changes edits as needed.  
  Summary of next steps for finalizing the working report and developing the journal article, and road map to the Partners’ Forum |
|             | Close                                                                                                                                            |
Journal article development and authorship guidelines

Following the multistakeholder review of the longer case study working report, the next step would be to draft a 3000-word journal article for submission to the BMJ. As it is likely that the success case studies will be prepared by a multi-author group, the group ideally should decide who will be an author and who will be the lead author, which should be from the country team, before the work is started.

When the journal article is submitted to the BMJ, it will follow the standard BMJ peer review and publication process. While the aim is to produce a high-quality journal article, there is no guarantee a journal article will be accepted through the peer review process for publication. If this is the case, many other opportunities will be available to highlight the learnings of the case study, including through the working report and multistakeholder meeting report, panel discussions at the Partners’ Forum, digital, video and social media as well as national and international media.

Journal article format

The journal article format should follow the requirements of the BMJ for an Analysis article. The BMJ has an international readership that includes policy makers, health professionals, and doctors of all disciplines. Authors are advised to keep this readership in mind and to write their article for the non-expert. It’s important to avoid jargon. Specialised terminology and references to organisations or practices that are specific to one country need to be explained. Clear writing and an attractive presentation are essential.

- **WORD COUNT:** 3000-words, excluding boxes, tables and figures.
- **TITLE and STANDFIRST:** A short engaging title is followed by an italicised single sentence (the standfirst) which encapsulates the article’s central message.
- **INTRODUCTION:** Articles should begin with a brief paragraph that captures readers’ attention and explains the aim of the piece.
- **TEXT:** The body of the text should be broken up under sub headings that provide a logical narrative structure. Avoid acronyms and abbreviations unless they are universally recognised e.g. DNA. Also to explain the limitations of the study.
- **EVIDENCE:** The evidence on which key statements are based should be explicit and referenced, and the strength of the evidence (published trials, systematic reviews, observational studies, expert opinion, etc) made clear.
- **BOXES, TABLES and FIGURES:** These should extend and substantiate points made in the body of the paper. Words in boxes and tables are excluded from the word count of the body of the text, but the additional material should be concise.
- **KEY MESSAGES:** This is a box at the end of the article containing 2-4 short sentences summing up the main conclusions.
- **REFERENCES:** Must be in Vancouver style and should be kept to a minimum; ideally no more than 20.
- **CONTRIBUTORS AND SOURCES:** We ask for a 100-150 word supplementary paragraph (excluded from word count) to explain the article’s provenance. It should include the relevant experience and expertise of each author, his or her contribution to the paper, and the sources of information used to prepare it. One author must be nominated as the guarantor of the article.
• REPORT OF PATIENT INVOLVEMENT: As The BMJ is seeking to advance partnership with patients, we also ask authors to seek their input into articles wherever relevant, and document their involvement as patient contributors or co-authors.

• CONFLICTS OF INTEREST: All authors should read the BMJ’s competing interests policy and include the appropriate declaration in their manuscript. Where a competing interest exists that might disqualify an author from contributing, it is wise to discuss it with a BMJ editor before writing the article.

Peer review
The BMJ has fully open peer review for Analysis articles. This means that every accepted Analysis article now will have its prepublication history posted alongside it on thebmj.com. This prepublication history comprises all previous versions of the manuscript, the report from the manuscript committee meeting, the reviewers’ signed comments, and the authors’ responses to all the comments from reviewers and editors. Authors are welcome to suggest names of suitable reviewers, including patient / beneficiary reviewers.

Authorship guidelines
The journal articles are intended for publication in the British Medical Journal (BMJ). As this journal complies with International Committee of Medical Journal Editors (ICMJE) Recommendations on Authorship, the case studies will also need to be consistent with this guidance.

The following recommendations are intended to ensure that contributors who have made substantive intellectual contributions to a paper are given credit as authors, but also that contributors credited as authors understand their role in taking responsibility and being accountable for what is published.

The ICMJE recommends that authorship be based on the following 4 criteria:

• Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND

• Drafting the work or revising it critically for important intellectual content; AND

• Final approval of the version to be published; AND

• Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

All those designated as authors should meet all four criteria for authorship, and all who meet the four criteria should be identified as authors. Those who do not meet all four criteria but made a substantial contribution should be included in the acknowledgements in the article.

The final order of the authors on the article should broadly reflect the extent of the contribution and usually is decided among the group once the article is close to submission to PMNCH and BMJ. All members of the group named as authors should meet all four criteria for authorship, including approval of the final manuscript, and they should be able to take public responsibility for the work and should have full confidence in the accuracy and integrity of the work of other group authors. They will also be expected as individuals to complete conflict-of-interest disclosure forms. In the case of national or international consultants supporting the preparation of the case studies, if they meet all four criteria, they should be included as authors.

Ethics approval
For developing the country case studies, a global formal ethics approval is not required as the analysis is mainly a retrospective programme evaluation conducted at the policy and programme level (not at the level of human subjects). These case studies were not conceived as primary research studies and draw on existing data and documentation. The analysis is based on literature reviews and analysis of publically available data, and data will be aggregated at the population level. To address specific knowledge gaps, key informants will be interviewed in relation to their professional capacity and their relationship to the programme under review, with no biomedical, personal or confidential information collected from them. Furthermore, the results of the interviews would be analysed in the aggregate and any quotes anonymized. If individual institutions participating in the case studies require ethics approval, they are welcome to process this at the level of the institutions or as a joint process for each case study.

Please see timeline in summary table at the beginning of this guide.
### ANNEX 1
Summary table of country case studies

PLEASE NOTE THE DETAILS OF THE SELECTED CASE STUDIES ARE EMBARGOED FOR PUBLIC COMMUNICATION UNTIL THE FORUM CURTAIN RAISER EVENT IN INDIA IN APRIL. PLEASE DO NOT CIRCULATE.

<table>
<thead>
<tr>
<th>REGION</th>
<th>COUNTRY</th>
<th>TITLE AND THEME</th>
<th>ORGANIZATION AND CONTACT</th>
</tr>
</thead>
</table>
| Africa | South Africa | **Title:** She Conquers  
**Theme:** Empowerment | **Organization:** Ministry of Health |
|        | Sierra Leone  | **Title:** Participatory Radio for Communications & Education  
**Theme:** Humanitarian and Fragile Settings | **Organization:** Child to Child |
|        | Malawi  | **Title:** A Mobile Health Solution  
**Theme:** SRHR | **Organization:** VillageReach |
| Eastern Mediterranean | Afghanistan  | **Title:** Multi-sector collaboration and innovation to scale up health services  
**Theme:** Humanitarian and Fragile Settings | **Organization:** Aga Khan University |
| Europe | Germany  | **Title:** Early Childhood Intervention  
**Theme:** ECD | **Organization:** National Centre on Early Prevention in the Federal Centre for Health Education |
|        | USA  | **Title:** Voices for healthy kids  
**Theme:** Adolescent Health and Wellbeing | **Organization:** American Heart Association |
| Americas | Chile  | **Title:** Chile Crece Contigo  
**Theme:** ECD | **Organization:** USACH Universidad de Santiago de Chile |
|        | Guatemala  | **Title:** Monitoring, advocacy and quality improvement of MCH services  
**Theme:** Empowerment | **Organization:** ALIANMISAR / HEP+ |
| South East Asia | Indonesia  | **Title:** Delivering Nutrition Programs through Secondary Schools  
**Theme:** Adolescent Health and Wellbeing | **Organization:** Nutrition International |
|        | India  | **Title:** Intensified Mission Indradhanush  
**Theme:** QED | **Organization:** Ministry of Health & Family Welfare, Government of India |
| Western Pacific | Cambodia  | **Title:** ID Poor and the role of reliable data Topic:  
**Theme:** QED | **Organization:** GIZ |
|        | Malaysia  | **Title:** Universal coverage of HPV vaccination  
**Theme:** SRHR | **Organization:** Ministry of Health |
ANNEX 2
Terms of Reference

1. Terms of Reference for lead organization/ operational lead(s)

Lead the development of a country case study documenting Success Factors for Improving Women’s, Children’s and Adolescents’ Health: What works and why in collaborating across sectors?

I. Objective

The Contractor was selected from a global call for proposals to develop a case study of how collaboration across sectors can advance action and accountability for one of the six themes of the Every Woman Every Child (EWEC) Partners’ Framework. This is one of 12 case studies that will be presented as a 3000 word article as part of a special issue of the British Medical Journal to be shared at the 2018 PMNCH Partners’ Forum in New Delhi on 5-6 December 2018 and globally through the PMNCH and Every Woman Every Child platforms. A multistakeholder review meeting will also be conducted as part of the case study development.

PMNCH will provide resources of $15,000 to the Contractor to lead the development of the case study at the country level. PMNCH will also engage an international consultant to provide additional technical and writing support. A methods guide will be made available to guide the development of the case study.

II. Tasks and deliverables

The Contractor will be responsible for the tasks and deliverables below:

- Convene and coordinate a country working group of key stakeholders related to the case study programme who could help provide information to address the questions in the Methods Guide and support case study development. Key stakeholders could include partners across the various PMNCH constituencies including: government; non-government organizations; academic, research and training institutes; health care professional associations; multilateral organizations; private sector; donors and foundations; global financing mechanisms; adolescents and youth, programme beneficiaries and other relevant stakeholders.

- Develop a background working report and conduct the multistakeholder meeting to review the working report – producing a short meeting report and updating the working report with stakeholder inputs.

- Ensure drafting and timely submission of a final, quality journal article (max 3000 words in English), following the requirements delineated in the Methods Guide.

- Contribute to the Partners’ Forum programme, especially the learning sessions as will be agreed between the Contractor and Forum Organizing Committee as the agenda develops.

- Ensure adequate arrangement of administrative support related to the project as required, including management of project workplan and budget and provision of visa letters for international consultants as required.
III. Contract value and budget

The total contract value is US$ 15,000

IV. Payment terms

Contract payments will be made according to the following schedule:

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Date</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>On signature</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>Plan and participant list for the multistakeholder review meeting</td>
<td>30 April 2018 (or earlier/later as agreed)</td>
<td>40%</td>
</tr>
<tr>
<td>Submission of final journal article and completion of peer review required revisions</td>
<td>By or before November (or earlier / later as agreed in line with BMJ publication processes)</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

V. Technical supervision

Rachael Hinton (hintonr@who.int) and Anna Gruending (gruendinga@who.int) are the responsible Technical Officers at the PMNCH Secretariat for this contract. Any queries related to tasks and deliverables should be directed to Rachael Hinton and Anna Gruending. Javier Arina-Iraeta (arinaairaetaj@who.int) is the responsible Finance and Administrative Officer for the contract. Any administrative / finance related contractual queries should be directed to Mr Arina-Iraeta.
2. Adaptable/optional Terms of Reference for national consultancy support (to be decided by country teams)

National Consultancy support for the development of a country case study on collaboration across sectors for women’s, children’s and adolescents’ health

These Terms of Reference (TORs) for the national consultancy support are illustrative only. The tasks are indicative of the broad areas of work but the specifics can be adapted and agreed by the lead organization together with the country working group. For example some country working groups might identify that they need more analytical and writing support, while others may need additional support with the planning and facilitation of the multistakeholder dialogue. The TORs for the national consultancy support should therefore be revised depending on what the needs are.

I. Background

Twelve proposals were selected from a global call for development as a case study of how collaboration across sectors can advance action and accountability for women’s, children’s and adolescents’ health. One of the successful proposals was [INSERT TITLE OF INITIATIVE] from [INSERT COUNTRY]. National Consultancy support is sought by the country team that is leading the country process to develop this case study, which includes undertaking a multistakeholder dialogue. The case study will be presented as a 3000-word journal article as part of a special issue of the British Medical Journal (BMJ), to be shared at the 2018 PMNCH Partners’ Forum in New Delhi on 5-6 December 2018 and globally through the PMNCH and Every Woman Every Child platforms.

II. Objective

National consultancy support will be for technical and writing support for the development of the country case study, including a 3000-word journal article and undertaking a multistakeholder review.

III. Tasks and deliverables

To meet the below deliverables, the consultant will work directly with the lead organization and country working group and will report to [INSERT NAME]. They will also work closely with the International Consultant provided by PMNCH to support the in-country process. The consultant will undertake the following tasks: (THESE TASKS CAN BE ADAPTED AND INCLUDED IN THE TORs AS NEEDED)

In collaboration with the country working group and supported by the international consultant, support the develop a working report using guiding questions in Table 1 of this methods guide to be used by all country case studies to collect, collate and review data and information, including but not limited to:

- Collect and collate relevant programme data, reports and evaluations and other peer-reviewed and grey literature and develop the working report (incl. a version in English);
- Review the initial collection and identify gaps in the data and information and develop follow up action to address gaps;
Consult with key informants who are identified to address specific gaps in the data and information as required.

Together with the lead organization and country working group and supported by the international consultant (technically) as required, support the planning and facilitation of a multistakeholder review meeting, including to:

- Help organize a multistakeholder review meeting in the country, including the preparation, planning, identification and invitation of participants, logistics, and process
- Contribute to undertaking and documenting the proceedings of the multistakeholder review meeting to review and update the working report

Together with all agreed authors, support the writing of a 3000-word journal article in English based on the working report and multistakeholder review

- Support the submission of the 3000-word paper with sign off from authors, including liaising with an editor and the PMNCH secretariat as required
- The consultant will be included as an author on the journal article if they meet the 4 criteria for authorship as outlined in journal article section of the methods guide.

Support activities leading up to the PMNCH Partners’ Forum, including:

- Input into the finalization of journal article based on peer review and editorial feedback
- Support the development of video about the case study and other media formats
- Develop communication materials that can be used to present the findings from the case study, including briefs or PowerPoint presentations as required

Other tasks as required and agreed as feasible within the contract.

IV. Requirements/Competencies

The Consultant should demonstrate the following experiences and competencies:

**Experience:**

**ESSENTIAL**

- Excellent writing skills in English, including the development and writing of reports, journal articles and communications materials
- Strong skills at reviewing and analyzing documents and qualitative and quantitative data, including analyzing and synthesizing information from multiple sources
- Experience in organization of high level workshops and conferences and facilitation experience and skills
- Excellent spoken and written English
- Experience in the field of women’s, children’s and adolescents’ health and/or sustainable development, working across sectors

**Competencies:**
• Excellent communication and interpersonal skills
• Ability to communicate effectively within different levels of governmental institutions, international agencies and NGOs,
• Excellent team work and commitment to contributing to improved health and development in [INSERT COUNTRY].

V. Activity Duration
• A fixed amount of work and timelines will be agreed in advance with the consultant and country teams, but it is estimated up to xxxx days work will be required. The work will be undertaken between [xxxxx e.g. 15 March 2018 and 30 August 2018].

VI. Contract value and budget
The estimated budget of the contract is outlined below (EXAMPLE ONLY):

<table>
<thead>
<tr>
<th>Rate</th>
<th>Days</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>xxxx</td>
<td>xxxx</td>
<td>xxxx</td>
</tr>
</tbody>
</table>

VII. Payment terms
Contract payments will be made according to the following schedule (EXAMPLE DELIVERABLES ONLY):

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Date</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>On signature</td>
<td>xxxx</td>
<td>xxx</td>
</tr>
<tr>
<td>Development of working report and undertaking a multistakeholder review</td>
<td>xxxx</td>
<td>xxx</td>
</tr>
<tr>
<td>On final invoice (includes revisions of 3000-word paper in response to peer review; development of briefs and presentations etc)</td>
<td>xxxx</td>
<td>xxx</td>
</tr>
</tbody>
</table>
3. Terms of Reference for international consultants

Technical Support to Country Teams Working on the Success Factors Case Studies

I. Objective

PMNCH and Every Woman Every Child (EWEC) will use the 2018 Partners’ Forum in New Delhi on 5-6 December 2018 to showcase twelve Success Factors case studies of how collaboration across sectors can advance action and accountability for the six EWEC priority themes. The case studies are being selected through a global call for proposals, and developed at the country level by a multistakeholder country team of content and programming experts. Multistakeholder Dialogue (MSD) processes will be conducted as part of case study development, drawing on methods from the PMNCH guide for multistakeholder dialogues. Together the case studies will be presented as part of a special issue of the BMJ, to be shared at the Partners’ Forum by country teams, and globally through the PMNCH and EWEC platforms. The Contractor will provide technical, writing and analytical support to two country teams for the development of high quality country case studies, including a multistakeholder dialogue process.

II. Tasks and deliverables

Provide support to country teams in case study development in 2 countries, including - as required

- input into the methods for developing the case studies and the protocol for the multistakeholder review
- coordination with other consultants as an integrated team, and with the overall project Global Steering Committee
- documentation and data review
- analysis and writing support to develop country case studies as a 3000-word paper for submission to the BMJ
- planning and support for facilitation of the multistakeholder dialogue process
- input into the synthesis of the findings across case studies, and the development of materials that can be used to present the findings from the case studies, including briefs or PowerPoint presentations as required
- other tasks as required and agreed by PMNCH and the contractor as feasible within the contract.

III. Requirements/Competencies

- Demonstrated expertise in the field of women’s, children’s and adolescents’ health and/or sustainable development, working across sectors
- Strong analytical skills, including synthesis of health and development data from multiple sources and methods and competence in qualitative and quantitative analysis
- Experience working with multidisciplinary teams and multistakeholder dialogue processes
- Proven experience in programme and implementation analysis or evaluation (within health as well as sectors outside of health, including education, water and sanitation, nutrition, among others), particularly in low-and middle-income countries
• Excellent writing skills in English, and demonstrated ability to communicate with diverse groups and in multicultural environments and to communicate information to a varied audience, particularly for advocacy purposes.

IV. Consultancy time
• The duration of this contract is 1 March 2018 to 21 December 2018
• We anticipate the number of days for scope of work is a total of 90 working days.

V. Travel
The number of international trips will be decided on a country by country basis but it is anticipated that two trips per country will be required during the contract as well as a trip to Geneva for planning / analysis purposes (Note: including for the synthesis papers). Once the case studies are selected from the call for proposals, dates of travel and timelines will be determined in consultation with PMNCH and country teams.

VI. Payment terms
Contract payments will be made according to the following schedule:

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Date</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>On signature</td>
<td>xxxx</td>
<td>xxx</td>
</tr>
<tr>
<td>Support for submission of draft 3000 word paper</td>
<td>xxxxx</td>
<td>xxx</td>
</tr>
<tr>
<td>On final invoice (includes support for revisions of 3000-word paper in response to peer review; input into synthesis documents, briefs and presentations)</td>
<td>xxxxx</td>
<td>xxx</td>
</tr>
</tbody>
</table>

VII. Technical supervision
Rachael Hinton and Anna Gruending are the responsible Technical Officers at the PMNCH Secretariat for this contract.

International consultants
Armstrong Global Health Consulting: Corinne Armstrong (Afghanistan; Malawi)
Equiact: Sarah Simpson (Guatemala; USA); Victoria Saint (Germany; Malaysia); Daria Ukhova (support for Guatemala and Germany)
Global Research Consultancy: Louise Bury (Indonesia; Cambodia)
John Murray Consulting: John Murray (Chile; India)
SB Consultancy World: Sarah Barnett (Sierra Leone; South Africa)
4. Global Steering Committee (GSC)- Terms of Reference and Members

Introduction
This document builds on the concept note on Success Factors country case studies. It outlines the terms of reference for the committee of partners that will have provide strategic and editorial oversight over the development of 12 country case studies selected through a global call for submissions.

PMNCH and Every Woman Every Child (EWEC) will use the 2018 Partners’ Forum as a common platform for bringing forward inspiring new examples of cross-sectoral action that has maximized impact, or ‘bent the curve’ for women’s, children’s and adolescents’ health. Twelve country case studies will explore how intentional collaboration among actors from different sectors is advancing action and accountability for the six priority themes of the 2020 EWEC Partners’ Framework: Early Childhood Development; Adolescent Health and Well-Being; Quality, Equity and Dignity in Services; Sexual and Reproductive Health and Rights; Empowerment of Women, Girls and Communities; and in Humanitarian and Fragile Settings.

Convening and responsibilities of the Global Steering Committee
A GSC of up to 15 members (see selection criteria below) will be convened by the PMNCH secretariat to provide the strategic direction for and editorial oversight over case study development, informing and advising the planning of the Partners’ Forum.

In addition, the GSC will work with other technical partners for the selection and development of the case studies, including:

- An independent group of experts identified from multistakeholder networks relevant to the priority themes to lead the technical review of the case study proposals.
- Case study development at the country level to be overseen and guided by a country team of content and programming experts. Strong links will be created between the GSC and this expertise residing at the country level.

The Committee will undertake the following:

- Agree criteria for case study proposals and solicit submissions
- Direct editorial review processes ensuring quality control, including liaising with independent consultants to assign eligible submissions for technical review and agree case study selection based on a balanced portfolio
- Support the preparation of the Guide on development of case studies, including citation and acknowledgement requirements
- Support the synthesis of content across the case studies (see Table 1 summary of the process)
- Review guidance materials, TORs, templates, deliverables and milestones for case-studies
- Advise on Partners Forum programme planning and alignment with key messages
- Represent the work of the GSC and contribute to communication about the project to partners and external audiences as needed and appropriate
Selection criteria

To meet these responsibilities, PMNCH will identify and convene members of the GSC for a range of expertise, skills and representation of wider networks, rather than institutional affiliation. It is anticipated the skills matrix could include the following:

<table>
<thead>
<tr>
<th>Skills / experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of research methods (e.g. call for proposals; country case study development and review)</td>
</tr>
<tr>
<td>Experience in multistakeholder dialogue processes</td>
</tr>
<tr>
<td>Experience working on programmes for women’s, children’s and adolescents’ health in country settings, including with cross-sectoral implementation</td>
</tr>
<tr>
<td>Expertise in communication and media related to health and development programmes and research</td>
</tr>
<tr>
<td>Links to external platforms and networks</td>
</tr>
<tr>
<td>Willingness and ability to afford the time and resources required for the Committee’s work</td>
</tr>
</tbody>
</table>

There is no requirement for GSC members to be experts in one or all of the six priority themes, but members will be those who can bring technical expertise across the SRMNCAH continuum and also offer unique and relevant perspectives to the selection process and to the process of developing case studies.

Coordination mechanisms

The PMNCH secretariat has requested Shyama Kuruvilla (WHO) and Wendy Graham (LSHTM) co-lead the GSC. Technical support for the project in countries will be aligned with established H6 technical processes. It will also link closely with GFF investment case activities in countries where relevant and engage with Countdown to 2030, the Alliance for Policy and Health Systems Research and other stakeholders as relevant to each country context.

Duration and time commitment

The GSC will be active across the duration of the project, from November 2017 to the launch at the Partners Forum in December 2018.

The GSC will meet once a month for an hour via teleconference or in person whenever possible. The meetings will be convened by the PMNCH secretariat. It is expected that Committee members will dedicate on average 2 days per month to attend the monthly meetings (virtual in most cases), and review documents and provide guidance.

Out of pocket expenses and remuneration

The GSC members will not be remunerated for their time, but any reasonable out of pocket expenses (e.g. should travel be required for an in-person meeting) will be reimbursed through standard WHO expenses and per-diems policy.
Facilitation, administrative and technical support

The GSC will be supported by the Partnership Secretariat, ensuring members have access to documents, collating comments from the group, scheduling meetings etc.

Table 1: Summary of the process to develop the synthesis papers and opinion pieces for the BMJ

<table>
<thead>
<tr>
<th>KEY MILESTONES</th>
<th>KEY TASKS FOR DEVELOPING THE SYNTHESIS PAPERS AND OPINION PIECES</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>By early April</td>
<td>Steering committee to start work on the synthesis papers including the case study methods and lessons across countries</td>
</tr>
<tr>
<td>By end-June</td>
<td>Steering Committee reviews the country working reports, provide feedback for the multistakeholder meetings, and continue development of the synthesis papers</td>
</tr>
<tr>
<td>By mid-July</td>
<td>PMNCH secretariat to identify some key Opinion pieces to accompany the journal articles</td>
</tr>
<tr>
<td>By mid-August</td>
<td>Steering Committee to submit the synthesis papers to the BMJ Opinion pieces to be drafted and submitted to the BMJ (these could have a later timeline - by September - as do not go through the full peer review process)</td>
</tr>
</tbody>
</table>

Members of the Global Steering Committee

**Partners’ Forum Global Organizing Committee**

1. Petra Tenhoope-Bender - Co-chair of Partners Forum Global Organizing Committee

**Members of the Global Steering Committee**

2. Shyama Kuruvilla (Co-chair) - World Health Organization (WHO)
3. Wendy Graham (Co-chair) - London School of Hygiene and Tropical Medicine
4. Nuria Casamitjana - Barcelona Institute for Global Health
5. Jennifer Requejo - Countdown to 2030, Johns Hopkins University
7. Susan Papp - Women Deliver
8. Kumanan Rasanathan - WHO, Cambodia
9. Rafael Cortez - World Bank
10. Paul Simpson - The BMJ
11. Karlee Silver - Grand Challenges Canada
12. Yael Velleman - WaterAid/WHO
13. Patricia Fracassi - Scaling up Nutrition (SUN) Secretariat
14. Natalie Poulson - Global Partnership for Education

**PMNCH Secretariat project management team**

Rachael Hinton
Anna Gruending
Lori McDougall
Anshu Mohan
### ANNEX 3

**Stakeholder mapping**

This table provides examples of key considerations for a stakeholder mapping.

<table>
<thead>
<tr>
<th>NAME</th>
<th>ROLE</th>
<th>PHASES IN WHICH ENGAGED</th>
<th>INVOLVEMENT</th>
<th>INFLUENCE</th>
<th>INCENTIVES/ DISINCENTIVES</th>
<th>ADDITIONAL NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization/group (or individual if significant)</td>
<td>Role specifically related to collaboration</td>
<td>Refer to phases in table/framework - methods guide</td>
<td>High, medium, low level of involvement e.g. in terms of time, resources</td>
<td>High, medium, or low &amp; positive (+) or negative (-)</td>
<td>Incentives + or disincentives - related to the collaboration</td>
<td>Examples and explanation</td>
</tr>
</tbody>
</table>
ANNEX 4
Theory of Change, Logical framework and Summary Timeline

The Logical framework and Theory of Change and Timeline will help summarize programme activities and achievements.

Please start with a Theory of Change figure.12

The Logical Framework should be 1 to 2 pages when completed.

<table>
<thead>
<tr>
<th>SUMMARY PROGRAMME AREAS, ACHIEVEMENTS</th>
<th>INDICATORS/DELIVERABLES</th>
<th>RISKS / ASSUMPTIONS</th>
<th>KEY PARTNERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>Specific overarching goals e.g. national, SDGs etc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impacts</td>
<td>Main health, societal and sustainable development impacts - linked to activities, outputs, outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td>Main results – policy, service quality and coverage etc - linked to activities and deliverables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outputs</td>
<td>Main programme deliverables - around 3 to 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities/budget</td>
<td>Priority activity areas – 10 or fewer</td>
<td>Budget for each activity area</td>
<td></td>
</tr>
</tbody>
</table>

Example of summary timeline for the programme
REFERENCES


5. Quality of evidence could be described as High, Medium or Low e.g. based on a checklist of agreed quality criteria: 1) clear statement of objectives/questions; 2) standardized methods used; 3) ethics, rights, gender and equity issues addressed; 4) data collected in a way appropriate to addressing the objectives/questions; 5) efforts to include key stakeholders perspectives; 6) analytical rigour; 7) clear statement of findings and limitations; 8) review process whether institutional or other; 9) whether the evidence informed the programme and helped achieve local results; and 10) other considerations. (This list of quality criteria is adapted from Critical Appraisal Skills Programme (CASP) checklists: http://www.casp-uk.net/casp-tools-checklists).

6. For more information see WHO CSDH SDH briefing series about working with other sectors and shared interests — see http://www.who.int/social_determinants/publications/policies/en/


12. 2020 Every Woman Every Child Partner Framework: Early Childhood Development; Adolescent Health and Well-Being; Quality, Equity and Dignity in Services; Sexual and Reproductive Health and Rights; Empowerment of Women, Girls and Communities; and in Humanitarian and Fragile Settings.