Working report
Case Study Development based on a rapid review of the evidence: Collaborating Across Sectors for Women’s, Children’s, and Adolescents’ Health

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1.1 Introduction

PMNCH’s Success Factors study, launched at the 2014 Partners’ Forum in Johannesburg,\(^1\) demonstrated around 50% of the gains in child mortality reduction in low- and middle-income countries (LMICs) resulted from investments in the health sector, such as coverage of high-impact health interventions, and the remaining 50% from health-enhancing investments in other sectors, including education and women’s political and economic participation.\(^2\) These findings justified a clear focus on collaboration across sectors in the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030)\(^3\) in order to achieve its three overarching objectives of Survive (end preventable deaths), Thrive (ensure health and well-being), and Transform (expand enabling environments). The findings also support the wider 2030 Sustainable Development Goals’ emphasis on integrated approaches across sectors.

The Global Strategy’s Operational Framework\(^4\) identifies key mechanisms to enable a multi-sectoral response. This framework was further supported by Unicef’s development of a Guidance Document for Multisectoral Action for Health (in press) that describes key principles and approaches for how to address challenges in implementing a multi-sectoral response for health in four interconnected areas: governance, financing, monitoring and accountability, and prospective impact evaluation. WHO has also recently outlined the need and practical action required for collaboration across sectors in the development of national health policies, strategies and plans.\(^5\)

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But what is working with responses across sectors and why? How is collaboration being operationalized? What stories can countries and their partners tell about their own efforts to implement action across sectors towards lasting impact on women’s, children’s, and adolescents’ health? In its project Documenting Success Factors for Improving Women’s, Children’s and Adolescents’ Health: What works and why in achieving cross-sectoral results?, PMNCH is supporting case study development for twelve programmes that are taking action across sectors and currently being carried out by country partners in the following six Every Woman Every Child priority areas:  

1. Early Childhood Development  
2. Adolescent Health and Well-Being  
3. Quality, Equity and Dignity in Services  
4. Sexual and Reproductive Health and Rights  
5. Empowerment of Women, Girls’ and Communities  

The PMNCH project is focused specifically on stories of implementation across sectors in which stakeholders in health and one or more sectors (such as education, transport, or environment) are working together to plan and implement programmes at national and/or subnational levels. These stories of success in collaborating across sectors will describe the process of planning and operationalizing the joint action on behalf of women’s, children’s, and adolescents’ health in order to better understand what worked and why, and key lessons learned for working together. The stories will be developed through multi-stakeholder dialogue processes in countries and will be presented at the Partners’ Forum in New Delhi on 5-6 December 2018.

This report provides a conceptual framework and checklist, presented in Part 1, for the development of the case studies—stories of success of collaborating across sectors for women’s, children’s, and adolescents’ health. It draws on published and unpublished literature, presented in Part 2, of the factors and case examples that explain how action across sectors is planned, implemented, and sustained at the national or subnational levels. Documents were included in the development of the conceptual framework and checklist if they explained the “how-to” of collaborating across sectors (rather than merely the “what” of collaboration or the “importance” of collaboration). Research and pilot projects were not included, as the focus was instead on implementation of programmes across sectors at national or subnational levels. Literature was sought to identify specific initiatives related to the six Every Woman Every Child priority areas, and these are highlighted in this report. However, there were limited examples that documented the “how-to” of planning, implementing, and sustaining collaboration across sectors for women’s, children’s, and adolescents’ health. The PMNCH-supported case studies—the “stories of success”—will address this gap in the literature.

1.2 What is a Case Study?

A case study is an in-depth empirical method, using multiple sources of evidence, that attempts to systematically investigate the unfolding and development of a complex—yet time, space, or activity

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6 These are the six priority themes for multi stakeholder alignment and action through the Every Woman Every Child Partners’ Framework. Additional information is available at: https://www.everywomaneverychild.org/advocacy-roadmaps/  
7 This review of the literature updated a review originally conducted for Unicef’s development of a Guidance Document for Multisectoral Action for Health (in press).  
8 Much of the literature on the “how-to” of collaborating across sectors is in the area of nutrition, and increasingly One Health.
bounded—event within its context. Case studies tell the story of how and why something happened, illuminating key moments, people, and processes to enable the extraction of broader learning points. Case studies typically rely to a large extent on qualitative data, but they may also utilize quantitative data. They can be descriptive, exploratory, explanatory, illustrative, or evaluative. They can focus on a single case, or compare multiple cases. They can be used to test existing hypotheses, or derive hypotheses to be tested using other methodologies. The PMNCH-supported case studies seek to tell the story of how an action across sectors unfolded over time in a given context, why it worked, and what made it successful.

1.3 Conceptual Framework for Case Study Development—Successful Collaboration Across Sectors

The conceptual framework for the case study of successful collaboration across sectors builds on an existing framework on multisectoral action for nutrition and captures four intersecting components (see Figure 1):

1) **Factors** in collaborating across sectors: What key factors contribute to the design, implementation, coordination, and sustainability of responses across sectors?

2) **Levels** of collaborating across sectors: What are the vertical building blocks of responses across sectors, across administrative levels?

3) **Phases** of collaborating across sectors: How do responses across sectors unfold and evolve over time?

4) **Impacts** of collaborating across sectors: What are the impacts of responses across sectors, particularly in terms of the Global Strategy’s objectives of Survive, Thrive, and Transform? Annex A on page 9 demonstrates illustrative impacts in collaborating across sectors.

Figure 1

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This conceptual framework provides the basis for a checklist of questions that will aid in case study development of the stories of success in collaborating across sectors for women’s, children’s, and adolescents’ health. Part 2 provides a detailed description of the framework’s four intersecting components and the literature that underpin the conceptual framework and the checklist.

1.4 Checklist for Case Study Development—Successful Collaboration Across Sectors

The checklist presented in Table 1 can support case study development—specifically it supports the documentation of a story about how an initiative across sectors for women’s, children’s, and adolescents’ health unfolded over time in a given context, and what made the collaboration across sectors successful.

Table 1: Checklist for case study development

<table>
<thead>
<tr>
<th>Sections</th>
<th>General questions</th>
<th>Guiding questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Introduction</strong></td>
<td>What is the collaboration across sectors and where is it being implemented?</td>
<td>• What is the topic of the story?</td>
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<td></td>
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<td>• What is the nature of the problem that necessitated the collaboration across sectors?</td>
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<td>• What is the background with respect to the country/state/province of the story?</td>
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<tr>
<td><strong>2. Phase I: Getting started</strong></td>
<td>How do initiatives to work across sectors for health get started? What are the triggers?</td>
<td>The context and challenge:</td>
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<tr>
<td></td>
<td></td>
<td>• What were the specific environmental, political, social, economic, institutional and/or epidemiological contextual triggers that led stakeholders to launch a collaboration across sectors?</td>
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<td>• Who are the principal stakeholders, including individuals, moving the initiative forward?</td>
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<td>• Why were these sectors/individuals interested in a collaboration across sectors? What were their incentives for involvement?</td>
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<td></td>
<td></td>
<td>• What environmental, political, social, economic, institutional and/or epidemiological contexts affected/influenced - either positively or negatively - the launch of the initiative across sectors?</td>
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<td></td>
<td>• Did any of these contexts influence the type/degree of convergence across sectors at this phase of the collaboration? If so, how?</td>
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<td>• Were there existing institutional contexts for collaboration across sectors with respect to this story? If so what were they?</td>
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<tr>
<td></td>
<td></td>
<td>• Were stakeholders familiar with working across sectors? If so, did previous experience inform how they approached this particular issue?</td>
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<tr>
<td></td>
<td></td>
<td>Framing the issue and prioritizing action</td>
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<tr>
<td></td>
<td></td>
<td>• What was the process for securing political priority for collaboration across sectors?</td>
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<tr>
<td><strong>3. Phase II: Working together</strong></td>
<td><strong>The context and challenge:</strong></td>
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<tr>
<td>How does collaboration across sectors work? How does it evolve over time? What are the dynamics and mechanisms of the process?</td>
<td>- What environmental, political, social, economic, institutional and/or epidemiological contexts affected/influenced—either positively or negatively—the evolution of the response across sectors during the “working together” phase? What contexts facilitated the roll out of collaboration across sectors? What contexts impeded the “working together” stage of the collaboration across sectors?</td>
<td></td>
</tr>
<tr>
<td><strong>Architecture and mechanisms:</strong></td>
<td>- Did any of these contexts influence the type/degree of convergence across sectors in the “working together” phase?</td>
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<tr>
<td>- How was the appropriate architecture to host the collaboration across sectors decided upon?</td>
<td>- How was the issue framed for the different audiences and sectors, and by whom?</td>
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<tr>
<td>- Was the architecture to host the collaboration already in place? If so, did institutional restructuring have to take place to accommodate collaboration and what happened?</td>
<td>- What upstream and downstream advocacy strategies were used to generate support across sectors? What was the involvement of high-level champions and leaders?</td>
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</tr>
<tr>
<td>- Alternately, did architecture have to be custom built? What considerations had to be taken when building new architecture? How did this work?</td>
<td>- What upstream and downstream advocacy strategies were used to generate support across sectors? What was the involvement of high-level champions and leaders?</td>
<td></td>
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<tr>
<td>- How might the degree of convergence be characterized at this stage across sectors, stakeholders, and levels?</td>
<td>- Architecture and mechanisms:</td>
<td></td>
</tr>
<tr>
<td>- How were membership, roles, responsibilities, and incentivization of sectors, stakeholders, and levels decided upon at this stage?</td>
<td>- How was the issue framed for the different audiences and sectors, and by whom?</td>
<td></td>
</tr>
<tr>
<td>- How did mobilization of resources—financial, human, infrastructural—take place? How did stakeholders decide upon the relative contribution of resources by different sectors, stakeholders, and levels?</td>
<td>- What upstream and downstream advocacy strategies were used to generate support across sectors? What was the involvement of high-level champions and leaders?</td>
<td></td>
</tr>
<tr>
<td><strong>Monitoring, evaluation, and learning</strong></td>
<td>- How were membership, roles, responsibilities, and incentivization of sectors, stakeholders, and levels decided upon at this stage?</td>
<td></td>
</tr>
<tr>
<td>- Was there a process to develop joint indicators, targets, and a monitoring framework? If so, how did this process unfold and what was agreed upon?</td>
<td>- Architecture and mechanisms:</td>
<td></td>
</tr>
<tr>
<td>- Who was given responsibility for monitoring? How were findings from monitoring to be disseminated?</td>
<td>- How was the issue framed for the different audiences and sectors, and by whom?</td>
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<tr>
<td>- How did stakeholders agree on what to measure in evaluation and how? Was agreement reached on transparency and sharing of data? Who was given responsibility for evaluation?</td>
<td>- What upstream and downstream advocacy strategies were used to generate support across sectors? What was the involvement of high-level champions and leaders?</td>
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</tr>
</tbody>
</table>
### Framing the issue and prioritizing action:
- Did advocacy work continue over the “working together” phase? If so, what were the activities and who conducted them?
- What policy, strategy, and legislative frameworks existed or were built to support the response?
- Was a mapping conducted of each sector’s core interests and incentives, as well as their existing policies and programmes? If so, who did this and how was the information utilized?
- Was a shared vision created for the collaboration across sectors? How? Were there opportunities for informal and formal trust-building? What were these?
- Were there leaders who developed the vision and structures that supported the implementation of action across sectors? If so, who were they?
- Overall, was a culture of collaboration established across sectors and levels? If so, how?

### Architecture and mechanisms:
- Once implementation was underway, was architecture for the response across sectors adequate or was adaptation required? If adaptations were needed, was the architecture flexible enough to respond to learnings? How did this process of adaptation work?
- How might the degree of convergence be characterized in the “working together” stage across sectors, stakeholders, and levels? Did it change? If so, why and how?
- Did membership, roles, responsibilities, and incentivization of sectors, stakeholders, and levels change during the “working together” stage? If so, why and how?
- Did mobilization and/or the relative contribution of resources—financial, human, infrastructural—change during the “working together” stage? If so, why and how?

### Monitoring, evaluation, and learning
- How were monitoring and evaluation carried out in the “working together” phase? Were the M&E systems established for the collaboration across sectors adequate or was adaptation required?
- What capacities, processes, or tools needed to be built for monitoring and evaluation? How were they built?
- How was the evidence generated from M&E packaged
and disseminated? Were stakeholders able to use this evidence for learning and adaptations to the collaboration? If so, how?
- What were the resources and timelines provided for M&E? Were these sufficient for planning, data collection, stakeholder engagement, and dissemination?

| 4. Phase III: Sustaining collaboration across sectors | **The context and challenge:**
| What issues surround the sustainability of collaboration across sectors? | - What environmental, political, social, economic, institutional and/or epidemiological contexts have affected/influenced—either positively or negatively—the sustainability of collaboration across sectors? What contexts are facilitating sustainability? What contexts are impeding sustainability?
- Have any of these contexts influenced the type/degree of convergence across sectors at this sustainability phase of the response?

| Framing the issue and prioritizing action: |
| What environmental, political, social, economic, institutional and/or epidemiological contexts have affected/influenced—either positively or negatively—the sustainability of collaboration across sectors? What contexts are facilitating sustainability? What contexts are impeding sustainability? |
- Have political commitment and advocacy been sustained over the duration of the collaboration across sectors? If so, how?
- How have stakeholders, including high-level champions, across sectors and levels remained or not remained committed to the collaboration across sectors? How does this affect the sustainability?

| Architecture and mechanisms: |
| Has the architecture for the response across sectors been sufficient to sustain action? Has adaptation been required for sustainability? If so, has the architecture been flexible enough ensure sustainability? |
- How might the degree/type of convergence be characterized across sectors, stakeholders, and levels with respect to sustaining the collaboration? Has the degree/type of convergence had to change to sustain the response? If so, why and how?
- Has membership, roles, responsibilities, and incentivization of sectors, stakeholders, and levels changed in order to ensure sustainability? If so, why and how?
- Has mobilization and/or relative contribution of resources—financial, human, infrastructural—had to change to ensure sustainability? If so, why and how?

| Monitoring, evaluation, and learning |
| Did information gathered during the monitoring and evaluation activities influence the sustainability of the collaboration? If so, how? |
5. Impacts

<table>
<thead>
<tr>
<th>What are the impacts of the collaboration across sectors?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What evidence exists to demonstrate the impacts of the collaboration (see Annex A for illustrative impacts of collaborating across sectors)? What is the evidence of outcomes or impact or cost-effectiveness?</td>
</tr>
<tr>
<td>• What are stakeholder perceptions of the impacts of the response across sectors? Are there elements of the response that are valued by stakeholders that may not necessarily be reflected in quantitative data?</td>
</tr>
<tr>
<td>• How has the collaboration across sectors impacted the Global Strategy’s key indicators related to Survive (ending preventable deaths), Thrive (ensuring health and well-being), and Transform (expanding enabling environments) (see Annex B)?</td>
</tr>
</tbody>
</table>

6. Summary

<table>
<thead>
<tr>
<th>What were the key barriers, strategies, and lessons learned from collaborating across sectors?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What were the key barriers encountered in the response across sectors?</td>
</tr>
<tr>
<td>• What strategies were used to overcome these barriers, and what are the remaining challenges?</td>
</tr>
<tr>
<td>• What key lessons were learned from this response that can inform future collaboration across sectors in this and other countries?</td>
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</tbody>
</table>

7. Annexes

<table>
<thead>
<tr>
<th>Bibliography</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
</tr>
<tr>
<td>Optional annexes: maps or key data; timeline of the collaboration across sectors; list of major actors or implementers</td>
</tr>
</tbody>
</table>

Final questions

<table>
<thead>
<tr>
<th>Has the story been told? Are there gaps? Are all events accounted for? Have all voices been heard?</th>
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</table>

## Annex A. Illustrative Impacts of Collaborating Across Sectors for Women’s, Children’s, and Adolescents’ Health

<table>
<thead>
<tr>
<th>Collaboration impacts</th>
<th>Operational impacts</th>
<th>Policy impacts</th>
<th>Service/coverage impacts</th>
<th>Societal impacts and health and development outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Joint vision and shared purpose</td>
<td>• Time (prevention or reduction of duplicative activities or services)</td>
<td>• Policy-making</td>
<td>• Reach/coverage of services</td>
<td>• Knowledge, attitudes and behavior related to health and development</td>
</tr>
<tr>
<td>• Shared resources and responsibilities</td>
<td>• Achieve more together than separately</td>
<td>• Policy networks</td>
<td>• Quality of services</td>
<td>• Health outcomes (eg Global Strategy Survive, Thrive &amp; Transform)</td>
</tr>
<tr>
<td>• Cooperation and mutual support</td>
<td>• Value for money (cost-effectiveness)</td>
<td>• Political capital</td>
<td>• Equity of services</td>
<td>• Development outcomes (eg Sustainable Development Goals)</td>
</tr>
<tr>
<td></td>
<td>• Human resources (motivation, skills, retention of staff)</td>
<td></td>
<td></td>
<td>• Human rights</td>
</tr>
<tr>
<td></td>
<td>• Capacity-strengthening of local community or government to manage across sectors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Networks across sectors</td>
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</table>

Annex B. Key Indicators for the Global Strategy’s Objectives of Survive, Thrive, and Transform

| Survive | | | | | |
|---|---|---|---|---|
| | 1. Maternal mortality ratio (SDG 3.1.1) | 2. Under-5 mortality rate (SDG 3.2.1) | 3. Neonatal mortality rate (SDG 3.2.2) | 4. Stillbirth rate |
| | 5. Adolescent mortality rate | | | |
| Thrive | | | | | |
| 6. Prevalence of stunting among children under 5 years of age (SDG 2.2.1) | 7. Adolescent birth rate (10-14, 15-19) per 1000 women in that age group (SDG 3.7.2) | 8. Coverage index of essential health services, including for infectious diseases, noncommunicable diseases and RMNCAH: family planning, antenatal care, skilled birth attendance, breastfeeding, immunization, childhood illnesses treatment (SDG 3.1.2, 3.7.1, 3.8.1) | 9. Out-of-pocket health expenditure as a percentage of total health expenditure | 10. Current country health expenditure per capita (including specifically on RMNCAH) financed from domestic sources |
| 11. Number of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information and education (SDG 5.6.2) | 12. Proportion of population with primary reliance on clean fuels and technology (SDG 7.1.2) | | | |
| Transform | | | | | |
| 13. Proportion of children under 5 years of age whose births have been registered with a civil authority (SDG 16.9.1) | 14. Proportion of children and young people in schools with proficiency in reading and mathematics (SDG 4.1.1) | 15. Proportion of women, children and adolescents subjected to violence (SDG 5.2.1, 16.2.3) | 16. Percentage of population using safely managed sanitation services including a hand-washing facility with soap and water (SDG 6.2.1) | |

Part 2: Supporting Literature for the Conceptual Framework and Checklist

The conceptual framework and checklist for the stories of success build on an existing framework on multisectoral action for nutrition. The framework captures four intersecting components (see Figure 1):

1) **Factors** in collaborating across sectors: What key factors contribute to the design, implementation, coordination, and sustainability of responses across sectors?

2) **Levels** of collaborating across sectors: What are the vertical building blocks of responses across sectors, across administrative levels?

3) **Phases** of collaborating across sectors: How do responses across sectors unfold and evolve over time?

4) **Impacts** of collaborating across sectors: What are the impacts of responses across sectors, particularly in terms of the Global Strategy’s objectives of Survive, Thrive, and Transform?

**Figure 1**

### 2.1 Factors

There are multiple factors affecting the design, implementation, and sustainability of collaboration across sectors. These factors can be grouped into four categories: 1.1 context and challenge; 1.2 framing and prioritisation; 1.3 architecture and mechanisms; and 1.4 monitoring, evaluation, and learning.

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2.1.1. Framing the context and challenge
Context refers to the social, economic, political, and systems-related factors external to both the collaboration across sectors itself, and internal to each of the respective sectors and levels (see section 2) within, that influence, facilitate, or impede the creation, implementation, and sustainability of the response across sectors.\(^{13}\)

Contextual factors external to the collaboration across sectors include, for example, **events, research findings, and national development priorities that draw attention to the particular problem and open a policy window** within which a response across sectors can be discussed, adopted, planned, and launched. For example, in 2000, a political party candidate running for governor of Antioquia Department, Colombia—a region which was then experiencing measurable spikes in child mortality rates—carried out a series of countryside walks to better understand the problems of potential constituents. Community members highlighted child mortality from malnutrition as one of the most critical problems in the department. Upon winning the election, the new governor immediately pressed for action on malnutrition, thus opening a policy window for the development of a malnutrition response across sectors.\(^{14}\) The convergence of elections, political interest of a candidate and malnutrition champion, empirical and anecdotal evidence of a reversal of progress on child mortality, and the needs of a new administration to act quickly to achieve campaign promises coalesced to create the impetus for a nutrition response across sectors. The stories of success should describe the broader factors that triggered collaboration across sectors and shaped implementation and sustainability.

Contextual factors internal to responses across sectors include **institutional backgrounds, cultures, systems, structures, linkages and dis/incentives**\(^{15}\) **specific to the sectors or stakeholders involved in the response** that 1) fed into these sectors/stakeholders’ decision, willingness, and ability to participate in the response, and 2) affected how they may have approached participation. For example, in 1995, the government of New South Wales launched a physical activity and health programme involving multiple sectors—Active Australia—with help from the Federal Australian Sports Commission and Commonwealth Department of Health, taking advantage of the Commission expanding its agenda to include community-level physical activity. However, over the next decade, political transition at the federal level and subsequent restructuring of the Sports Commission’s mandate to begin focusing only on elite sports, had considerable effect on the ability of New South Wales to hold together a coalition across sectors at the state level.\(^{16}\) The stories of success should look at the contextual factors that influenced participation by the specific sectors, stakeholders, and levels in collaborating across sectors across all phases.

Oftentimes, internal and external contextual factors converge. Pakistan, for example, has faced numerous barriers in developing an improved national nutrition response in the context of increased provincial devolution coupled with the fact that most sectors continue to work within sharply delineated silos. Additionally, responses on malnutrition involving multiple sectors have been hampered by poverty, economic, and gender-based inequity, inadequate coverage of nutrition-influencing services, and province-specific insecurity, natural disasters and political upheaval.\(^{17}\) The stories of success should describe the contextual events influencing the establishment,

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\(^{13}\) Garrett J, Natalicchio M, Bassett L. 2011. \\
\(^{14}\) Garrett J, Natalicchio M, Bassett L. 2011. \\
\(^{15}\) Incentives are considered broadly here. They could include sector-wide financial incentives like access to shared budgets, or personal financial incentives like salary top-ups. However, it can also be access to technical assistance, opportunities for cost-sharing or research, raised sectoral profiles, etc. \\
implementation, and sustainability of the collaboration across sectors both with respect to the collaboration itself, and with respect to the participation of its relevant sectors, stakeholders, and administrative levels.

2.1.2. Framing the issue and prioritisation
This group of factors involves the framing of the solution and the prioritisation and support for collaborations across sectors from political leaders, as well as support from stakeholders across sectors and levels and within the collaboration itself. These factors involve political processes, rather than merely technical challenges, and may act as barriers or facilitators to the design, implementation, and sustainability of responses across sectors.

Political priority exists when political leaders see an issue as worthy of sustained attention, backed up with a commitment of financial, human, and technological resources. The securing of political priority and support for collaborations across sectors is a critical “first step” for moving ahead with joint action.

**Box 1: Priority Theme: Adolescent Health and Well-Being**

During the first phase of India’s Adolescent Girls’ Anaemia Control Programme, advocates used evidence from global research, the second National Family and Health Survey, and UNICEF-supported research trials among Indian adolescent girls to build a compelling case that anaemia was a critical health problem among girls aged 15-19 within India and globally, and to demonstrate that weekly folic acid supplementation was as effective as daily supplementation to reduce the prevalence of anaemia in adolescent girls. This case was key to securing political support from the government of India and state governments for a five-year pilot programme—led by the three state departments of Health and Family Welfare, Education, and Women and Child Development—to test innovative delivery of folic acid across fifty-two districts in thirteen states. Based on the pilot’s success, the programme was subsequently replicated and scaled up nationwide.

It is also essential to maintain political priority and support over time since context, needs, and political actors change both because of the collaboration itself and external factors. The stories of success should therefore examine the securing of political priority and support that influenced joint action and whether and how it was maintained over time.

Generating support from groups and individuals across sectors and levels who might have a stake in and contribute to responses across sectors is also important for beginning, implementing, and sustaining this response. One key factor in gaining this support from groups and individuals is appropriate framing of the issue—using evidence and language that helps people in both health and non-health sectors see the importance of the joint response, and how they will benefit from it. For example, malnutrition emerged on the national agenda in Thailand in the 1970s after advocates framed nutrition problems not as diseases but as resulting from social disparities in access to nutritional foods and knowledge about proper diet. Advocates also framed the issue as being a national investment, rather than a social welfare issue. This strategy led to the establishment of a National Nutrition Committee including high-level representatives from multiple sectors. How the

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issue was framed, and its influence on gaining participation of individuals and organizations across sectors and levels should be a focus of the stories of success.

**Advocacy** is also important for encouraging participation—upstream advocacy to high level stakeholders across sectors, and downstream advocacy with local governments and community leaders and organizations. A related factor involves the use of **high-level champions** who can generate needed support for collaborating across sectors. Relying on champions can also have a negative impact in that the champion may be seen by stakeholders as representing only a certain sector and may also disengage in the response over time. For example, a road safety initiative in Malaysia, involving the Ministries of Education, Transport, and Health, was created because a powerful champion strongly believed in education as a way to create a culture of road safety amongst children. A study of this initiative pointed out that transitioning from a champion-based initiative to a systems-approach to the problem will be needed for its longer-term sustainability. While champions are important, responses across sectors also require strong **leadership** at national and subnational levels to create the vision and architecture to support action. The stories of success should examine the role of advocacy, champions, and leadership in generating support for collaborating across sectors both at the design stage, and over the course of implementation.

**Establishing a culture of collaborating across sectors** within and across sectors and levels is also essential for stakeholder participation in a collaboration over time. This requires **ensuring optimal policy, strategy, and legislative frameworks** such as national plans, sector-specific strategies, legislation, or global compacts. It also necessitates the **mapping of each sector’s stake in the issue** since each sector has its own mandate, interests, areas of influence, incentives to participate, and risks and benefits to participation in the action across sectors. This mapping will need to be updated periodically since each sector’s stake may evolve over the planning, implementation, and scale up stages of the response across sectors. Finally, it requires the **development of a shared vision for the response and the building of mutual trust**. Creating a shared understanding of the problem and a common agenda for solving it has been identified in the literature as one of five key conditions for collective impact. Similarly, a review of success factors contributing to responses across sectors on non-communicable disease risk in adolescents argued that shared vision was the most critical success factor for partnerships involving multiple sectors.

Developing this shared vision requires **dialogue** amongst sectors to understand similar and different interests and incentives, agree on a common agenda and mutual goals, and settle on mutually-understood language so that objectives within individual sectors can be aligned. Through this process, both informal and formal trust-building between sectors begins to take place. For example, the Health Bridges Programme in South Australia emphasized formal (development of Memoranda of Understanding) and informal (development of relationships between stakeholders) trust-building activities between the health and education sectors, and the community, in rolling out the HPV vaccine for adolescent girls. How a culture of working across sectors has or has not been established, and its influence on the response over time, should be emphasized in the stories of success.

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2.1.3. Architecture and mechanisms

Architecture refers to the mechanisms, processes, fora, and institutions that support and manage the convergence of horizontal (across sectors) and vertical (across administrative levels) linkages necessary to mount a response across sectors. Collaborating across sectors requires either identifying (and potentially restructuring) existing architecture, or creating custom built architecture, so to bring sectors, stakeholders, and levels together to plan, advocate, mobilize resources, implement, monitor, and sustain activities over time. They also require establishing where architecture is housed institutionally within existing government structures—both nationally and subnationally—which, in turn, may have implications for roles, responsibilities, incentives, and perceived ownership of the response across sectors, as well as for the degree to which implementation is able to be devolved. The stories of success should describe the architecture of the collaboration across sectors: How was it established? What did it look like? Who was involved and how? What were the challenges?

Box 2: Priority Theme: Humanitarian and Fragile Settings

In 2013, the International Rescue Committee (IRC) in partnership with Akkar Network for Development implemented an unconditional cross-sector cash programme in Akkar, north Lebanon, for Syrian refugee and vulnerable Lebanese households. Through the programme, heads of households—the majority of whom were women—received monthly cash assistance of $200 USD to meet basic needs across sectors. The aim was to decrease negative coping strategies, such as the sale of assets and sending children to work, and to lesson social tensions between Syrian and Lebanese households. One key challenge encountered by IRC during implementation was that existing humanitarian coordination mechanisms were sector-specific and did not therefore accommodate a programme involving multiple sectors effectively, making coordination across organizations and sectors challenging. An assessment pointed out that the appropriate architecture for the planning and coordination of cross-sector programming in humanitarian settings needs to be designed and implemented.26

The stories of success should be interested in whether, how, and why organizational decisions with respect to architecture were made, how this architecture was then established, barriers or facilitating factors with respect to its establishment, and how and why architecture may have changed or adapted over time.

In addition to creating institutional mechanisms and linkages, architecture for an effective response across sectors explicitly clarifies roles and responsibilities for participating sectors, stakeholders, and levels.27 For example, stakeholders in England’s Health Weight, Healthy Lives Strategy (2008-2011) to reduce the population burden of obesity cited the strategy’s consultative process and establishment of a framework to elaborate roles and responsibilities of participating government departments and agencies—Department of Health, former Department of Children, Schools and Families, regional government offices and Strategic Health Authorities, and local Primary Care Trusts—as one of the most important elements of effective implementation of the strategy.28 Roles,  

responsibilities and incentives, moreover, are not necessarily fixed and may need to change over the duration of collaboration across sectors.²⁹ Meanwhile, there is extensive documentation in the literature on responses across sectors that cites the failure to clearly define roles as one of the biggest obstacles to effectiveness.³⁰ For example, the implementation of Uganda’s Nutrition Action Plan faced numerous bottlenecks—especially at the district level—due to a lack of clarity of roles and responsibilities.³¹ The stories of success should address how roles and responsibilities were allocated for the response across sectors and whether there was sufficient clarity, and how roles and responsibilities played out over time. Architecture for collaboration across sectors also require sufficient resources—financial, human, infrastructural—and capacity to plan, coordinate, implement activities, measure impact and sustain itself. The stories of success should delve into the resource and capacity needs of the collaboration over time. How were these needs met? Were resources and capacity sufficient? How did these needs change over time?

Box 3: Priority Theme: Sexual and Reproductive Health and Rights

In Mozambique, an adolescent sexual and reproductive health programme—Programa Geração Biz—required external support to build capacity within the Ministries of Health, Education, and Youth and Sports and across multiple administrative levels in order to be able to plan and implement activities across sectors. Capacity-building led to improved commitment and financial prioritisation of the programme within respective ministries, enabling the programme to have sufficient resources to act. The programme was initially externally financed by a range of development partners and funding for provincial implementation of activities was provided by UNFPA. The government committed human, infrastructural, material, and financial resources and, over time, gradually integrated the programme into sector budgets so UNFPA financing could be phased out.³²

Ultimately, the architecture for collaboration across sectors determines the level of convergence of sectors, stakeholders, and levels (see Figure 2). **Convergence** can be characterized as the extent to which sectors, stakeholders, and administrative levels have been organized to work together with respect to a response across sectors for a certain issue. Convergence for responses across sectors can be understood along a continuum, from **cooperation** (least convergence with sectors all working on a single issue, but maintaining separate remits, activities, and plans) to **integration** (full convergence with sectors sharing structures, resources, and merged remits). Other types of convergence include **coordination** (some convergence with sectors sharing some activities and resources in order to achieve a common goal, but maintaining sectoral remits) and **collaboration** (greater convergence with sectors sharing activities, resources, and strategy to enhance mutual capacity, yet maintaining sectoral remits).\(^3^3\)

It is important to note that: 1) different issues may require different degrees of convergence; 2) different administrative levels may require different degrees of convergence; and 3) different stages of responses across sectors may require different degrees of convergence. The stories of success should attempt to capture the degree of convergence with respect to the sectors, stakeholders, and levels of collaborating across sectors through different levels and phases.

**Box 4: Priority Theme: Early Childhood Development**

Chile Crece Contigo (“Chile Grows With You”) is a multi-disciplinary approach introduced in Chile in 2005 to provide children, especially those of the poorest 40%, with services relevant to optimal early childhood development from the time of conception. The programme involved the creation of a multi-sectoral, fully convergent approach involving a central platform—the Presidential Council—responsible for development, planning, and budgeting. At subnational levels (regional, provincial, and local) integrated institutional bodies supervise and support planning, implementation, and budgeting for each respective level. Convergence is supported by the Chile Crece Contigo Law (No. 20.379) that institutionalizes these specialized multi-sectoral platforms across all levels of administration.\(^3^4\)

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2.1.4. Monitoring, evaluation, and learning

Monitoring refers to “the continuous oversight of an activity to assist in its supervision and to see that it proceeds according to plan...[including] the specification of methods to measure activity, use of resources, and response to services against criteria.” Monitoring-related factors that facilitate or create barriers to collaborations across sectors include the identification of joint indicators, acceptable and feasible targets, and a shared framework and plan for measurement; recognition of roles, responsibilities, and an architecture for monitoring (including making it interoperable); and capacity building for joint monitoring.

Box 5: Priority Theme: Empowerment for Women, Girls and Communities

Mama SASHA is a regional programme in Western Kenya that integrates agriculture, nutrition, and health sectors by increasing the production and consumption of Vitamin A-rich orange-fleshed sweet potato among pregnant women and infants. The programme empowers women by providing them opportunities to generate income and make critical decisions for their families with respect to household economy, nutrition, and health. Based on a participatory impact pathway analysis, the programme established an integrated monitoring system across sectors with detailed discussion about which variables on the impact pathway to measure, when and how to measure them, and who was responsible. These measures were discussed at monthly feedback meetings involving all key actors in local-level implementation, and together they identified emerging problems and designed solutions.

Evaluation is “the systematic and objective assessment of the relevance, adequacy, progress, efficiency, effectiveness and impact of a course of actions, in relation to objectives and taking into account the resources and facilities that have been deployed.” Evaluation-related factors that impede or facilitate responses across sectors include identification of whether to evaluate, why, and how; conducting of evaluations; and continuity and transparency of information flows from evaluation (and monitoring) activities. Factors related to monitoring and evaluation influence continuous feedback and learning—the use of data and insights to learn and make adaptations to the implementation of collaborating across sectors. These factors also affect the accountability of a response across sectors to stakeholders, with implications for scale-up and sustainability.

Box 6: Priority Theme: Quality, Equity and Dignity in Services

Mexico’s Oportunidades programme is the Mexican government’s anti-poverty programme. It involves a conditional cash transfer to mothers in poor families, conditional on their children’s regular attendance at school and visiting a health center. From its inception, monitoring and evaluation have been included as part of Oportunidades with two evaluation components: internal continual process evaluation and external impact evaluation (both quantitative and qualitative anthropological and ethnographic studies). Oportunidades contracted researchers to design a prospective impact evaluation and build it into the programme as it was rolled out into participating communities. The results from the first impact evaluation stage were impressive, and contributed to the government’s decision to continue the programme, and led to several program modifications.

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credibility of the evaluation increased the programme’s legitimacy in-country and gave Oportunidades increased international recognition, including a loan from the Inter-American Development Bank. There are now more than 5.5 million households across Mexico that are beneficiaries of Oportunidades.38

The stories of success should identify the M&E-related factors that impede or facilitate learning and accountability of collaborations across sectors, and their impact on scale-up and sustainability.

2.2 Levels
The degree of convergence varies at different administrative and operational levels. While a response across sectors is often launched, planned, and financed at the national level, implementation frequently takes place at lower levels of government—e.g. states, provinces, districts, municipalities, and communities—all of which might have different structures, mandates, and experiences with organizing across sectors. Moreover, the degree of decentralization and/or devolution within a country also influences how collaborations across sectors play out at scale, with effectiveness largely determined by the administrative contexts of particular subnational units. In such decentralized systems, understanding “what works” is often complicated by the fact that making collaborations across sectors “work” requires coordinating not only horizontally across sectors, but vertically across various autonomous or semi-autonomous governments, within which different sectors may have varying degrees of independence from the central government.39

The degree of decentralization of administrative or operational levels may impede the effectiveness of collaborations across sectors. For example, Bolivia’s Zero Malnutrition Programme involving multiple sectors was able to mobilize high-level advocates and champions, but encountered bottlenecks at the municipality level due to a lack of internal and existing administrative structures to support cooperation across sectors, so structures had to be created and, thus, were viewed as “externally imposed.” Additionally, roles, expectations, functions, and interests were never clarified for municipality stakeholders and subnational initiatives quickly became dependent on financing and guidance from the central Ministry of Health which, in turn, led to issues of perceived “ownership” of nutrition by health.40 Decentralization may also, by contrast, facilitate responses across sectors. For example, a maternal and child nutrition response involving multiple sectors in Thailand was facilitated by the fact that the country already had subnational structures across sectors in place to support integrated health and development activities—structures that included shared targets and indicators—and the national architecture for nutrition was placed not within particular sectors but at the office that was charged with supporting integrated community responses.41 The stories of success, therefore, should attempt to describe and analyze how planning, implementation, sustainability, and degree of convergence looks at all levels relevant to the case.

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2.3 Phases

The importance of the multiple factors influencing collaborations across sectors, and the degree of convergence at different levels, vary and evolve over three phases. The first of these is the exploratory, **getting started** phase in which there is an emerging understanding of the need for solutions involving multiple sectors for a particular problem. Partners begin to meet and conduct dialogue about conditions for working together, identify focal points within partner agencies, and discuss potential financing and governance mechanisms. Interactions become more formal as institutional mechanisms are enacted, and partners embark on planning. For example, in the development of the Programa Geração Biz in Mozambique (see Box 3), an initiative for the improvement of sexual and reproductive health of adolescents, the country’s delegation returned from the 1994 International Conference on Population and Development with a commitment to improve the lives of adolescents in their country. This led to the establishment of the Intersectoral Committee for Development of Youth and Adolescents involving multiple government ministries, NGOs, and faith-based agencies, and a National Plan for the Development of Adolescents and Youth.43

The second phase—**working together**—occurs when partners begin implementation across sectors. In Mozambique, PGB emerged from the efforts in the first phase, and involved three government ministries—health, youth and sports, and education—with support from UNFPA and Pathfinder International. The partners agreed on a package of activities, identified personnel within each organization to provide technical support for implementation, allocated budget, rolled out the programme nationwide, and conducted monitoring and evaluation.44

The final phase involves the **sustaining** of a response across sectors over time as long as it is needed. Merely initiating a collaboration across sectors is not sufficient for ensuring its sustainability over time.45 Key challenges include programme fatigue, lack of sustainable financing, leadership changes, and turnover of public officials. While there is limited literature on how to institutionalize and sustain programmes across sectors, case studies of multi-sectoral nutrition programmes in Senegal and Colombia suggest that sustainability depends on the building of widespread understanding and political commitment, so that a diverse set of actors support the prioritisation of collaboration across sectors over the long term.46 The stories of success, therefore, should examine factors and degrees of convergence at different levels throughout the three different phases of collaboration.

2.4 Impacts

The final component of the conceptual framework centers on the impact of collaborating across sectors. What types of impacts can be identified, including impacts on the Global Strategy’s key indicators of Survive (end preventable deaths), Thrive (ensure health and well-being), and Transform (expand enabling environments)? Annex A shows that responses across sectors can have a range of impacts including on the collaboration, programme operations, policies, services, health and development outcomes, and broader society. The stories of success should examine the impact of collaborating across sectors on Survive, Thrive, and Transform (see Annex B), as well as consider other impacts as suggested in Annex A.

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