Annex 2. Overview of case studies

Target issue	**Title**	**Location of case study**	**Year(s)**	**Brief description of the initiative**	**Sectors involved**	**Key successes and challenges of multi-sectoral implementation at sub-national levels**
HIV/AIDS	National and sub-national HIV/AIDS coordination: are global health initiatives closing the gap between intent and practice?[21]	China, Georgia, Kyrgyzstan, Mozambique, Peru, Ukraine, Zambia *Sub-national units not specified*	2006 – 2008	Development and functioning of national and sub-national HIV coordination structures, and the extent to which global HIV/AIDS coordination efforts (i.e. GFATM, PEPFAR, and the World Bank) are aligned with and strengthen country health systems.	Government *Not specified* International organizations i.e. GFATM, PEPFAR, World Bank	Successes • **Investment from key members of coordination bodies** and **commitment of high-level government leaders** were important factors in addressing HIV/AIDS epidemics through multi-sectoral efforts. • **Multi-sectoral coordination** improved participation of relevant departments/ministries and other stakeholders in decision-making processes. Challenges • **Donors' priorities undermined alignment with country priorities and processes** by generating competition for scarce resources and by stifling country ownership and decision-making authority. • **Proliferation of national and subnational HIV/AIDS coordination structures** has challenged effective governance. • **Perceived health sector's sole responsibility of HIV/AIDS** negatively impacted participation and engagement of non-health departments and non-governmental stakeholders in national and sub-national coordination structures. • **Limited financial resources, awareness of roles and responsibilities,** and **capacity of staff** undermined the ability of coordination structures and sub-national staff.
HIV/AIDS	Implementing a multi-sectoral response to HIV:	South Africa	2012 – 2016	Implementation of the National Strategic Plan to	Government All government departments, led by the	Successes *Not specified*

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	a case study of AIDS councils in the Mpumalanga Province, South Africa[20]	*Mpumalanga province* *All 3 districts (Gert Sibande, Ehlanzeni, and Nkangala)* *2 municipalities per district*		address HIV, STIs, and tuberculosis through mandated multi-sectoral AIDS Councils (ACs) at national, provincial, district and local municipality levels	Department of Health *(specific departments not specified)* Civil society Community-based organisations (i.e. Mothers to Mothers) Faith-based organisations (i.e. pastors and traditional healers forums) NGOs (i.e. Anova Health, All Seasons Home Based Care) Private sector *Specific companies not specified*	Challenges • **Voluntary membership** and **lack of financial support for participation** in the ACs led to poor government and private sector engagement and frequent membership changes. • **Lack of standard operating procedures** and **unclear roles and responsibilities** resulted in divisions and tension between sectors, and parallel activities within government and between government and civil society. • **Lack of decision-making power** and **funding,** coupled with **inadequate senior political leadership,** hindered operationalization of the ACs' recommendations. • **Power inequalities** and **mistrust** between government and civil society hindered effective collaboration. • **Limited capacity** amongst AC members hindered their ability to undertake the activities necessary for coordinating implementation.
Nutrition	Multisector Nutrition Program Governance and Implementation in Ethiopia: Opportunities and Challenges[18]	Ethiopia *All 4 regions (Amhara, Oromia, SNNPR, and Tigray)*	2013 – 2015	Implementation of the multi-sectoral National Nutrition Program at national, regional, and woreda (district) levels	Government All Ministries with direct or indirect involvement in nutrition, led by the Ministries of Health, Agriculture, and Education *(specific departments not specified)* Civil society International movements (i.e. Scaling Up Nutrition (SUN) and Renew Efforts	Successes • **Definition of the key nutritional problems and their drivers in each region** facilitated targeted interventions. • **Designated nutrition focal points at the *woreda* level** supported implementation and accountability. Challenges • **Limited involvement in the development of the national program, low awareness of the program,** and **limited prioritization of nutrition at sub-national levels** (especially among non-

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					against Child Hunger and under nutrition (REACH)) NGOs *(not specified)*	health ministries) hindered buy-in and implementation. • **Diversity of opinions across sectors about drivers of nutritional problems** hindered definition of the intervention packages at the regional level. • **Perceived ownership of the national program by the Ministry of Health** and **lack of a coordinating body and multi-sectoral roles, responsibilities, and accountability mechanisms** hindered collaboration between other ministries (especially agriculture) • **Budget shortages** (including lack of a specific line item for nutrition in each Ministry budget) and **lack of incentives for collaboration** contributed to the perception that government was asking sub-national staff to do more work with no additional financial or human resources. • **Limited capacity and retention of staff** hindered effective and sustained multi-sectoral implementation.
Nutrition	Explaining the reduction in child undernutrition in the Indian state of Maharashtra between 2006 and 2012: An analysis of the policy[16]	India *Maharashtra state* *3 districts (Thane, Nagpur, and Amravati)*	2006 – 2012	State-level coordination of the 'Nutrition Mission' set up by the Indian state of Maharashtra, and its contribution to Maharashtra's rapid decline in child undernutrition	Government Relevant ministries (i.e. Agricultural, Education, Food and Civil Supplies, Housing. Social Justice, Tribal Affairs) Civil society NGOs (i.e. Citizen's Alliance against Malnutrition Committee) Media	Successes • **Framing of the issue**, and **generation and communication of evidence** played a key role in building credibility, putting the issue on the government's agenda, and generating a swift response. • **Political leadership and a focus on system-wide capacity** gave the issue priority and supported bureaucratic structures that enabled implementation. • **The multi-sectoral Nutrition Mission coordination structure** improved coordination between departments of health and women and

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						child development, and gave emphasis to strengthening sub-national level capacity. • **Locally collected and locally credible data** (outside of national level surveys) was also critical in highlighting the need for action and tailoring interventions at the state level. Challenges *Not specified*
Nutrition	How Senegal created an enabling environment for nutrition: A story of change[15]	Senegal *1 administrative department (not specified)* *4 Collectivités Locales (districts)* *1 village per Collectivités Locale*	2001 – 2015	Mobilization of political commitment and increased coherence in national and sub-national action to address child undernutrition	Government Relevant ministries (i.e. Agriculture, Health, Women and Children, Women's Entrepreneurship, Education, Trade, Industry, Finance) Civil society NGOs (i.e. Yaajeende, the Helen Keller International, Eau Vie Environnement, CONGAD, the Micronutrient Initiative) International organizations (i.e. UNICEF, WFP)	Successes • **National policies** integrated nutrition in multiple sectors' mandates (i.e. health, education, agriculture) and promoted partnerships with civil society and the private sector. • **Targeted advocacy** created increased understanding among agriculture, health, and education stakeholders of how nutrition relates to their individual mandates • **Increased high-level engagement and ownership** of nutrition as a priority development issue, including housing of the issue in the Prime Minister's office, spearheaded and sustained action. • **Establishment of a national coordinating body** fostered shared ownership (i.e. by facilitating the incorporation of nutrition into sectoral agendas); pushed for coordination between government, civil society, and international organizations; and centralized political and administrative processes. Challenges • **Lack of nutrition-specific objectives and budget items in other sectors** (i.e. within the National

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						Agricultural Investment Program) hindered multi-sectoral engagement and monitoring. • **Lack of authority of the national coordinating body to enforce collaboration** (including budgetary commitment) forces reliance on the willingness of the sectors involved. • **Lack of clear guidance for sub-national authorities** on how to incorporate nutrition into their local development plans stifled progress at local levels
Nutrition	From coherence towards commitment: Changes and challenges in Zambia's nutrition policy environment[19]	Zambia *1 district (Mumbwa)*	2011 – 2015	Implementation of nutrition policy linked to the SUN movement through piloting of District Nutrition Coordinating Committees	Government Relevant ministries (i.e. Health, Agriculture and Livestock, Community Development, WASH) Civil society NGOs (i.e. Concern Worldwide) Faith-based organisations Village women's groups	Successes • **International movements** helped to bypass the need for political prioritization by channeling resources and technical support directly to the technical sections of government tasked with nutrition issues. • **Support from NGOs** helped to catalyse the coordination of different stakeholders during preliminary implementation. Challenges • **Leadership and engagement from international movements and NGOs** limited broader government attention and system-wide commitment (esp. financial) and monitoring. • **Different roles, mandates, and priorities among government ministries** was a challenge for messaging and hindered engagement. • **Limited use of local level data** in development of policy/programme had potentially negative impact on relevance of intervention in different sub-national regions.
GBV/VAW	One stop crisis centres: A policy	Malaysia	1985 onwards	Development and national	Government	Successes

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	analysis of the Malaysian response to intimate partner violence[17]	*2 states (Penang and Kelantan)*		scale-up of the One Stop Crisis Centre policy and subsequent health model for violence-response	Relevant departments (i.e. health, social welfare, police, legal aid) <u>Civil society</u> Joint Action Group of NGOs (i.e. Women's Aid Organisation, Association of Women's Lawyers, Malaysian Trade Unions Congress Women's Section, University Women's Association, Selangor and Federal Territory Consumers' Association)	• **Advocacy and piloting of the intervention model by civil society** established legitimacy of GBV/VAW as a national problem and shaped service protocols. • **Regular meetings at the sub-national level with multi-sectoral partners** strengthened coordination and monitoring. <u>Challenges</u> • **Lack of clear roles and responsibilities** hindered the handover of the pilot intervention by NGOs to the Department of Health for institutionalization and scale up. • **Lack of clear policy guidance and operational details** from the Department of Health left the implementation of services to the sub-national level, with negative implications for quality. • **Lack of financial resources** to implement services severely constrained the ability of sub-national stakeholders to deliver the necessary services.
Maternal health	Maternal death inquiry and response in India - the impact of contextual factors on defining an optimal model to help meet critical maternal health policy objectives[22]	India *3 states (Rajasthan, Madhya Pradesh, and West Bengal)* *4 districts per state*	2005 – 2009	Implementation of the standardised community-based Maternal and Perinatal Death Inquiry and Response (MAPEDIR) initiative	<u>Government</u> Ministry of Health and Family Welfare and Panchayati Raj (local government jurisdiction) <u>Civil society</u> NGOs Women's self-help groups <u>Academia</u> Medical university faculties	<u>Successes</u> • **Sharing data, with careful attention to confidentiality and maintaining a non-blaming environment,** at multiple levels resulted in a common understanding of the issue and interventions required, which was useful for advocacy. • C**lear division of labour among different stakeholders** (i.e. district health authority, NGOs, UNICEF) enabled district-wide implementation. • **Support from an international organization** (i.e. UNICEF) eased transition of responsibility of

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					JHBSPH <u>Private sector</u> Private providers <u>International organizations</u> i.e. UNICEF	analysing and entering data to district health offices. • **Support from NGOs** helped to ensure bottom-up sectoral planning and community involvement in policy processes, and supported service delivery in the public health system when the local government was unable to do so <u>Challenges</u> • **Lack of full integrated into the government's health programme's management structure** negatively impacted scale up and sustainability. • **Lack of coordination with different ministries and non-governmental stakeholders** resulted in multiple referrals between facilities with associated costs and delays. • **Lack of data on the scale of the problem** (i.e. number of maternal deaths) impacted ability to meet policy objectives (i.e. reducing maternal mortality). • **Weak engagement of communities as active participants and partners** negatively impacted local level implementation.