Guide for the formulation of a WHO Country Cooperation Strategy
Guide for the formulation of a WHO Country Cooperation Strategy

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### Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>BRICS</td>
<td>Brazil, Russia, India, China and South Africa</td>
</tr>
<tr>
<td>BWP</td>
<td>biennial workplan</td>
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<tr>
<td>CCA</td>
<td>Common Country Assessment</td>
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<tr>
<td>CCS</td>
<td>Country Cooperation Strategy</td>
</tr>
<tr>
<td>CCU</td>
<td>Department of Cooperation with Countries and Collaboration with the UN System (WHO)</td>
</tr>
<tr>
<td>CFS</td>
<td>Country Focus Strategy</td>
</tr>
<tr>
<td>CO</td>
<td>country office</td>
</tr>
<tr>
<td>CSU</td>
<td>Country Support Unit</td>
</tr>
<tr>
<td>DaO</td>
<td>Delivering as One</td>
</tr>
<tr>
<td>ERF</td>
<td>Emergency Response Framework</td>
</tr>
<tr>
<td>ERM-H</td>
<td>emergency risk management for health</td>
</tr>
<tr>
<td>FCTC</td>
<td>Framework Convention on Tobacco Control</td>
</tr>
<tr>
<td>Gavi</td>
<td>Global Alliance for Vaccines and Immunizations (formerly)</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Funds to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>GPW</td>
<td>General Programme of Work</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HERA</td>
<td>health emergency risk assessment</td>
</tr>
<tr>
<td>HQ</td>
<td>Headquarters</td>
</tr>
<tr>
<td>HWO</td>
<td>Head of WHO Office in countries, territories and areas</td>
</tr>
<tr>
<td>IASC</td>
<td>Inter-Agency Standing Committee</td>
</tr>
<tr>
<td>IHP+</td>
<td>International Health Partnership</td>
</tr>
<tr>
<td>IHR</td>
<td>International Health Regulations</td>
</tr>
<tr>
<td>IRIS</td>
<td>Institutional Repository for Information Sharing (WHO)</td>
</tr>
<tr>
<td>LDC</td>
<td>least-developed country</td>
</tr>
<tr>
<td>MoH</td>
<td>ministry of health</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MDTF</td>
<td>Multi-Donor Trust Fund</td>
</tr>
</tbody>
</table>
NCDs  noncommunicable disease
NGO  nongovernmental organization
NHA  national health authority
NHPSP  national health policy, strategy and plan
OECD  Organisation for Economic Co-operation and Development
OECD/DAC  Organisation for Economic Co-operation and Development/Development Cooperation Directorate
PB  Programme Budget
PoEs  points of entry
RO  regional office
SDGs  Sustainable Development Goals
SIDS  Small Island Developing States
SMART  specific, measurable, achievable, realistic, time-bound
SOP  standard operating procedure
SP  strategic priority
SSFFC  substandard/spurious/falsely-labelled/falsified/counterfeit (medicines)
UHC  universal health coverage
UN  United Nations
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNCT  United Nations Country Team
UNDAF  United Nations Development Assistance Framework
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
UNWOMEN  United Nations Entity for Gender Equality and the Empowerment of Women
WG  working group
WHO  World Health Organization
1. **What is a Country Cooperation Strategy?**

The World Health Organization (WHO) Country Cooperation Strategy (CCS) is WHO’s medium-term strategic vision to guide its work in and with a country in support of the country’s national health policy, strategy or plan (NHPSP).

It is the **strategic basis for the elaboration of the biennial country workplan.**

It is the main instrument for **harmonizing WHO’s cooperation in countries with that of other United Nations (UN) system organizations and development partners.**

The time frame is flexible to align with national planning cycles. It is generally **4–6 years.**

The key principles guiding WHO’s cooperation in countries and upon which the CCS is based are:

- ownership by the country of the development process
- alignment with national health priorities and strengthening national health systems in support of the NHPSP
- harmonization with the work of other organizations of the UN system and other partners in the country towards effective development cooperation; and
- collaboration with Member States in shaping the global health agenda

2. **Purpose of the CCS**

The main purposes of the new CCS are:

- to function as an interface between country health priorities and WHO’s medium-term vision for health, as defined in the 12th General Programme of Work (GPW) 2014–2019
- to provide a framework facilitating a bottom-up planning process
- to ensure that both WHO’s global and regional priorities, as well as national health priorities, inform the biennial workplan
- to guide the country-level programme budget and resource allocation
- to enable WHO priorities to be advocated in the country and to facilitate mobilization of resources for the health sector
- to provide a significant opportunity to mobilize a multisectoral approach to address priorities of the NHPSP

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3. CCS Guide 2014 – why a new version?

The revised CCS guide will address the following issues:

- Various analyses of CCSs developed in recent years have revealed the need to improve the CCS process, especially to ensure co-ownership of the CCS by the government and the WHO Secretariat and improve the inclusiveness of the CCS process at the country level. The new guide will allow for more targeted WHO work in countries to support the achievement of internationally agreed health outcomes, including WHO’s contributions to a wider global health agenda.

- The new guide will help to produce shorter, less descriptive and more analytical and strategic documents through analysis of the country requirements and WHO’s added value.

- The revised process will incorporate a more thorough stakeholders’ analysis and selected strategic priorities for WHO collaboration, based on the Organization’s added value and comparative advantage.

- Critical to the revised CCS Framework is the establishment of a stronger link between the CCS and other WHO planning instruments and tool. The CCS is the tool to inform the biennial planning exercise and both should be seen as part of a continuum that includes the new results chain of the GPW and regional strategic plans, resolutions or mandates.

- There is a need for greater complementarity and information sharing between the CCS and the Common Country Assessment (CCA)/United Nations Development Assistance Framework (UNDAF) process and vice versa. The two processes should be mutually reinforcing and the identified priorities should be aligned.

- The number of development partners has grown considerably over the past two decades and poses new challenges, such as ensuring national and local ownership of the development process.

- The revised CCS guide takes into account the new political, economic, social and environmental realities and the global development agenda such as the Sustainable Development Goals (SDGs).

Country specificity

The scope of the CCS varies according to the country’s context – this goes beyond classification according to income: WHO needs to respond to all Member States. The CCS needs to be more contingent on Member States’ specificities and circumstances. For example, stable countries will require cooperation of a different nature than countries with complex programmes or fragile situations including emergencies, the presence of a wide-reaching UN country team (UNCT) and/or a peacekeeping mission. In addition, countries in fragile situations may benefit from a shorter duration of CCS that allows for review and appropriate modification as required. The special needs of the various countries are captured in the document, with some additional guidance for countries in fragile situations (see Annex 1a).

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2 Kickbusch 2006 from presentation given at the graduate institute Geneva 2014: “Global health comprises “those health issues that transcend national boundaries and governments, and call for international action on the global forces and global flows that determine the health of people”.
Some high-income countries have embraced the process of developing a CCS as a way of detailing their cooperation with WHO and other countries, with WHO playing the role of a knowledge broker and convener in the pursuit of joint interests.

Last but not least, depending on the country’s specificities, the nature of WHO’s activities may vary from direct operational technical cooperation to convening, upstream policy support and knowledge brokerage, in line with WHO’s core functions.

**Grounding the CCS in a wider organizational framework**

The high-level strategic vision of the Organization, the 12th GPW 2014–2019, establishes the six leadership priorities that define the key areas in which WHO seeks to exert its influence in the world of global health, and that drive the way that work is carried out across the organization. The GPW reflects the three main components of WHO reform: programmes and priorities, governance and management.

The WHO reform process has been designed to make the Organization more fit for purpose, and emphasizes the need for WHO to strengthen and better align its work to country needs. As a way of translating the WHO reform process into actions at country level, a number of streams of work have been undertaken. In particular, a draft **WHO Country Focus Strategy (CFS)** anchored in WHO reform has been proposed, based around three pillars of action:

- redefining how WHO does business at country level to improve support to Member States;
- aligning the planning and resource allocation processes with the priorities for WHO cooperation at country level; and
- addressing country-level human resources challenges.

The new CCS guide is a strategic management tool that will help to respond to these three pillars of action.

**Linkages with the WHO results framework**

Another component of the reform process has included revisions to the results framework. In 2012, Member States agreed that WHO’s work should be organized around five technical categories and one category covering all corporate services. Categories are further divided into programme areas. For each of the 30 programme areas, there are specific outputs. These outputs define what the Secretariat will be accountable for delivering during each biennium (three bienniums, hence three workplans from 2014–2015, 2016–2017 and 2018–2019).

Outputs within programme areas contribute to outcomes, which in turn contribute to impacts; these are all clearly defined by the GPW through a results chain (see Figure 1).
Each programme area within the programme budget is associated with one specific outcome. The achievement of each outcome is dependent on the work of each programme but some factors are beyond the control of WHO (i.e. political instability).

Not every country will have to work towards deliverables for a particular programme area, as not every programme that is part of WHO’s broad range of programmes is relevant to every country. The strategic priorities for technical cooperation in a country should be based on a thorough situational analysis of the health and development situation in that country, taking into consideration the NHPSP and the six leadership priorities. The CCS’s strategic priorities will facilitate the selection — by the Secretariat and the Member State — of those GPW outcomes that are most relevant to the achievement of the NHPSP, and that will lead to the formulation of WHO’s biennial programme budget and workplan for the country concerned.

Based on the CCS, its analysis and clearer strategic priorities, country offices will be better able to inform the biennial workplan and, in turn, to better respond to the country’s needs and priorities.
4. The CCS process

The formulation of the CCS is a corporate process, involving the three levels of the Organization.

**Country level:** The Head of the WHO Office (HWO) leads the CCS process, with the support of the country office staff, as well as technical backstopping from the regional office and Headquarters (HQ).

**Regional and headquarters levels:** The Country Support Unit (CSU) at regional level assumes a support and oversight role during the process. This entity ensures the timely initiation of the CCS process, provides technical support (promoting an analytical and holistic approach to the process), and facilitates backstopping missions if necessary. In some countries where WHO does not have a physical presence, the regional office (RO) leads the development of the CCS.

HQ provides additional technical support, reviews drafts of the document, facilitates inputs from the technical programmes and participates in missions if required. There is also a role of quality control at the regional and HQ levels, including the category networks, to ensure a corporate, whole-of-organization approach.

**UN system and partners:** The CCS process also fully involves all development partners, including the UN system. The process of establishing CCS strategic priorities can be used to shape the health dimension of the UNDAF and other partnership platforms in the country. The CCS provides a significant opportunity for using a multisectoral approach to address the priorities of the NHPSP.

The CCS process involves extensive consultations between WHO and the government, as well as other UN system organizations; bilateral and multilateral agencies; civil society and nongovernmental organizations (NGOs); community groups; academic institutions; collaborating centres; and the private sector, as appropriate. Inclusive dialogues during the CCS process should include consultation with women and men representing socially excluded or disadvantaged subpopulations, as well as national bodies concerned with human rights and with women (see Annex 2). These dialogues contribute to ensuring broad support and to the maximization of complementarity and synergies with partners throughout the CCS process.

The CCS process is flexible and can be applied to a variety of country contexts. The general principles are as follows (see Figure 2 and Table 1).
Figure 2: The process of developing a CCS

1. Identify the CCS working group
2. Draft the roadmap
3. Gather and share information with the team
4. Critical analysis: country context
5. Critical analysis: National development and health plans
6. Critical analysis: WHO leadership priorities
7. Critical analysis: WHO cooperation during previous CCS
8. Critical analysis: Partnerships and contribution to the global health agenda
9. Policy dialogue with national counterparts for joint prioritization
10. Development of CCS document
11. Publication and dissemination
12. Implementation of the CCS

Evaluation
Mid-term evaluation
Final evaluation
Table 1: Detailed process of building and evaluating a CCS

<table>
<thead>
<tr>
<th>Phase of CCS building process</th>
<th>When?</th>
<th>Who?</th>
<th>What?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initiation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiate the CCS</td>
<td>2 months before</td>
<td>Head of WHO Office (HWO) leads the process, with country office staff.</td>
<td>Determine whether there is a CCS or other relevant planning tools upon which to base the future CCS.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regional office</td>
<td>Identify key documents to be made available to the CCS team, such as General Programme of Work, NHSP, previous CCS.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Headquarters</td>
<td>Ensure resources for the CCS process, request support from the regional office and headquarters (training or other).</td>
</tr>
<tr>
<td><strong>Preparation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify the CCS working group</td>
<td>Month 0</td>
<td>Country office</td>
<td>The HWO leads the process, with country office staff, national counterparts, members of UN agencies and other stakeholders. All staff participate in the process, although only a selection is part of the Working Group (WG).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regional office</td>
<td>Ensure a balanced team that also has broad representation (may not form part of the WG but can be called upon, e.g., from the different technical programmes, human rights associations). It is recommended to have no more than six to eight people in the WG and to appoint a person to take charge of logistics.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Headquarters</td>
<td>In fragile states and/or disaster-prone countries, ensure at least one team member has the appropriate competence for diplomacy and an understanding of the political context, as well as expertise in the health systems of countries with a fragile situation, and/or humanitarian issues. (see Annex 1a).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Note: An external consultant may be appointed for information gathering and drafting but it is essential that the critical analysis and elaboration of strategic priorities is done by the WG.</td>
</tr>
<tr>
<td>Draft the roadmap</td>
<td>Month 1</td>
<td>CCS WG</td>
<td>The roadmap lays out:</td>
</tr>
<tr>
<td>Gather and share information with WG</td>
<td>Month 1</td>
<td>CCS WG</td>
<td>WG collects and shares:</td>
</tr>
</tbody>
</table>

WG collects and shares:
- national development policies
- health policies, strategies and plans
- annual reports, vital statistics, surveys
- external reports on the country, its vulnerable populations, human rights and gender (see Annex 2), International Health Partnership (IHP+) reports
- disaster risk assessment (refer to Annex 1b)
- regional and headquarters information
- international agreements and mandates ratified and/or signed by the country.

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5 CCU, Department of Cooperation with Countries and Collaboration with the UN System.
### Analysis

<table>
<thead>
<tr>
<th>Critical analysis: country context</th>
<th>Months 2–3</th>
<th>CCS WG</th>
<th>Critical analysis of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>• main achievements</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• areas to be strengthened</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• challenges and gaps including vulnerable populations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• socio-political situation (states in fragile situations) (see Annex 1a and 1b).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Critical analysis: national development and health plan</th>
<th>Months 2–3</th>
<th>CCS WG</th>
<th>Analysis of national development and health policies, plans and strategies to determine:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>• coherence of strategies and plans according to the health situation analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• inclusivity and degree of ownership in the development process</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• inclusion of financing, implementation and management arrangements (including monitoring and reviewing mechanisms).</td>
</tr>
</tbody>
</table>

| Critical analysis: WHO leadership priorities | Month 2-3 | CCS WG | Selection of the relevant questions from the CCS guide (see pages 15–19) to facilitate the team’s reflection on achievements, progress and challenges for each leadership priority. |

<table>
<thead>
<tr>
<th>Critical analysis: WHO cooperation during previous CCS</th>
<th>Months 2–3</th>
<th>CCS WG</th>
<th>Assessment of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>• degree of implementation of strategic priorities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• WHO’s contribution to the six leadership priorities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• engagement with the UN.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Critical analysis: partnerships and contribution to the global health agenda</th>
<th>Months 2–3</th>
<th>CCS WG</th>
<th>Analysis of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>• health dimensions of United Nations Development Assistance Framework UNDAF and other international platforms (i.e. Busan Partnership for Effective Development Cooperation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• country’s contribution to the wider global health agenda.</td>
</tr>
</tbody>
</table>

### Development

<table>
<thead>
<tr>
<th>Policy dialogue with national counterparts for joint prioritization</th>
<th>Months 3–4</th>
<th>CCS WG, with particularly active role of HWO national counterparts</th>
<th>Taking into consideration the critical analysis of previous steps and WHO’s comparative advantage and added value, the dialogue aims to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>• prioritize strategic priorities and CCS focus areas</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• ensure buy-in from national counterparts.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Development of CCS</th>
<th>Months 4–5</th>
<th>CCS WG, plus HWO national counterparts regional office headquarters</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• drafting of document</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• ensuring the identification of resources and partnerships needed for the implementation of the CCS</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• sharing draft document with national authorities and other stakeholders</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• ensuring clearance from ministry of health, regional office and Headquarters</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• signature of the CCS and launching (if necessary).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Publication and dissemination</th>
<th>Months 5–6</th>
<th>CCS WG, plus HWO national counterparts</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• wide dissemination at country level by country office and national counterparts</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• publication of document through the Institutional Repository for Information Sharing (IRIS) and on the global WHO Internet site.</td>
<td></td>
</tr>
</tbody>
</table>
### Implementation

<table>
<thead>
<tr>
<th>Implementation</th>
<th>4–6 years</th>
<th>HWO and country office staff (lead) regional office and Headquarters (contribute and support)</th>
</tr>
</thead>
</table>

- The CCS is an endorsement by the entire Secretariat of the commitment to pursue the strategic agenda in the country (the Regional office and HQ informs the technical units of the CCS for country missions).
- The CCS informs the biennial programme budget and workplan every two years.
- The CCS informs the UNDAF in Delivering as One (DaO) countries and other countries.

### Monitoring and Evaluation

<table>
<thead>
<tr>
<th>M&amp;E</th>
<th>Year 2 or 3</th>
<th>Country office HWO and country office Regional office Focal point from regional CSU Headquarters CCU focal point</th>
</tr>
</thead>
</table>

#### Midterm Evaluation

- Assessment of:
  - Process and degree of implementation of the CCS strategic priorities
  - WHO's engagement with the UN system
dcountry's context
  - According to results and context, consider changes in strategic priorities and workplans.

<table>
<thead>
<tr>
<th>M&amp;E</th>
<th>Year 4 or 6</th>
<th>Country office HWO and country office Regional office Focal point from regional CSU Headquarters CCU focal point</th>
</tr>
</thead>
</table>

#### Final Evaluation

- Assessment of:
  - Degree of implementation of the CCS strategic priorities
  - WHO's contributions to the six leadership priorities
  - WHO's contributions to the NHPSP
  - WHO's engagement with the UN system
  - Informs the formulation of the next CCS.

Should be guided by the WHO evaluation practice handbook and should ideally involve partners in the process.
5. The CCS document

The main result of the process outlined above is the clear formulation of a limited number of strategic priorities that are to be included in the CCS document. The document should include:

- the main document
- the “CCS at a glance” (CCS Brief), a two-page brief that communicates the essence of the CCS. This Brief should be updated annually as needed during the CCS cycle (see format in Annex 3)

The main document is concise and ideally no more than 20–25 pages in length. The outline follows the structure elaborated below.

Structure of the CCS document

Table of contents
- List of abbreviations and acronyms

0. Executive summary
1. Introduction
2. Health and development situation: achievements, challenges, development cooperation and partnerships and the global health agenda
3. Review of WHO’s cooperation during the past CCS cycle
4. Strategic agenda for WHO’s cooperation
5. Implementing the strategic agenda: implications for the entire WHO Secretariat
6. Evaluation of the CCS
Annexes

Chapter 0 • Executive summary

Suggested length: 1–1½ pages

This is a concise summary of the entire document that:

- highlights the country’s main health priorities and achievements;
- captures the focus areas of the CCS consultation process; and
- focuses on the strategic agenda for WHO cooperation.
Chapter 1 • Introduction

*Suggested length: 1–1½ pages*

This section sets out the policies underlying the role of the CCS in the wider health development landscape. It includes:

- an overview of the WHO policy framework: the GPW, as well as regional and subregional orientations and priorities
- the country context, which explains the choices made and the timing of the CCS formulation, relevant features of the CCS process, including composition of the team, people met and key actions undertaken

Chapter 2 • Health and development situation

*Suggested length: 6–8 pages (The weight of each subsection will depend on the country’s specificity.)*

This chapter deals with the current situation in the country and comprises two subsections, detailing

2.1. the country’s main health achievements and challenges

2.2 the country’s landscape of development cooperation, partnerships and collaboration with the UN and obligations under regional resolutions, agreements and commitments

2.1 Main health achievements and challenges

This section analyses and summarizes the country’s main health and development issues based on a comprehensive review of key national reference documents and country intelligence.

1. The first paragraph should describe the **political, social and macroeconomic context of the country** and mention membership or participation in any relevant regional or subregional political bodies (i.e. BRICS, LDC or SIDS). The section should highlight any risk factors, for example if the country is in the midst of a conflict, is in proximity to a conflict zone, or is prone to natural disasters (see Annexes 1a and 1b for countries in fragile situations and other hazards with a potential health impact) and take into account a framework for gender, equity and human rights (see Annex 2).

2. The **health situation analysis** should take place within a broader development framework, such as the existence of a national development plan, a poverty reduction strategy, the country’s commitment to achieving the Millennium Development Goals (MDGs), its preparedness for crises and emergencies and within the context of the anticipation of the post-2015 SDGs.

3. The next paragraphs should analyse the **health status of the population** and provide a brief description of the **health system** including private for-profit and not-for-profit institutions that have an impact on access to health care and health outcomes. Maps, graphs and boxes may be used to summarize information as appropriate. A list of essential indicators should be included using statistics from the Global Health Observatory (See template in Annex 4). Significant differences (if any) between the data from the Global Health Observatory and other sources (i.e. national data), should be noted

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6 BRICS, Brazil, Russia, India, China and South Africa; LDC, least-developed country; SIDS, Small Island Developing States.
and sources of information acknowledged. Other indicators should be added according to the country’s specificity. Trend analysis of burden of disease is encouraged to show progress and the remaining challenges (e.g. to track progress over time of prevalence of a specific disease). Disaggregation by sex and other variables should be used to highlight health-related human rights and gender issues, as well as underlying root causes.

4. The analysis of the country’s response to health issues should include a reference to the NHPSP, a document or set of documents that lays out the context, vision, objectives, spending priorities and key interventions for health development in a country. NHPSPs may differ considerably in scope and nature. In some countries, the aforementioned elements may be enumerated in several laws, norms and policy papers. The following attributes of the NHPSP may be considered:

✓ the coherence of strategies and plans according to the health situation analysis;

✓ the inclusiveness and degree of ownership of its development process; and

✓ the inclusion of financing, implementation and management arrangements, including monitoring and review mechanisms.

5. The health situation analysis should be further facilitated by considering the country’s progress in the six WHO leadership priorities. The set of following questions is proposed to facilitate reflection on the achievements, progress, and challenges a country has experienced for each leadership priority, and to elicit the priority area where WHO offers a comparative advantage and added value.

Each country can choose the questions that are most relevant to its context and specific attributes.
## Questions for a health situation analysis

### Universal health coverage (UHC)

**More about universal health coverage**

- Is there any explicit country strategy for implementing or advancing UHC at the country level?
- Does the UHC strategy include, at least:
  - an explicit definition of what UHC means in terms of populations covered, services provided and financial protection guaranteed?
  - findings of situation analysis, main issues, challenges and obstacles?
  - a roadmap for moving towards UHC by addressing the main issues and obstacles?
  - involvement of different stakeholders that play a role in its realization?
  - a clear and feasible monitoring system to assess progress?
- Who initiated this strategy and has it been endorsed at the highest level within the country?
- Is UHC part of broader efforts to deal with (extreme) poverty, social exclusion and gender inequity?
- Does UHC take into account possible hazards that could interrupt the CCS review process?
- Has the UHC strategy been backed by appropriate country legislation?
- Does the UHC strategy take (or in the absence of an explicit strategy, has the national health authority (NHA) taken) steps to improve access to comprehensive, person-centred, integrated health services based on primary health care, quality and continuity of care, and closer links between medical, social and long-term care services?
- Does the UHC strategy (or in the absence of an explicit strategy, does the NHA) take into account all relevant sources of health financing in the country and is it aimed at increasingly pooling revenues and substantially reducing out-of-pocket expenditure on health? Is the country taking measures to improve efficiency?
- Does the UHC strategy (or in the absence of an explicit strategy, has the country taken) steps to effectively meet the health needs of vulnerable members of the population such as women of reproductive age, children and older people at the country level?
- Is the UHC strategy consistent with the human, technological, and organizational resources available (current and future) in the country?
- Is the UHC strategy debated at the public level?
- Does the UHC strategy take (or in the absence of an explicit strategy, has the country taken) steps to improve the country’s health information system, with a focus on vital registration?
- If the country has a protracted emergency where access to health services is low or disrupted, does the country have a strategy for increasing health service coverage and/or delivery? Does the humanitarian country team have such a strategy?
### International Health Regulations (2005) (IHR 2005)

**More about International Health Regulations**

- Have the capacity requirements for IHR been met by the country? If so, when?
- If not, has an extension until 15 June 2016 been formally requested?
- Is there a national coordinating mechanism to implement IHR? (List stakeholders and partners.)
- Is there a national action plan to implement and meet IHR requirements?
- Are annual updates on the status of IHR implementation conducted?
- Are there annual updates involving stakeholders across all relevant sectors?
- Has the surveillance system been strengthened at national and local levels and does it include surveillance within high-risk groups and of unexplained illnesses in health workers?
- Does the country have a disease early warning system?
- Is the country prepared, and does it have the capacity, to respond in a timely and coordinated fashion to a major epidemic or pandemic?
- Are needs assessments conducted to identify gaps in human resources and training needed to meet IHR requirements?
- Has progress been made in meeting targets for workforce numbers and skills consistent with IHR requirements?
- Are there specific programmes with allocated budgets, to train workforces to deal with IHR-relevant hazards?
- Have all diagnostic laboratories been certified or accredited to international standards or to national standards adapted from international standards?
- Is bio-risk assessment conducted in laboratories to guide and update biosafety regulations, procedures and practice, including for decontamination and management of infectious waste?
- Are there, or does the country have access to, biosafety levels 3 and 4 laboratory facilities?
- Are national risk assessments to identify potential urgent public health events, and the most likely sources of these events, properly conducted?
- Have national resources been mapped for IHR-relevant hazards and priority risks?
- Are stockpiles (critical stock levels) accessible for responding to priority biological, chemical and radiological events and other emergencies?
- Is there a risk communication plan? If so, has it been implemented or tested in an actual emergency or in a simulation exercise and updated in the past 12 months?
- Is evaluation of public health communications conducted after emergencies, for timeliness, transparency and appropriateness of the communications?

### Points of entry (PoEs)

- Have designated PoEs been identified and properly assessed?
- Are there public health emergency contingency plans at the designated PoEs? Are they tested and updated as needed?
- Are relevant legislation, regulations, administrative acts, protocols, procedures and other government instruments to facilitate IHR implementation at designated PoEs updated as needed?
- Are standard operating procedures (SOPs) for response at designated PoEs available?
## Increasing access to essential, high-quality, effective and affordable medical products

*More about essential medicines*

- Is increasing the access to essential, high-quality, effective and affordable medical products (medicines, vaccines, diagnostics and other procedures and systems) a major component of health policies at the country level?
- Have mechanisms for coordination with stakeholders been established to increase access to essential, high-quality, effective and affordable medical products?
- Is there up-to-date legislation on how to produce, register and commercialize medicines, vaccines and other biological products for human and veterinary health at country level?
- Is the legislation implemented and enforced?
- Are the regulatory authorities well equipped to fulfil their duties at country level (this includes the existence of specific regulatory bodies or agencies)?
- Is the quality of medical products periodically tested using validated international norms and standards?
- Is the control of substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products a relevant issue at country level?
- Is multidrug resistance or antimicrobial resistance an issue in the country?
- Is a national list of essential medicines currently in use?
- Is rational prescription of medicines a specific priority at country level?
- Is there a specific policy that favours greater use of generic over originator brands at country level?
- Are the procurement and supply management processes and procedures for medical products and technologies currently working efficiently at country level?
- In protracted emergency situations, are the supply and distribution of essential medicines and other health technologies adequately guaranteed?
- Is cost-effectiveness taken into consideration in public financing of medical products?
- Is the evaluation of other health technologies, equipment and procedures a priority at the country level?
- Is the global strategy and plan of action on public health, innovation and intellectual property being implemented in the country?
- Is research and innovation on medical products promoted at country level, including networking with the regional level?
Social, economic and environmental determinants

More about social determinants of health

- How is the country placed, and how is it evolving, in terms of the Human Development Index (HDI)?
- Are social and economic determinants of health placed in the mainstream of the public policy agenda at the country level?
- Are social and economic determinants of health, including gender equality and women’s empowerment, periodically monitored and the results widely communicated and discussed at the country level?
- Has the country effectively integrated gender, equity and human rights into public policies, strategies and operational planning?
- Are climate change and environmental health on the public policy agenda of the country?
- Is the country strengthening its capacity to assess and manage the health impacts of environmental risks and to develop policies and plans on environmental health and sustainable development?
- Is the country strengthening its capacity for preparedness and response to environmental emergencies related to climate, water, housing, sanitation, chemicals, air pollution, and radiation and for convening partners and conducting policy dialogue on these matters?
- Have intersectoral mechanisms been established to address social determinants of health? (Health in All Policies, UN and other coordination platforms.)

Gender, equity and human rights in the CCS

Mainstreaming gender, health equity and human right issues into the CCS is critical (see Annex 2). Two key questions to be asked to ensure that the issues of gender, health equity and human rights are mainstreamed into the health situation analysis in the CCS as well as the agreed CCS strategic agenda are:

- Who are the socially excluded or disadvantaged subpopulations that might experience differential exposure, vulnerability, access or treatment outcomes/consequences, because of characteristics such as place of residence, race or ethnicity, occupation, gender/sex, religion, education or socioeconomic status?
- How does the country ensure that health-care services are available, accessible, acceptable and of adequate quality, to socially excluded or disadvantaged subpopulations?
### Noncommunicable diseases (NCDs)

*More about noncommunicable diseases*

- To what extent has the prevention and control of NCDs been given high priority at the country level?
- Is there a multisectoral national plan for the prevention and control of NCDs (namely, cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, and mental health problems) containing priorities, targets that take into account the voluntary global targets, strategies and indicators, based on evidence generated at the international and country level?
- Is the country strengthening national capacities, leadership, governance, multisectoral action and partnership to accelerate national efforts towards NCDs prevention and control?
- Is the country making efforts to reduce the major modifiable risk factors for NCDs, namely, tobacco use, the harmful use of alcohol, unhealthy diet and physical inactivity?
- Are there risk-factor-specific national plans and programmes, such as a national tobacco control programme? If so, how are these programmes aligned to the NCDs action plan?
- What steps is the country taking towards implementing effective tobacco control measures at country level, as required by the WHO Framework Convention on Tobacco Control (FCTC)?
- Is the country strengthening and (re)orienting health systems to address the prevention and control of NCDs, including mental health disorders, and the underlying social determinants through people-centred primary health care and UHC?
- Is the country making efforts to strengthen human resources and institutional capacities to address the prevention and control of NCDs including mental health?
- Is the country making efforts to monitor the determinants and trends of NCDs and evaluate progress in their prevention and control, including developing baselines, national targets and indicators, establishing or strengthening comprehensive surveillance systems and integrating them with national health information systems?
- Do these surveillance systems include data disaggregated by sex and other variables?
- Are violence and injuries a significant health problem in the country and has the country taken steps towards evidence gathering, prevention and control?
- Is the country supporting national capacity for high-quality research for the prevention and control of NCDs?
- Is the country reporting on progress made towards fulfilling the commitments made in the Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of NCDs and the Global Action Plan, including the nine voluntary targets? Is the country reporting on progress made with NCD regional or subregional plans and/or strategies?
- Is the country introducing innovative approaches to finance NCDs prevention and control plans?
The UN will adopt a new post-2015 development agenda in September 2015, referred to as the Sustainable Development Goals (SDGs), to ensure follow-up on the implementation of the MDGs. The suggested draft set of 17 SDGs is already influencing the work of the UN system in support of the Member States’ development priorities. It is essential to ensure continued relevance of health-related goals and targets in setting up national actions on implementing the SDGs, including relevant indicators. The proposed SDGs contain one health-specific goal: “Ensure healthy lives and promote well-being for all at all ages”, but there are a number of health-related targets across other SDGs. The following questions should be considered.

- Have the MDGs had a high priority in the political agenda, i.e. influencing the public policies of the country?
- Have specific strategies to achieve MDGs been put in place?
- Have the MDGs been monitored and evaluated, and the evaluation results publicized?
- Did the country develop the MDG Acceleration Framework (MAF) and MAF Action Plan?
- What were the main successes and challenges in achieving the MDGs?
- Are there established mechanisms for collaboration on the achievement of the MDGs (improving maternal health, including sexual and reproductive health, as well as newborn and child health)?
- What interventions are identified as priorities (e.g. providing free access to health care to pregnant women, mothers and children, emergency obstetrics, immunization, nutritional supplements)? Is there a focus on equitable immunization coverage and the introduction of new vaccines?
- Do the HIV/AIDS, tuberculosis and malaria programmes adopt an integrated approach and do they include a health systems strengthening component?
- Did the country organize national consultation in preparation for the post-2015 agenda? What were the health priorities identified at national level?
- Are any of the proposed SDG targets (other than MDGs) considered a priority: premature mortality from NCDs? Mental health? Road safety? Prevention of substance abuse? UHC?
- Is the support of the UN system in the implementation of the SDGs at the national level discussed in the United Nations Country Team?
- Is WHO leading the work on identifying health targets and indicators relevant for the country?
2.2 Development cooperation, partnerships and contributions of the country to the global health agenda

2.2.1 Partnership and development cooperation

Over the years, health has become ever more prominent, including in the post-2015 development agenda and the proposed SDGs and targets.

The growing number of development partners in health provides a potential for increased resources. However, this poses challenges for coordination and alignment with country needs and priorities and increases transaction costs for the Organization. Both the Paris Declaration followed by the Busan Partnership provided key principles for effective development cooperation. They are in turn reinforced by the International Health Partnership (IHP+) behaviours. The Busan principles to achieve common goals are:

✓ **Ownership** of development priorities by counties: Countries should define the development model that they want to implement.

✓ **A focus on results**: Having a sustainable impact should be the driving force behind investments and efforts in development policy making.

✓ **Partnerships for development**: Development depends on the participation of all actors, and recognises the diversity and complementarity of their functions.

✓ **Transparency and shared responsibility**: Development co-operation must be transparent and accountable to all citizens.

WHO’s role is to support the government in effectively coordinating partners and external resources so as to enhance effectiveness and ensure that all external resources respond to country needs and priorities. This role was reiterated in the 12th GPW and draft Country Focus Strategy (CFS). The CCS team therefore needs to analyse the roles fulfilled by key development partners, the allocation of resources by these partners in the health sector, and major areas of support.

The CCS working group should collect and analyse information on bilateral and multilateral agencies, global health partnerships and initiatives, development banks and international financial institutions, civil society and NGOs, community groups, academic institutions, collaborating centres, the private sector, and others as appropriate. The stakeholder mapping should be captured and details should be included in the annexes.
Integrating principles of development cooperation effectiveness

The working group (WG) should consider: existing partnership platforms for health sector and related aspects such as coordination and division of labour (if available), including:

- the extent to which these platforms and mechanisms help to avoid duplication and foster coherence and cooperation, filling critical gaps;
- the extent to which technical cooperation and health-sector aid flows are aligned with national policies, strategies, plans and planning cycles;
- existing mechanisms for the monitoring and assessment of partnership and development cooperation e.g. Busan partnership and IHP+ results, and progress made over the years on alignment and harmonization;
- WHO’s role in supporting the government in effective coordination and monitoring of development cooperation (e.g. does WHO chair or co-chair local development partner coordination partnerships or groups?); and
- WHO’s relationship with the above cooperation platforms and within the development cooperation effectiveness framework (as outlined in the Paris and Busan principles), as well as based on WHO’s added value and comparative advantage, including the demands placed on WHO by the government and development partners.

2.2.2 Collaboration with the UN system at country level

The CCS process provides an opportunity to initiate a strategic dialogue with the UN agencies on challenges and opportunities for cooperation in the country. The UNCT is the platform through which WHO can strengthen dialogue among UN agencies, foster a multisectoral response to health challenges, and mobilize additional resources to achieve national health goals.

The UNDAF is the strategic programme framework that describes the collective response of the UN system to national development priorities. The UNDAF provides an opportunity to highlight the role of health in the broader development agenda by reinforcing a multisectoral response to health challenges and addressing key socioeconomic and environmental determinants.

The CCS and the health dimension of the UNDAF should be harmonized and mutually reinforcing for better health results in the country.
There are two main issues to be considered in the analysis of WHO collaboration with the UN system:

A. WHO needs to leverage the expertise of other UN agencies in the country

Understanding the available expertise available in other UN agencies at country level is part of the WHO coordinating role among health partners and facilitates the convening role and support provided to ministry of health (MoH) in aligning the work of health partners around national priorities. In addition, other UN organizations have direct communication channels with different line ministries and can facilitate the involvement of non-health sectors in a whole-of-government approach in addressing health challenges.

1. Which UN system organizations are part of the UNCT (both resident and non-resident)?
2. What is the scope of activities and available expertise in health of other UN system organizations in the country? (Check the analysis of the comparative advantages of the UN system organizations in the country, which could have been done as part of the UNDAF preparation process.)
3. If the country adopted the Delivering as One approach (DaO), which DaO pillars are implemented?
4. What is the ministry of health’s role in the Joint National/UN Steering Committee?
5. What is WHO’s role in the Steering Committee?
6. Are there joint programmes dedicated to health? What is WHO’s role in the joint programmes?
7. Is intersectoral action being considered to address “health in all policies” issues?
8. Has the UNCT established a joint mechanism to mobilize resources for health? Is there a Multi-Donor Trust Fund (MDTF) in the country (One Fund in the DaO context)?
9. Are there any other UN-wide initiatives or processes active in the country? (For example, MDG Acceleration Framework, IHP+ or H4+.

B. CCS and Common Country Analysis (CCA) and UNDAF

The health situation analysis of the CCS should inform the CCA and the UNDAF and vice versa. The analysis should be shared and harmonized. WHO should contribute to the health-related outputs and outcomes of the UNDAF and the UNDAF should be informed by the CCS strategic priorities.

1. Are there any health-related outcomes in the current UNDAF (nutrition, social protection, water and sanitation, specific vulnerable groups or others)?
2. What are the main health-related challenges identified in the country analysis of the UNDAF or DaO programme?
3. Are there health thematic groups (these might be called sectoral groups or results groups in the DaO context) i.e. is there a UN interagency task force on NCDs?
4. What are the specific outputs agreed upon by health thematic groups?
5. What is WHO’s role in these groups?

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3 WHO and partners programmes UNAIDS, UNFPA, UNICEF, UN WOMEN, and the World Bank work together as the H4+ in a joint effort to improve the health of women and children and accelerate progress towards achieving Millennium Development Goals (MDGs) 4 (reducing child mortality) and 5 (improving maternal health).
2.2.3 Contributions of the country to the global health agenda

Taking into account the country’s context, this subsection of the CCS should highlight:

- the experiences, knowledge and research existing in the country, and concrete lessons learnt that can be shared to enhance resilience and contribute positively to health development in other countries and globally;
- the country’s concrete financial and technical support to other countries for health development through bilateral or multilateral cooperation; the latter including logistics, human resources, transfer of technologies and research skills;
- sharing of experience and cooperation among countries, through triangular and south-south cooperation; and
- the country’s level of participation and leadership role (if any) in subregional or other intercountry political integration groupings that have health agendas, and the extent to which it participates in WHO and regional office governing bodies’ meetings.

Chapter 3 - Review of WHO’s cooperation over the past CCS cycle

Suggested length: 2–2½ pages

This chapter reflects on WHO’s cooperation with the country during the past CCS cycle. It should take into consideration the results of existing midterm and final CCS evaluations. If such evaluations have taken place recently, they can be used for this purpose and an additional review is unnecessary. See Chapter 6.

Chapter 4 - The Strategic Agenda for WHO cooperation

Suggested length: 8–10 pages

The Strategic Agenda is the core of the CCS process, and consists of a set of strategic priorities and CCS focus areas for WHO’s cooperation with the country. These are jointly agreed to with national authorities to support the NHPSP.

The CCS strategic priorities (3–5 maximum) constitute the medium-term priorities for WHO’s cooperation with the country, on which WHO will concentrate the majority of its resources over the CCS cycle. Each strategic priority makes a specific contribution towards achieving at least one country health priority and should convey a message about the objective of the technical cooperation. The achievement of each strategic priority is the joint responsibility of the government and WHO.

The CCS focus areas (maximum 1–3 per strategic priority) are the “what” under each strategic priority to which WHO will specifically contribute. They reflect the expected achievement(s) required for reaching the strategic priority and they are consistent with and contribute to the national health priorities and the global level outcomes in the GPW (see Figure 5). Each focus area will link directly with a specific GPW outcome. The same GPW outcome can be used more than once if necessary. CCS focus areas should adopt the SMART format (specific, measurable, achievable, realistic and time-bound).
The CCS WG should undertake the prioritization exercise with the government at the highest level possible, as well as with partners, especially other UN agencies.

The following list highlights the main elements to be considered in the selection of the strategic priorities.

1. the NHPSP
2. the health and development achievements and challenges identified in the strategic analysis of Chapter 2. (Note: not every challenge needs to be translated into a strategic priority)
3. the outcomes of consultations with key stakeholders
4. the outcomes identified in the UNDAF or DaO programme, if applicable
5. the lessons learnt from the review of the ongoing or past CCS cycle
6. the lessons learnt from the country’s experiences and the potential for contribution to health development in other countries and globally
7. GPW and WHO’s comparative advantage, added value and core functions
8. WHO’s financial and human resources (present and future forecasts)
9. the country’s specificity: depending on the context, strategic priorities may be identified for emergency response, addressing the global health agenda, or other priority issues that are not reflected in the six leadership priorities, but which are reflected in the strategic plans or other frameworks for technical cooperation of the respective regional office.

One example of how this is reflected in the CCS is shown in Figure 3. It illustrates how the national health plan feeds into the CCS and how different steps in the assessment refine the approach further. Figure 4 shows the full process of CCS formulation indicating the processes that need to be taken into consideration and the parties responsible for each stage.
Figure 3: Elements to be considered in the prioritization of the CCS strategic priorities

Ensuring the quality of the Strategic Agenda

All strategic priorities and CCS focus areas must be submitted to the checklist in Table 2 to ensure relevance.

Table 2: Quality checklist for the Strategic Agenda

<table>
<thead>
<tr>
<th>Item</th>
<th>Checklist for quality assurance</th>
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</table>
| CCS strategic priority | Q1. Is the strategic priority clearly linked to an NHPSP objective?  
Q2. Is the strategic priority backed by the analysis?  
Q3. Is the strategic priority consistent with the GPW and one or more of the leadership priorities?  
Q4. Does the statement indicate or describe a contribution of WHO that is relevant\(^8\) and achievable\(^9\) within the CCS period (4–6 years)?  
Q5. Is the whole set of strategic priorities comprehensive in that they reflect the full range of objectives for the entire CCS period (4–6 years)? |
| CCS focus area | Q6. Are the CCS focus areas linked to the national health priorities and results?  
Q7. Are the CCS focus areas linked to GPW outcomes? (See Annex 5 for a country example of linking CCS focus areas with GPW outcomes.)  
Q8. Are the CCS focus areas backed by the analysis?  
Q9. Do the CCS focus areas reflect a change or accomplishment for which WHO is willing to be held accountable?  
Q10. Will the completion of the CCS focus areas contribute to achieving the objective stated in the strategic priority?  
Q11. Is the scope of the work specific,\(^10\) measurable, relevant, achievable and time-bound?\(^11\) |

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\(^8\) Relevant: it responds to the country priorities and needs or challenges identified in the national policies, strategies and plans, and is within the mandate of the organization, the GPW, and the regional priorities.

\(^9\) Achievable: it is realistic given the resources likely to be available.

\(^10\) Specific: it identifies the nature of the expected achievements or changes, and the target should be as detailed as possible without being wordy.

\(^11\) Time-bound: it can be achieved within the CCS period (4–5 years).
There needs to be an explicit link between the CCS focus areas and the GPW outcomes (see Figure 4). Each CCS focus area should be linked to one GPW outcome only. This should be mapped, guided by Figure 4 and using Annex 5 as a format, and added to the final document.

The CCS strategic agenda should inform the elaboration of the biennial workplan. However, if a biennial workplan is already in place, efforts should be made to make programme changes to ensure consistency between the two. It is also necessary to keep track of current challenges to inform planning of the next biennial workplan.

**Formulating a CCS for countries in fragile situations**

In emergency contexts, the Strategic Agenda will address immediate priority health and health development needs of the country, based on vulnerability and risk assessments and WHO's functions in emergency situations.

It is recommended that CCSs in countries in fragile situations include strategic priorities to cover unforeseen events that may require emergency action, including disease outbreaks and natural or man-made disasters (see Annexes 1 and 1b).

**Preparation of the final version of the Strategic Agenda**

Once the draft Strategic Agenda has been validated with the NHPSP, the six leadership priorities and UN-DAF outputs and outcomes, the CCS team should prepare the final version of the Strategic Agenda to be included in the main CCS document.
Figure 4: Global model of CCS and results chain linkages

Sustainable Development Goals and other global commitments and agreements

National development plan

National health policy, strategy or plan

UNDAF

Health component of the UNDAF

WHO Global Programme of Work

Leadership Priorities

Country Cooperation Strategy

CCS Strategic Priority

CCS focus area

CCS focus area

CCS focus area

CCS focus area

Selected jointly by the Member State and CCS Working Group

-used for strategic analysis

CCS focus areas must link to one GPW/PB outcome
### GPW/PB Outcomes

#### Category 1
- Increased access to key interventions for people living with HIV
- Increased number of successfully treated tuberculosis patients
- Increased access to first-line antimalarial treatment for confirmed malaria cases
- Increased and sustained access to essential medicines for neglected tropical diseases
- Increased vaccination coverage for hard-to-reach populations and communities
- Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors
- Increased access to services for mental health and substance use disorders
- Reduced risk factors for violence and injuries with a focus on road safety, child injuries and violence against children, women and youth
- Increased access to services for people with disabilities
- Reduced nutritional risk factors

#### Category 2
- Increased access to interventions for improving health of women, newborns, children and adolescents
- Increased proportion of older people who can maintain an independent life
- Gender, equity and human rights integrated into the Secretariat's and countries' policies and programmes
- Increased intersectoral policy coordination to address the social determinants of health
- Reduced environmental risk factors

#### Category 3
- All countries have comprehensive national health policies, strategies and plans updated within the last five years
- Policies, financing and human resources are in place to increase access to people-centred, integrated health services
- Improved access to, and rational use of, safe, efficacious and quality medicines and health technologies
- All countries have properly functioning civil registration and vital statistics systems

#### Category 4
- All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response
- Increased capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics
- Countries have the capacity to manage public health risks associated with emergencies
- All countries are adequately prepared to prevent and mitigate risks to food safety
- No cases of paralysis due to wild or type-2 vaccine-related poliovirus globally
- All countries adequately respond to threats and emergencies with public health consequences

#### Category 5
- Number of new perinatal HIV infections (ages 0-5)
- Number of people living with HIV on antiretroviral treatment
- Percentage of HIV+ pregnant women provided with antiretroviral treatment (ARV prophylaxis or ART) to reduce mother-to-child transmission during pregnancy
- Cumulative number of voluntary medical male circumcisions performed in 14 priority countries
- Cumulative number of TB patients successfully treated in programmes that have adopted the WHO-recommended strategy since 1995
- Annual number of IB patients with confirmed or presumptive multidrug-resistant TB (including rifampin-resistant cases) placed on multidrug-resistant TB treatment worldwide
- Percentage of confirmed malaria cases in the public sector receiving first-line antimalarial treatment according to national policy
- Number of Member States certified for eradication of dracunculiasis
- Number of Member States having achieved the recommended target coverage of population-at-risk of lymphatic filariasis, schistosomiasis and soil-transmitted helminthiases through regular anthelmintic preventive chemotherapy
- Global average coverage with three doses of diphtheria, tetanus and pertussis vaccines
- WHO regions that have achieved measles elimination
- Proportions of the 75 Countdown countries that have introduced pneumococcal, typhoid or human papilloma virus (HPV) vaccines and concurrently scaled up interventions to control pneumonia, diarrhoea or cervical cancer
- Halt the rise of diabetes
- Halt the rise of hypertension in adults
- Halt the rise of overweight and obesity
- Halt the rise of mental disorders
- Halt the rise of tobacco use
- Halt the rise of illicit drug use
- Halt the rise of harmful alcohol use

#### GPW/PB Outcomes Indicators

<table>
<thead>
<tr>
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<th>Description</th>
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<tbody>
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<tr>
<td>Global average coverage with three doses of diphtheria, tetanus and pertussis vaccines</td>
<td>Percentage of cases treated</td>
</tr>
<tr>
<td>WHO regions that have achieved measles elimination</td>
<td>Percentage of cases treated</td>
</tr>
<tr>
<td>Proportions of the 75 Countdown countries that have introduced pneumococcal, typhoid or human papilloma virus (HPV) vaccines and concurrently scaled up interventions to control pneumonia, diarrhoea or cervical cancer</td>
<td>Percentage of cases treated</td>
</tr>
<tr>
<td>Halt the rise of diabetes</td>
<td>Percentage of cases treated</td>
</tr>
<tr>
<td>Halt the rise of hypertension in adults</td>
<td>Percentage of cases treated</td>
</tr>
<tr>
<td>Halt the rise of overweight and obesity</td>
<td>Percentage of cases treated</td>
</tr>
<tr>
<td>Halt the rise of mental disorders</td>
<td>Percentage of cases treated</td>
</tr>
<tr>
<td>Halt the rise of tobacco use</td>
<td>Percentage of cases treated</td>
</tr>
<tr>
<td>Halt the rise of illicit drug use</td>
<td>Percentage of cases treated</td>
</tr>
<tr>
<td>Halt the rise of harmful alcohol use</td>
<td>Percentage of cases treated</td>
</tr>
</tbody>
</table>
Chapter 5 - Implementing the Strategic Agenda: implications for the entire Secretariat

Suggested length: 2–3 pages

Once the draft Strategic Agenda is validated, the team should consider its implications and the appropriate clearance processes. In determining the implications, the team should address the following questions:

✓ Is the core capacity (in terms of human and financial resources, infrastructure (including information and communication technology) and other resources) needed to implement the CCS Strategic Agenda available in the WHO country office?

✓ If not, what are the implications for the entire Secretariat of filling the gaps identified in terms of priority-setting, programming and responsibility?

Therefore, in addition to analysing country office resources, the team should analyse resources available through, or from, the subregional, regional and global levels of WHO, as well as from other countries, to take advantage of south–south and triangular cooperation opportunities, if feasible.

Table 4: Clearance process and use of the CCS document

<table>
<thead>
<tr>
<th>Action</th>
<th>CO</th>
<th>RO</th>
<th>HQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final review by regional office (RO) and Headquarters (HQ)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clearance by ministry of health (MoH), RO and HQ</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Agree on the process for the publication of the CCS document with the RO, ensuring the proper use of the WHO logo and publishing standards</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Signature and launch of the CCS document by MoH and HWO[^a^]</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Widely disseminate the CCS document to all staff of the country office, to the government and other partners working in and with the country, as well as publishing on the country office Internet site</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upload the finalized CCS to the regional database of IRIS (Institutional Repository for Information Sharing)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Use CCS priorities to revise existing workplans, to inform the elaboration of the Biennial Workplan and budget, to define and shape the health component of the UNDAF and other partnership platforms</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Use the CCS for advocacy and resource mobilization for health</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Widely disseminate the CCS document and the Brief to all WHO departments and divisions, and to other relevant partners and stakeholders</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Ensure that technical interactions with the country offices and governments are consistent and based on the CCS priorities</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ensure that CCS priorities are used as the basis for the preparation of strategic and operational plans including budgets and resource allocation</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ensure CCS evaluation with support from HQ</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Back the approved priorities with relevant resources</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

[^a^]This could include the Regional Director or even HQ depending on the circumstances.
Chapter 6 • Evaluation of the CCS

6.1 Purpose of the evaluation
The country office, under the leadership of the HWO, with the support of the region and HQ, and in full coordination with the MoH and other partners, should ensure the evaluation of the CCS to assess WHO’s contribution to the national health priorities. The proper evaluation of the CCS is the first step towards assessing WHO’s performance in countries.

6.2 Timing
The CCS is reviewed halfway into, and again near the end of, the CCS cycle, coinciding with other national review processes in the country (as relevant). This exercise needs to be linked with the biennial workplan monitoring and assessment of the UNDAF, if feasible.

6.3 Type of evaluation
The midterm review should be more process-oriented and will be used to correct the implementation process of the CCS. (Is the implementation of the CCS going as planned? Is the country facing a particular situation or crisis, which warrants a change in priorities?)

The end evaluation will focus on determining whether the achievements of the strategic priorities have contributed to the NHPSP. The findings of the evaluation will inform the formulation of the next CCS.

If both reviews are done at the appropriate time, the information gathered can readily be integrated in the next CCS process.

6.4 Evaluation process
The evaluation process, led by the HWO, includes the designation of a CCS evaluation WG (which may include an external element especially for the final evaluation), the elaboration of a roadmap and the selection of evaluation questions.

6.4.1 Midterm review
The midterm review should consider the following components and questions:

✓ the relevance of the strategic priorities in the present context and progress
✓ the involvement of the country staff in the CCS process
✓ the support received from the regional office and HQ for the CCS development
✓ the hiring of an external consultant
✓ the consultation and or involvement of other stakeholders
✓ the dissemination of the CCS document
✓ usage of the CCS strategic agenda by country office staff for the elaboration of the biennial workplan (BWP) and by national authorities and other stakeholders

6.4.2 Final evaluation

The end evaluation criteria are relevance, effectiveness, efficiency and impact. These criteria are applied along the lines of the Organisation for Economic Co-operation and Development/Development Cooperation Directorate (OECD/DAC) criteria for development aid.\(^\text{13}\)

The relevant information will come through review of documents and from the midterm and programme budget assessment report, as well as from meetings with country staff and external stakeholders.

1. **The review of the relevance and achievement of the strategic priorities**

   - **Relevance**: Are the CCS strategic priorities aligned to the national development plan and/or NHPSP? Is each strategic priority linked to one or more leadership priority? Is each CCS focus area linked to a GPW outcome? Are CCS strategic priorities linked to the regional strategic plan?

   - **Effectiveness**: Were the strategic priorities achieved? “If not, which parts were not achieved and why?”

   - **Efficiency**: Did the CCS inform the biennial workplan and budget in an appropriate way?

   - **Impact**: Have the strategic priorities of the CCS been achieved? What was the extent of achievements in relation to the GPW outcome indicators, the national health priorities and regional strategic focus areas?

2. **The input of the analytical element of the CCS to other planning tools (desk review and meetings with WHO country staff)**

   - Were workplans informed by the CCS priorities? Note that the country’s context may signal the impending necessity for a shift in workplans if a crisis situation emerges.

   - Was WHO’s comparative advantage and added value taken into consideration during the planning process?

   - Are the tools and resources provided aligned with Member States’ needs and with the needs of other relevant country partner organizations?

   - Did budget allocations reflect the priorities identified in the CCS?

   - Were budget allocations linked to the outcomes of the workplans?

   - Has the CCS been used for advocacy and mobilization of resources for implementing the CCS strategic agenda?

   - Has the CCS been used for adjusting the mix of competencies and skills in the country office?

   - Is the human resources plan consistent with the competencies and skills required to implement the CCS priorities?

   - Was the technical, managerial and administrative support from the regional office and HQ timely and adequate?

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\(^{13}\) OECD DAC criteria for evaluation in development cooperation, http://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm
Did the information technology and communication infrastructure provide required support for CCS implementation?

3. The consistency between the CCS strategic priorities and the UNDAF

- Have the CCS strategic priorities been used to inform the health priorities of the UNDAF?
- The extent to which the CCS contributed to increased collaboration with a wider array of partners at country level should also be considered.

4. The analysis of WHO cooperation with partners

The meeting with stakeholders aims to capture the partners’ perceptions of:

- WHO’s contribution to enhancing national ownership
- WHO’s alignment to national health priorities
- WHO’s contributions to the achievement of MDGs and the development of the post-2015 Sustainable Development Agenda
- Areas where WHO’s contribution was required, but was insufficient to achieve the stated objectives
- WHO as a member of the UNCT
- WHO as a broker for health among partners and across sectors
- Areas in which WHO has a comparative advantage and added value, and on which it should focus, as well as areas from which it should shift its focus, during the next CCS cycle.

6.5 Conclusions and recommendations

In this concluding section, describe the main achievements, gaps and challenges and make appropriate recommendations. The document should be shared for comments with the regional office and HQ. The main areas to be summarized here are the strategic priorities to inform the BWP, WHO’s contribution to national health priorities and outcomes, WHO’s contribution to UNDAF and the One UN programme and the different stakeholders’ perception of WHO’s performance.

Lessons learnt from the monitoring and evaluation of CCSs should be shared with other countries, particularly within similar country groupings, within the Secretariat and with government and partners.
Annex 1a: Guidance for developing a CCS in countries in fragile situations

The purpose of this document is to provide guidance to WHO CCS teams to develop more responsive and effective CCSs with countries in fragile situations. The overall CCS process in countries in fragile situations will be in accordance with the process set out in the current CCS guide 2014 and this document has been designed to complement that guide.

1. Guiding principles for articulating the CCS with countries in fragile situations

In addition to the principles of ownership, alignment, harmonization and collaboration as a two-way process that guides the development of all CCSs, the CCS process in countries in fragile situations will need the following additional guiding principles. These are:

- **Sound analysis of the fragility characteristics:** This is a critical starting point for developing effective responses in situations of fragility.

- **Institutional development:** A key objective of the CCS process in countries in fragile situations is capacity-building of the national health authorities and restoration of the functionality and steering role of the ministry of health, including at subnational levels, as a component of state building.

- **Focus on service delivery:** In parallel to the institutional development, the CCS needs to focus on ensuring that people have access to health services, including in areas where the public health service delivery has been disrupted.

- **Alignment and strategic partnerships:** The CCS should take into account the *Principles for good international engagement in fragile states and situations* as defined by the Organisation for Economic Co-operation and Development (OECD) in 2007. These principles provide a set of guidelines for actors involved in development cooperation, peace building, state building and security in fragile and conflict-affected states as well as the decision of the UN Secretary-General on UN support of the New Deal for Engagement in Fragile States dated 12 July 2012.14

2. Defining and analysing fragility

There are several definitions of fragility and/or fragile states, often used to identify and group countries. The Organisation for Economic Co-operation and Development/Development Co-operation Directorate (OECD/DAC) has defined a state as being fragile when “*state structures lack the political will and/or capacity to provide the basic functions needed for poverty reduction, development and to safeguard the security and human rights of their population*.”

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14 The New Deal outlines an agenda for more effective aid to fragile states, based on five peace-building and state-building goals (legitimate politics, security, justice, economic foundations, and revenues and services), stronger alignment and mutual accountability, and more transparency and investments in country systems based on a shared approach to risk management. The five peace- and state-building goals are at the core of UN engagement in most countries affected by conflict and crisis. See also http://www.g7plus.org/new-deal-document/
Caution is required when classifying or grouping such states, as countries labelled as fragile are heterogeneous and the modalities for interventions need to be adapted to the context-specific priorities and underlying political settlements.\textsuperscript{15} Furthermore, fragility is dynamic, and changes over time. Some countries with fragile situations could be in post-conflict, early recovery, transition, or development phases, or faced with recurrent disasters and humanitarian crises, while in other countries all these different contexts of fragility might exist simultaneously.

To allow for flexibility and context specificity, it is important to identify factors that either contribute to fragility or that result from it. This way, we can see which of these factors apply at a particular time to a particular country and what their influence is on the health sector and the CCS process and content. It is therefore important for all HWOs and CCS development teams to assess and analyse fragility in their host countries and see how this guidance note could accompany the CCS process. There are various tools for analysing fragility.\textsuperscript{16} The CCS team needs to identify reports in which such analyses have been done, and then determine how these may affect the health sector.

3. Characteristics of fragile situations and justification for developing context-specific CCSs with countries in fragile situations

Countries in fragile situations are often characterized by severe development challenges such as insecurity, weak capacity or unwillingness to deliver basic state functions, chronic or recurring humanitarian crises, persistent social tensions, economic and political instability, lack of accountability, poorly functioning institutions and significant constraints on achieving the MDGs.

There are several socio-political and security factors noted in countries in fragile situations that impact the health sector and should be taken into consideration when developing the CCS. These include:

- Pervasive security problems with violence caused by armed conflict, drug or human trafficking, leading to restrictions on UN staffing or their movement in country, which could result in “remote controlled” programme management.

- Widespread human rights violations including effects on the right to health and possible exacerbation of pre-existing inequities. The impact on the health sector may be reduced access of the affected population to services, deliberately excluded or marginalized groups, and risk of violations of the principles of medical neutrality, whereby the health sector may become a target, or where health-care providers may participate in the human rights violations.

- Opposition groups controlling significant parts of the country, and different parts of the country differently affected by fragile situations. The impact for the health sector may be that there is a need to engage in areas that are not under government control, and to have approaches that are adapted to the differences that may exist in the various regions in the country.


4. Adapted CCS process with countries in fragile situations

Although aligned with the 2014 CCS Guide, some of the approaches within each element will need to be adapted in countries with fragile situations.

a. Preparation

- **Composition of the CCS team** – It is important that at least one of the team-members has the appropriate competencies for diplomacy and an understanding of the political context, as well as expertise on health systems in countries with fragile situations and/or humanitarian contexts.

- **Choosing appropriate timing and timeframe for the CCS** – The timing of the CCS should take into account specific planning cycles linked to fragility to ensure synergies and reduce transaction costs. The CCS cycle could be shorter to bring it into alignment with the cycles of national plans or strategies such as the national reconstruction, recovery and development plan. Where applicable, the CCS should articulate with humanitarian strategies and the Common Humanitarian Action Plan of the Consolidated Appeal Processes. However, where the CCS cycle has to be as long as 5 years, it will be essential to have an annual or biennial review of the CCS.

- **Security briefing** – This is necessary to obtain adequate information on the conflict dynamics and possible movement restrictions, as well as to ensure the safety of the CCS team.

- **Inclusiveness of the CCS process and dialogues** – It is critical to undertake a wide stakeholder consultation. There may be a need to identify a mixture of alternative approaches to ensure inclusive dialogues for the health and development situation analysis as well as the strategic agenda formulation (e.g. interviews using Skype or making use of the national staff to consult with stakeholders that are not accessible to international staff who may be constrained by security concerns or restrictions on movement).

- **Sensitivity to conflict dynamics** – Stakeholder analysis and mapping should be sensitive to conflict dynamics, ensuring representation of views of various parties to the conflict.

- **Scenario, situation and fragility analysis** – There is a need to understand the underlying causes of fragility, identify immediate risks of instability, to consider in greater depth the political context, country capacity and resilience, and possible scenarios.

- **Specialized information sources** – Key information on context and conflict analyses can be found in country-specific publications, such as:
  - the International Crisis Group http://www.crisisgroup.org/
  - the Economist Intelligence Unit http://www.eiu.com/index.asp?&rf=0
  - the Centre for Research on the Epidemiology of Disasters http://www.cred.be/

For further reading see the WHO manual for Analysing disrupted health sectors (http://www.who.int/hac/techguidance/tools/disrupted_sectors/en/index.html).
b. **Development**

- Strategic Agenda – undertake a context-specific prioritization process with all the relevant stakeholders to ensure the agreed strategic priorities are relevant, aligned with national reconstruction and development priorities and have the potential to be effectively implemented.

- Recovery may take up to 15 years or more, therefore, it is necessary to develop a strategy that takes a long-term view, while aiming for short-term, realistic, incremental steps.

c. **Implementation**

- The timing of the CCS launching should be carefully selected, preferably to be in line with the state-and-peace-building agenda or other national multisectoral policy and planning processes, to generate maximum effect.

- Furthermore, the implementation of the CCS strategic agenda may be affected by changes in the fragility situation in the country. Emerging from fragility is often not a linear process and implementation of any plan or strategy can therefore face unexpected constraints or setbacks.

d. **Monitoring and evaluation of the CCS**

- The possible shorter implementation cycle of the CCS in countries in fragile situations, and the fact that there are often significant changes in the context and characteristics of fragility, also call for a shorter period for reviews and the necessary revisions after such reviews. For example, annual reviews of the CCS undertaken at the same time as reviews of other national recovery processes can be considered.

5. **Outline of the CCS document for countries in fragile situations**

*Chapter 1: Introduction*

*Chapter 2: Health and development situation*

2.1 *Main health achievements and challenges*

- This chapter should start with a summary of the context, conflict and/or fragility analyses, scenarios and evolution, including health emergency risk assessment and the presence of disparities, as different parts of the country are often differently affected by fragile situations and this may change over time.

- The next step is a critical analysis of the health system with particular focus on the effects of fragility on:

  ✓ **Service delivery** – damaged and/or destroyed health infrastructure; unequal access to health services.

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17 Include examples of characteristics of fragility that will need to be taken into account in relation to the respective chapters.

18 To increase the flexibility of the scenario analysis, the analyses should cover the three classic scenarios of: improvement, status quo, and deterioration.
✓ **Governance** – interruption of policy process and sector coordination with weak steering role of the national and subnational health authorities and ineffective emergency preparedness and response. There may be a new interim government and possible revision of the NHPSP, which can be seen as an opportunity to restore a policy dialogue that gives prominence to health. The multiplicity of actors with diverse agendas, undermines the governance role of the national health authorities and leads to fragmentation or duplication of health service delivery.

✓ **Health information system** – fragmented and many challenges in validating existing data sets.

✓ **Human resources for health** – loss of staff, unequal distribution of human resources, untrained staff or uncertified training by various NGOs, task shifting, loss of human resources for health to aid agencies or diaspora returning.

✓ **Health financing** – weak financial management capacity of the ministry of health and high dependence on external assistance. Humanitarian funding may involve Multi-Donor Trust Funds and/or pooled funding mechanisms for humanitarian aid, including consolidated appeal and/or central emergency response fund for underfunded emergencies.

✓ **Pharmaceutical products** – national production and distribution may be interrupted. There is absence of regulation of import and quality.

✓ **Health status of the population including trends, disparities and disaggregation of data:** Poor maternal and child health, excessive burden of communicable diseases, or disruptions of access to diagnosis and treatment for chronic and noncommunicable diseases.

✓ **Health determinants including inequity and gender-based violence**

2.2 **Collaboration with the UN and other partners**

- Review the specific coordination arrangements with the UN and international partners that may or may not support national coordination, the presence of a humanitarian coordinator or humanitarian coordination team (health cluster coordination).

- Take into consideration the existence of recovery/transition coordination and planning mechanisms, for example linked with post-conflict needs assessment and recovery planning supported by the World Bank–European Commission–United Nations (WB-EC-UN) and coordination mechanisms outside the country, including coordination for multiple countries affected by the same hazard.

2.3 **Contributions of the country to the global agenda**

- Role of the country in regional, and global activities (if any) on health management in fragile situations (for example being a member of the Busan “new deal”).

- Global health initiatives such as Gavi, or the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), may have adapted programmes, coordination structures and implementation channels to take into account the fragility in that context.

- Global eradication or elimination programmes often face difficulties in achieving effective implementation and coverage in countries with fragile situations.
Chapter 3: Review of WHO cooperation

Critical analysis of what WHO and other actors and stakeholders have done to address consequences of fragility for the health sector and how principles of engagement with countries in fragile situations were taken into account: identifying gaps, and what has worked and why.

Chapter 4: A Strategic Agenda for WHO cooperation

The Strategic Agenda must be responsive to the characteristics of fragility identified in the country, based on inclusive dialogue with stakeholders, strategic analysis and prioritization. The team must consider the potential role of the health sector and social services in state- and peace-building and focus on service delivery, seeking multiple channels for implementation adapted to the context. A useful reference is “Principles for engagement in countries in fragile situations and the Busan “New deal”: http://www.aideffectiveness.org/busanhlf4/en/about/key-documents.html.

Chapter 5: Implementing the Strategic Agenda – implications for the entire Secretariat

The implications for the WHO Secretariat involve capacity, pooling of resources, and application of standard operating procedures (SOPs) for emergencies. See also the WHO Emergency Response Framework (ERF) document that provides guidance on WHO country office structures during emergencies.19

Principles for good international engagement in states in fragile situations20 – as applicable to CCS development with such countries

✓ Take context as the starting point – Ensure that the strategic agenda is adequately rooted in an understanding of the country context. The country context covers issues of political economy analysis, conflict analysis and the assessment of state-building challenges.

✓ Do no harm – CCS development and the agreed strategic agenda should not lead to the weakening of state capacity and/or legitimacy, neither should the uneven distribution of technical support lead to an unintentional widening of social disparities.

✓ Focus on state-building as the central objective – technical focus or investments in institutional development/capacity-building in the Strategic Agenda should not be limited to the governance level.

✓ Prioritize prevention – analyse risks in a systematic and sustained manner and ensure that interventions are not patchy but are planned within the overall strategy for crisis prevention and health system rebuilding with a special focus on capacity-building for sustainability.

✓ Recognize the links between political, security and development objectives – aim for integrated whole-of-government approaches and seek the required buy-in across the various relevant sectors through inclusive dialogue and consultations.

19  http://www.who.int/hac/about/en/
✓ **Promote non-discrimination as a basis for inclusive and stable societies** – As far as possible, ensure that collated data and the related analyses are disaggregated to demonstrate disparities and trends. The agreed Strategic Agenda, in turn, should be as inclusive and non-discriminatory as possible and based on an analysis of the disaggregated data.

✓ **Align with local priorities in different ways in different contexts** – Ensure alignment of the CCS Strategic Agenda with national health priorities and deepen alignment in Strategic Agenda implementation through the use of country systems for example in monitoring and evaluation.

✓ **Agree on practical coordination mechanisms** – Ensure that the Strategic Agenda prioritization process and the implementation of the agreed Strategic Agenda do not foster fragmentation but rather seek to promote coordination of partner support for government plans and programmes.

✓ **Act fast** – but stay engaged long enough to give success a chance. Ensure a mixture of strategic priorities that can meet immediate needs as well as those that assure the country of medium-term predictability of technical support based on jointly agreed benchmarks.

✓ **Avoid pockets of exclusion** – Ensure an even distribution of technical support.
Annex 1b: Guidance for integrating health emergency risk assessment, capacity assessment on emergency risk management for health and WHO readiness for emergency response into CCSs

1. Introduction

All countries from community to national levels are at risk of emergencies or disasters arising from a range of hazards, which can affect public health, health infrastructure, services and progress on health development as well as WHO’s programme of technical cooperation with Member States. Hence the need during the development of all WHO CCSs to assess the potential risks in the country that could lead to emergencies with health consequences, the capacity of the country to manage such risks and WHO’s readiness to respond to emergencies.

This section has been developed to provide brief guidance to WHO CCS teams on how to integrate the outcomes of these three assessments into all new CCSs.

2. Definitions

An all-hazards national health emergency risk assessment

An all-hazards national health emergency risk assessment (HERA) describes the nature and extent of risks from all potential hazards and existing vulnerabilities that could cause harm to exposed people or cause damage or disruption to health infrastructure and services. HERA consists of four components namely: context analysis, risk identification (hazard and vulnerability analyses), risk analysis and risk evaluation.

Capacity assessment on emergency risk management for health

Capacity assessment on emergency risk management for health (ERM-H) provides information on the strengths of, and gaps in, the country’s multisectoral and health systems to manage the risks of emergencies, implement the International Health Regulations (2005) and strengthen community and national resilience.

Assessment of WHO readiness for emergency response

This assessment determines WHO’s readiness to provide a timely and effective response to emergencies and disasters in support of Member States and to be an effective partner with the UN and bilateral agencies at country level. This includes WHO’s ability to fulfil its responsibilities under the International Health Regulations (IHR), the Inter Agency Standing Committee (IASC) Transformative Agenda and as Global Health Cluster Lead.
3. How to integrate the three assessments into the CCS process and document

a. The CCS process

The following key steps should be taken by the CCS team to achieve integration into the CCS process:

- **Inclusiveness of the CCS process and dialogues** – include the key stakeholders responsible for multisectoral and health emergency risk assessment, emergency risk management for health, International Health Regulations and WHO readiness for emergency response in the CCS consultations.

- **Health and development situation analysis** – Note to solicit answers for the HERA, capacity assessment on ERM-H and WHO readiness for response.

b. The CCS document

The framework in Table 1b1 shows how and where to briefly integrate the outcomes of the HERA, capacity assessment on ERM-H and assessment of WHO readiness for emergency response into the CCS document.

<table>
<thead>
<tr>
<th>Table 1b1 Integrating outcomes of assessments into CCS document</th>
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<tbody>
<tr>
<td><strong>Sections in the CCS document</strong></td>
</tr>
<tr>
<td><strong>Chapter 1: Introduction</strong></td>
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<tr>
<td>Macroeconomic, political and social context</td>
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<tr>
<td>Other major determinants of health</td>
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<tr>
<td>Health status of the population</td>
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<tr>
<td>National responses to overcoming health challenges</td>
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<td>Health systems and services, and the response of other sectors</td>
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<tr>
<td>National contribution to and role in global health</td>
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<tr>
<td><strong>Chapter 2: Health and development situation</strong></td>
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<tr>
<th><strong>Chapter 3: Evaluation of WHO cooperation during the past CCS cycle</strong></th>
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<tr>
<td>Outcomes of internal and external review of WHO cooperation in strengthening national ERM-H and WHO readiness for response and recovery</td>
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<thead>
<tr>
<th><strong>Chapter 4: Strategic agenda for WHO’s cooperation</strong></th>
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<tbody>
<tr>
<td>Definition of strategic priorities</td>
</tr>
<tr>
<td>Based on the outcomes of the three assessments and if required, include a strategic priority for strengthening WHO readiness for emergency response in country, and developing national capacities on ERM-H, including the IHR</td>
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<table>
<thead>
<tr>
<th><strong>Chapter 5: Implementing the strategic agenda: implications for the Secretariat</strong></th>
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<tbody>
<tr>
<td>State briefly, the related implications in the case that a strategic priority related to HERA has been selected as part of the strategic agenda</td>
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## Annex 2: Integrating essential criteria of gender, health equity and human rights into the CCS process and document

### Gender, equity and human rights criteria

<table>
<thead>
<tr>
<th>Inclusive dialogue</th>
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<tbody>
<tr>
<td>- Inclusive dialogues during the CCS process, include consultation with women and men from subpopulations experiencing differential exposure, vulnerability, access, and treatment outcomes or consequences, as a result of characteristics that may contribute to social exclusion or disadvantage, such as place of residence, race or ethnicity, occupation, gender or sex, religion, education or socioeconomic status.</td>
</tr>
<tr>
<td>- Inclusive dialogues during the CCS process include consultation with national bodies on human rights and national bodies on women.</td>
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</table>

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<tr>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The analysis informing the CCS includes identification of the differences between men and women resulting from (i) gender norms, roles, and relations; (ii) differential access to and control over resources; and (iii) biological differences, across the life-course, in:</td>
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<tr>
<td>- The analysis informing the CCS includes identification of socially excluded or disadvantaged subpopulations.</td>
</tr>
<tr>
<td>- The analysis informing the CCS includes assessment of the: i) availability, ii) accessibility, iii) acceptability and iv) quality in the provision of health-care services for socially excluded or disadvantaged subpopulations.</td>
</tr>
<tr>
<td>- The analysis informing the CCS health and development challenges takes into consideration recommendations on the right to health made to the country as a result of one of the Treaty Body monitoring mechanisms, Special Procedures (e.g. Special Rapporteurs) or Universal Periodic Review to which the country is party.</td>
</tr>
</tbody>
</table>

### Strategic priorities and outcomes

| - Should advocate reducing or mitigating ways in which gender norms, roles or relations negatively impact, or benefit from, access to and use of health services. |
| - Should advocate reducing or mitigating inequitable exposure, vulnerability or access of socially excluded or disadvantaged subpopulations. |
| - Should advocate inclusion and participation of socially excluded or disadvantaged subpopulations. |

### Report

| - Data in the CCS report are disaggregated by sex and the following stratifiers where possible and relevant: age, rural/urban, household wealth, ethnic group, education. |
| - The CCS report includes information on gender analysis and equity analysis. |
| - The CCS report includes reference to international human rights treaties, conventions or standards on the right to health ratified by the country. |
Annex 3: Guidance and template for CCS brief

The template is customized for each country and sent by Headquarters. The data in the “current health indicators” box are automatically updated based on the most recent data available from the Global Health Observatory (http://apps.who.int/gho/data/node.cco). If indicators other than the “current health indicators” are used in the body of the text, the data used must be up to date and the data sources quoted. The country map is automatically generated using the standard WHO maps available on the website (http://apps.who.int/gho/data/node.cco).

The suggested maximum word count for the CCS brief is 1350 to 1600. Briefs may be produced in Spanish or French, in addition to English, depending on the language of the country.

The text of the CCS brief should be succinct, highly analytical and based on the content of the most recent CCS document.

Health situation (300–350 words)

Content should be concise and highly analytical based on the conclusions of the health situation analysis in the CCS document. It should cover:

- progress in health status of the populations, showing trends and disparities;
- disease patterns and burdens (including communicable, noncommunicable and re-emerging diseases) and major determinants of health;
- status of achievement of international agreements/commitments (e.g. MDG targets, WHO Framework Convention on Tobacco Control (FCTC) and International Health Regulations (IHR) implementation);
- key gaps and challenges in a population’s health status that justify the selection of the agreed CCS Strategic Agenda.

Health policies and systems (300–350 words)

Content should highlight in a concise and analytical manner the existing policy and systems issues that could facilitate or challenge the national priorities and the six leadership priorities of the 12th GPW which justify the selection of the agreed Strategic Agenda:

- key health policies (i.e. instruments, legislation and frameworks) existing in the country, with years, and including status of implementation;
- key health interventions put in place as a result of policy orientation of the country resulting from World Health Assembly (WHA) resolutions, international agreements such as MDGs and other developments in health;
- key features of the organization of the health system and delivery mechanism(s), including private for-profit and not-for-profit institutions in the country that affect access and health outcomes.
Cooperation for health (150–200 words)

Content should reflect key issues within the cooperation environment for health that justify the agreed Strategic Agenda.

Identify the key stakeholders and key processes for cooperation for health:

✓ UN systems and delivery mechanisms – Delivering as One (DaO), United Nations Development Assistance Framework (UNDAF) and joint programming where applicable;
✓ bilateral agencies and other non-state actors working in the country and with whom WHO works;
✓ partnership framework for development cooperation (e.g. Busan, International Health Partnership [IHP+] Every Woman Every Child) and contribution to global health where applicable.

Acronyms should be spelt out in full the first time they are used and subsequently the acronym can be used. Acronyms should be used sparingly to enhance readability.

Country offices are requested to maintain the standard font from the template, Calibri, for both the headings (size 12) and the body text (size 8, minimum size 7.5). The automatically generated text of the country name and indicators should remain in Arial, size 22 and 6, respectively. It is important to keep easy readability of the briefs in mind when selecting the appropriate font type and size. Text in the boxes should be justified. Briefs should be well edited to maintain technical integrity.

Once produced, country offices are requested to send the Word document to CCU for final editing, formatting and posting on the global website.
Figure 5: Template for CCS brief

Country Cooperation Strategy at a glance

HEALTH SITUATION

Current Health Indicators

- Total population in thousands (xxxx)
- % Population under 15 (xxxx)
- % Population over 60 (xxxx)
- Life expectancy at birth (xxxx) (xx years)
- Infant mortality rate per 1000 live births (xxxx)
- Under-five mortality rate per 1000 live births (xxxx)
- Maternal mortality ratio per 100,000 live births (xxxx)
- % DPT3 immunization coverage among newborns (xxxx)
- % births attended by skilled health workers (xxxx)
- Density of physicians per 1000 population (xxxx)
- Density of nurses and midwives per 1000 population (xxxx)
- Total expenditure on health as % of GDP (xxxx)
- General government expenditure on health as % of total government expenditure (xxxx)
- Private expenditure on health as % of total expenditure on health (xxxx)

cooperation for health

Population using improved drinking-water sources (xxxx) (xxxx)
- Population using improved sanitation facilities (%) (xxxx) (xxxx)
- Poverty headcount ratio at $1.25 a day (PPP) % of population (xxxx)
- Gender-related Development Index rank out of 185 countries (xxxx)
- Human Development Index rank out of 188 countries (xxxx)

Sources of data:
- World Health Organization
- World Bank
- UNICEF
- Other

http://www.who.int/countries/en/
**WHO COUNTRY COOPERATION STRATEGIC AGENDA** (20xx–20xx)

<table>
<thead>
<tr>
<th>Strategic Priorities</th>
<th>Country Cooperation Strategy Focus Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STRATEGIC PRIORITY 1:</strong></td>
<td>•</td>
</tr>
<tr>
<td><strong>STRATEGIC PRIORITY 2:</strong></td>
<td>•</td>
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<tr>
<td><strong>STRATEGIC PRIORITY 3:</strong></td>
<td>•</td>
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<tr>
<td><strong>STRATEGIC PRIORITY 4:</strong></td>
<td>•</td>
</tr>
</tbody>
</table>
### Annex 4: Basic indicators for CCS documents

<table>
<thead>
<tr>
<th>WHO region</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>World Bank income group</td>
<td></td>
</tr>
<tr>
<td><strong>CURRENT HEALTH INDICATORS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total population in thousands (year)</strong></td>
<td>«Population_in_thousands_total»</td>
</tr>
<tr>
<td><strong>% Population under 15 (year)</strong></td>
<td>«Population_proportion_under_15_»</td>
</tr>
<tr>
<td><strong>% Population over 60 (year)</strong></td>
<td>«Population_proportion_over_60_»</td>
</tr>
<tr>
<td><strong>Life expectancy at birth (year)</strong></td>
<td>«Life_expectancy_at_birth_years»</td>
</tr>
<tr>
<td><strong>Neonatal mortality rate per 1000 live births (year)</strong></td>
<td>«Neonatal_mortality_rate_per_1000_live_»</td>
</tr>
<tr>
<td><strong>Under-five mortality rate per 1000 live births (year)</strong></td>
<td>«Underfive_mortality_rate_probability_»</td>
</tr>
<tr>
<td><strong>Maternal mortality ratio per 100 000 live births (year)</strong></td>
<td>«Maternal_mortality_ratio_per_100_000_live»</td>
</tr>
<tr>
<td><strong>% DTP3 Immunization coverage among 1-year-olds (year)</strong></td>
<td>«Diphtheria_tetanus_toxoid_and_pertussis»</td>
</tr>
<tr>
<td><strong>% Births attended by skilled health workers (year)</strong></td>
<td>«Births_attended_by_skilled_health_personnel»</td>
</tr>
<tr>
<td><strong>Density of physicians per 1000 population (year)</strong></td>
<td>«Physicians_density_per_1000_population»</td>
</tr>
<tr>
<td><strong>Density of nurses and midwives per 1000 population (year)</strong></td>
<td>«Nursing_and_midwifery_personnel_density»</td>
</tr>
<tr>
<td><strong>Total expenditure on health as % of GDP (year)</strong></td>
<td>«Total_expenditure_on_health_as_a_percentage»</td>
</tr>
<tr>
<td><strong>General government expenditure on health as % of total government expenditure (year)</strong></td>
<td>«General_government_expenditure_on_health»</td>
</tr>
<tr>
<td><strong>Private expenditure on health as % of total expenditure on health (year)</strong></td>
<td>«Private_expenditure_on_health_as_a_percentage»</td>
</tr>
<tr>
<td><strong>Adult (15+) literacy rate, expressed as %, per 1000 (year)</strong></td>
<td>«Literacy_rate_among_adults_aged_15_and_over»</td>
</tr>
<tr>
<td><strong>Population using improved drinking-water sources (%) (year)</strong></td>
<td>«Population_using_improved_drinking_water»</td>
</tr>
<tr>
<td><strong>Population using improved sanitation facilities (%) (year)</strong></td>
<td>«Population_using_improved_sanitation_facilities»</td>
</tr>
<tr>
<td><strong>Poverty headcount ratio at $1.25 a day (PPP) (% of population) (year)</strong></td>
<td>«Poverty_headcount_ratio_at_125_a_day»</td>
</tr>
<tr>
<td><strong>Gender-related Development Index rank out of 148 countries (year)</strong></td>
<td>«Gender_inequality_index_rank»</td>
</tr>
<tr>
<td><strong>Human Development Index rank out of 186 countries (year)</strong></td>
<td>«Human_development_index_rank»</td>
</tr>
</tbody>
</table>

**Sources of data:**
Global Health Observatory xxMONTHxx, xxYEARxx
http://apps.who.int/gho/data/node.cco
## Annex 5: Country example of linking CCS focus areas with GPW outcomes

<table>
<thead>
<tr>
<th>CCS strategic priority</th>
<th>CCS focus area</th>
<th>GPW outcome</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Achieving and sustaining UHC through a revitalized PHC approach and sustainable service delivery through strengthening of health systems</td>
<td>1.1: Strengthened health systems capacity through human resources development, improved HIS, effective procurement and supply management, and improved regulatory mechanisms and quality assurance of health services</td>
<td>Policies, financing and HR are in place to increase access to people-centred integrated health services</td>
<td>Direct link to Category 4 Outcome “Policies, financing and human resources are in place to increase access to people-centred, integrated health services”</td>
</tr>
<tr>
<td></td>
<td>1.2: Costing and economic analysis and sharing of best international practices in financing health services, based on principles of universal access and equity</td>
<td>Policies, financing and HR are in place to increase access to people-centred integrated health services</td>
<td>Direct link to Category 4 Outcome “Policies, financing and human resources are in place to increase access to people-centred, integrated health services”</td>
</tr>
<tr>
<td></td>
<td>1.3: Increased availability of quality assured essential medicines and appropriate health technologies</td>
<td>Improved access to and rational use of safe, efficacious and quality medicines and health technologies</td>
<td>Direct link to Category 4 Outcome “Improved access to and rational use of safe, efficacious and quality medicines and health technologies”</td>
</tr>
<tr>
<td>2: Scaling up prevention, early detection, monitoring and treatment of NCDs and addressing their determinants through intersectoral collaboration</td>
<td>2.1: Enhanced national capacity and intersectoral action for prevention, early detection and management of NCD and to address determinants of NCDs</td>
<td>Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors</td>
<td>Direct link to Category 2 Outcome “Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors”</td>
</tr>
<tr>
<td></td>
<td>2.2: Scaled up response to mental health, alcohol and substance abuse and injury prevention</td>
<td>Increased access to services for mental health and substance use disorders</td>
<td>Direct link to Category 2 Outcome “Increased access to services for mental health and substance use disorders”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The CCS focus area links to two separate GPW Outcomes: Category 2 “Reduced risk factors for violence and injuries with a focus on road safety, child injuries and violence against children, women and youth” and Category 2 Outcome “Increased access to services for mental health and substance use disorders”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>In this case, the CCS focus area should be split in two, one dealing with violence and one dealing with mental health</td>
</tr>
</tbody>
</table>
Guide for the formulation of the WHO Country Cooperation Strategy

Guide 2014