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Guide 2016

WHO Country Cooperation Strategy

World Health Organization

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Abbreviations

AIDS	acquired immunodeficiency syndrome
CCA	Common Country Assessment
CCS	Country Cooperation Strategy
CCU	Department of Cooperation with Countries and Collaboration with the United Nations System (WHO)
CSO	civil society organization
CSU	Country Support Unit
DAC	Development Assistance Committee
DaO	Delivering as One
ERF	Emergency Response Framework
EDRM-H	emergency and disaster risk management for health
FCTC	Framework Convention on Tobacco Control
Gavi	formerly Global Alliance for Vaccines and Immunizations, now Gavi, the Vaccine Alliance
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHO	Global Health Observatory
GPW	General Programme of Work
HDI	Human Development Index
HERA	health emergency risk assessment
HRAP	Human Resources Action Plan
HQ	WHO Headquarters
HWO	Head of WHO Office in countries, territories and areas
IASC	Inter-Agency Standing Committee
IHP+	International Health Partnership
IHR	International Health Regulations (2005)
IRIS	Institutional Repository for Information Sharing (WHO)
ISF	Integrated Strategic Framework (UN)
LDC	Least-developed country
MoH	Ministry of health
MDGs	Millennium Development Goals

MDTF	Multi-Donor Trust Fund
MOPAN	Multilateral Organisation Performance Assessment Network
NCD	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
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
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
WG	working group
WHO	World Health Organization

PART 1.

INTRODUCTION

Part 1. Introduction

1.1 What is a Country Cooperation Strategy?

A Country Cooperation Strategy (CCS) is WHO's medium-term strategic vision to guide the Organization's work in and with a country, responding to that country's specific priorities and institutional resources needed to achieve its national health policies, strategies and plans (NHPSPs[1]), as well as the actions needed to achieve its national targets under the Sustainable Development Goals (SDGs).

It is the Organization-wide reference for WHO's work in and with a country.

A CCS is the strategic basis for the bottom-up planning process, consisting of the identification of a focused and coherent set of priorities responding to country needs. As such, it also serves for the elaboration of WHO's biennial programme budgets (PBs). The CCSs guide planning, budgeting and resource allocation for the work of the Organization in countries, directing its resources to the Member States and the programme areas where WHO technical cooperation is most needed.

The CCS informs and reinforces the health dimension of the United Nations Development Assistance Framework (UNDAF) and acts as the main instrument for harmonizing WHO's cooperation in a country with the work of other United Nations agencies and development partners towards achieving the SDGs.

The time frame of the CCS is flexible to align with national and United Nations planning cycles and to accommodate changing circumstances (e.g. emergencies, recurrent disasters, humanitarian crises, post-conflict situations, early recovery and transition).

1.2 Purpose of the CCS

The CCS

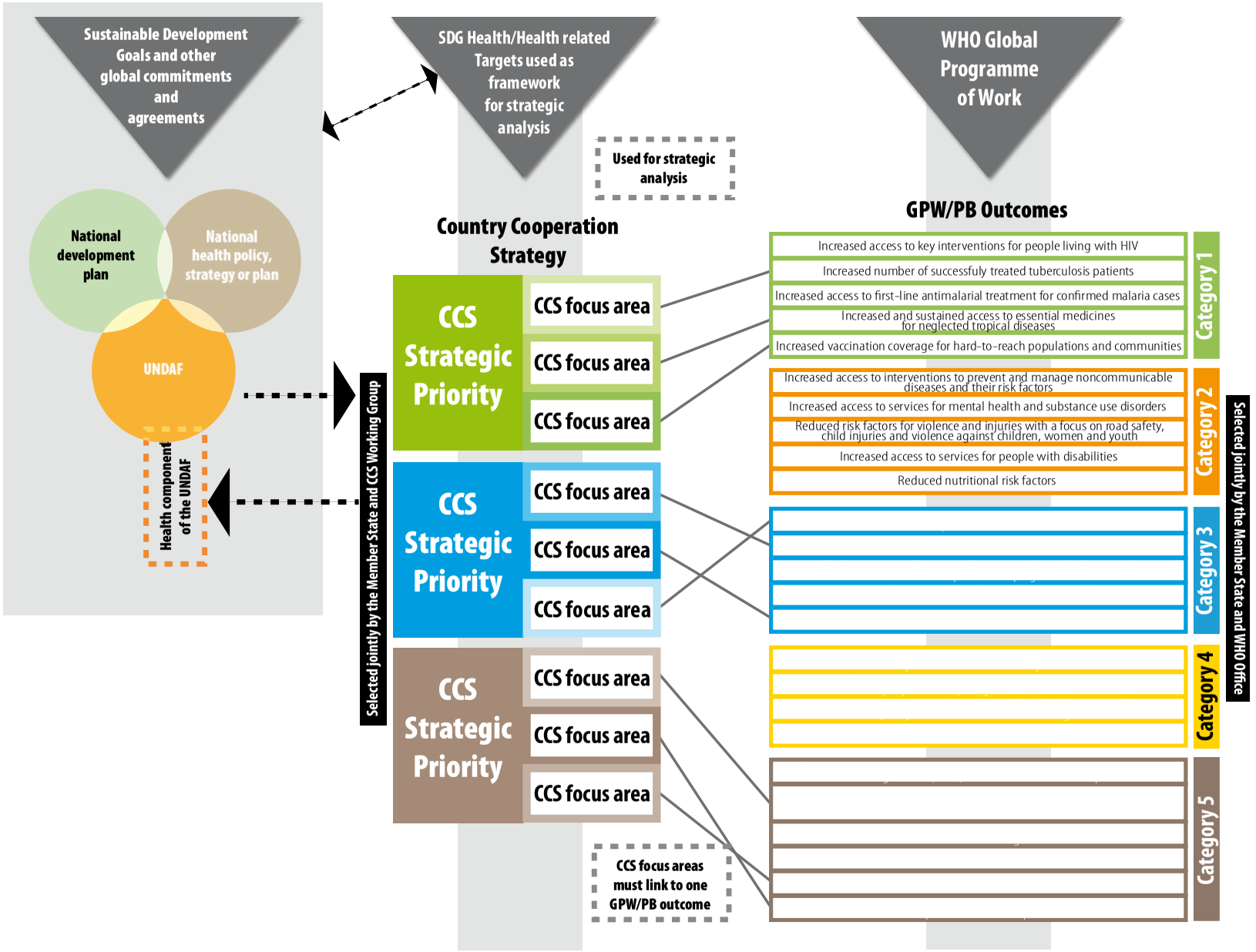
- **Provides** the strategic basis for the bottom-up planning process and contributes to the health dimension of the UNDAF, harmonizing WHO's cooperation with a country in order to achieve the SDGs.
- **Supports the achievement of the SDGs.** The CCS underlines WHO engagement to actively contribute to the achievement of the 2030 Agenda for Sustainable Development.
- **Supports and reinforces national health priorities, including national SDG targets.** The CCS ensures that WHO work at country level responds to national health priorities, including national SDG targets,[2] as well as supporting national health emergency risk assessments, national capacities in emergency risk and disaster risk management, and readiness for emergency response.

[1] A document or set of documents that lays out the context, vision, objectives, spending priorities and key interventions for health development in a country.

[2] The SDGs are global aspirational goals. Guided by this global level of ambition, each government will set its own national targets, taking into account different national realities, capacities and levels of development and respecting national policies and priorities. See http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E

- **Strengthens and harmonizes work with partners and other sectors.** The CCS provides an opportunity to strengthen partnerships and multisectoral approaches to address NHPSP priorities and SDG targets.
- **Aligns WHO work across the three levels of the Organization.** The CCS informs and reinforces WHO's global vision for health as defined in the high-level General Programme of Work (GPW). It facilitates advocacy of WHO priorities at country level. The CCS reinforces and informs the health dimension of the UNDAF as the main instrument for harmonizing WHO's cooperation in countries with the work of other United Nations agencies and partners.
- **Supports global and regional and subregional health frameworks and agendas.** The CCS reinforces and informs WHO's global vision for health as defined in intergovernmental frameworks and regional and subregional health agendas.
- **Mainstreams gender, equity and rights into WHO country-level work.** The CCS facilitates the integration of the principles of "gender, equity and the right to health" into the work of WHO at country level.
- **Facilitates resource mobilization for health** at country level; and
- **Ensures that WHO support is adapted to country specificities, changing circumstances and risk environments.** The CCS recognizes the importance of country specificities, circumstances and risk environments. For example, countries in fragile situations may benefit from a shorter CCS duration that allows for modification (see Annex 1). Some high-income countries have embraced the CCS as a way to detail their cooperation with WHO and other stakeholders and countries, with WHO as a knowledge broker and convener in the pursuit of joint interests. The CCS facilitates identification of core competencies for WHO cooperation and in-country presence. It guides the development of human resources action plans.

Figure 1. Linkages between CCS, NHPSPs, SDGs and the GPW



There is an explicit interaction between the CCS and the GPW from which the PB is developed before and during the CCS life-cycle. The analysis of CCS priorities and focus for WHO technical cooperation provides country-level input into the PB bottom-up planning process, the identification of the PB priorities, and budget allocations. During operational planning, the CCS Strategic Agenda influences the programmes, the planned results and resource allocation in the biennial workplan.

As the implementation of the biennial workplan is monitored and evaluated, the lessons learnt feed into the updating or preparation of the subsequent CCS. In addition, in situations where the PB is undertaken prior to the renewal of an outdated CCS, the PB priorities inform the CCS Strategic Agenda during the CCS renewal process.

1.3 The SDGs and implications for WHO CCSs

The 2030 Agenda for Sustainable Development has 17 goals and 169 targets. Goal 3, to "ensure healthy lives and promote well-being for all at all ages", is specific to health and comprises thirteen targets encompassing universal health coverage (UHC), the unfinished Millennium Development Goals (MDGs), and new challenges in global health. Furthermore, 40 targets in 14 of the goals are also indirectly related to health.

WHO country cooperation will support the mainstreaming of the SDGs into national plans, accelerate their implementation and provide demand-driven policy support. The key principles that guide WHO's cooperation in countries and upon which each CCS is based are reflective of those which underlie the SDGs. Namely, WHO work at country level is guided by a focus on:

- **Country ownership of development processes:** WHO prioritizes a country-led approach and aligns its cooperation with the health-related SDGs, working towards UHC and strengthened health security in support of NHPSPs. Furthermore, it collaborates with Member States to shape the national and global health agendas.
- **Results:** WHO prioritizes evidence-based and results-focused approaches along with country needs and capacity-determining support. It encourages innovation and experimentation, exploring tailored solutions based on the changing global and regional environments, country contexts and needs.
- **Inclusive development partnerships for sustainable development:** To advance the SDGs, inclusive partnerships are needed, involving not only governments and parliaments, but also civil society, media, the private sector and academia, among others. ***The United Nations Development Group (UNDG) core principles of collaboration for "delivering together in support of the 2030 Agenda" also underline the fact that United Nations agencies, including WHO as part of the UNDG***, are committed to adopting an integrated, harmonized approach to sustainable development, through:
  - adopting an integrated, multisectoral approach;
  - harmonization of work among United Nations agencies and partners in countries towards effective development cooperation for health, with a focus on:
    (a) expertise, not exclusivity, with joint work prioritized where it has the greatest impact with due recognition of agency mandates and expertise;
    (b) collaboration, not competition, with mutual recognition of respective contributions;
  - inclusive dialogue.

- **Accountability:** The implementation of the 2030 Agenda will rely on political will, accountability and national ownership, where targets are prioritized and adapted at the community level. Trust and credibility are essential, including with the most vulnerable and marginalized people, and including through upholding international agreed norms and standards.

Putting these principles into action in the CCS process means:

- **Leaving no one behind** – The agreed CCS Strategic Agenda is based on a critical analysis of the health situation using the SDGs as the framework for analysis. It is supported by disaggregated data to ensure equitable approaches that address the needs of disadvantaged or vulnerable groups.
- **Universality** – All countries are called on to achieve the SDGs. Accordingly, CCSs are responsive to different country contexts, income levels and circumstances, including fragile situations.
- **Multisectoral approaches** – Increased inclusiveness in the CCS process strengthens links with other sectors, fostering a multisectoral approach to addressing NHPSP priorities and country-level actions, in order to take forward the SDGs and encourage joint programming linked to the health component of the UNDAF.
- **Integrated and indivisible** – The evidence-based CCS Strategic Agenda ensures that the economic, environmental and social pillars of health in sustainable development are considered, with a strong focus on equity and adequate involvement of all programmes, and support for health.

1.4 What's new in the CCS Guide 2016?

- As in the previous version, the 2016 CCS guide presents the essential steps in the CCS process, including its formulation, implementation and monitoring, but the 2016 version also includes a revision which focuses on enabling the CCS to more fully address the health-related targets in all SDGs working within the framework of a country's overall NHPSP;
- The 2016 CCS guide encourages WHO to engage in greater multisectoral collaboration in countries, building on global commitments in the 2030 Agenda for Sustainable Development, such as through the Paris Agreement on Climate Change, the Sendai Framework on Disaster Risk Reduction, and the Addis Ababa Action Agenda, among others;
- It provides a more robust framework for monitoring and evaluating the CCS;
- It offers a quick revision option for updating the CCS Strategic Agenda where a full revision is not feasible; and
- It provides tools to facilitate the articulation of an analytical, high-quality CCS.

The WHO Global Country Support Unit Network prepared this guide with the guidance of the WHO Department of Cooperation with Countries and Collaboration with the United Nations System (CCU), and the participation of the six regional Country Support Units, heads of WHO offices (HWOs), and technical and planning departments in regional offices (ROs) and headquarters (HQ). The guide was field tested and revised accordingly.

An electronic version of the guide is available on the CCU Internet and Intranet pages.

PART 2.

THE CCS PROCESS

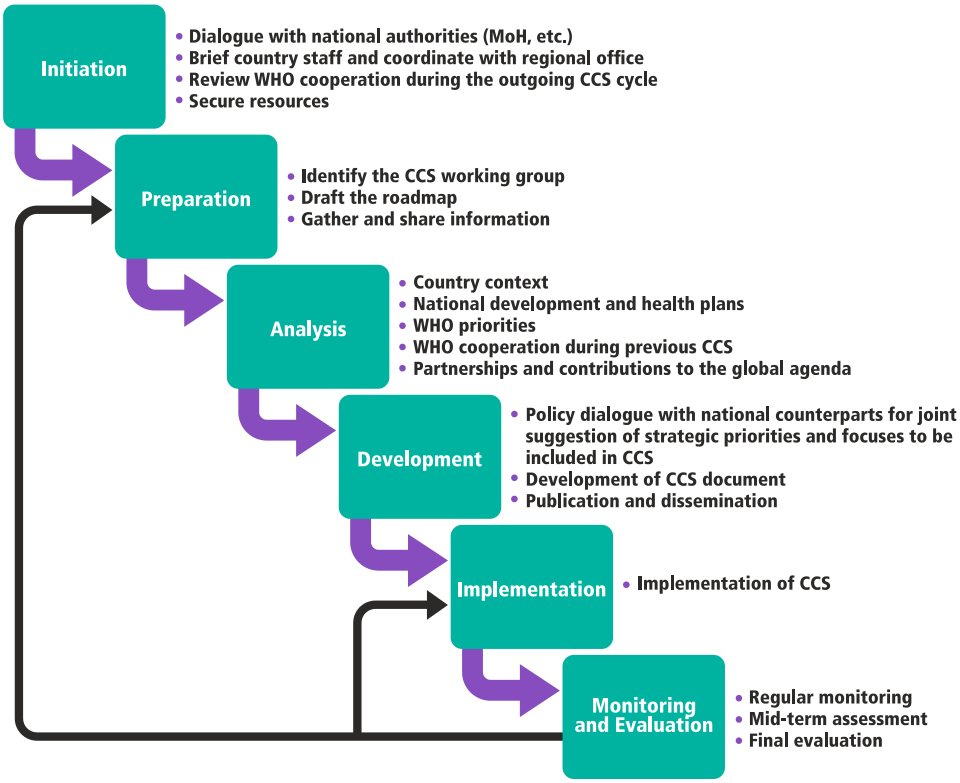
Part 2. The CCS process

2.1 An overview of the CCS process

CCS formulation, implementation and monitoring are corporate processes, involving the three levels of the Organization.

Figure 2 below presents the major steps in the CCS process. A more detailed description is provided in Annex 2.

Figure 2. The CCS development and renewal process



These processes are adaptable to different country contexts. See Annexes 1 and 17 for specific guidance on developing a CCS in countries in fragile situations (emergencies, recurrent disasters, humanitarian crises, post-conflict, early recovery and transition).

At the country level, CCS development involves extensive consultations between WHO, the government (health and health-related ministries) and partners (bilateral and multilateral agencies, civil society organizations (CSOs), nongovernmental organization (NGOs), academic institutions, WHO collaborating centres and the private sector).

The process should ensure that women and men representing socially excluded or disadvantaged groups, as well as gender and human rights organizations, are also included in the consultation process (see Annex 3).

In countries affected by conflict or protracted emergencies, humanitarian stakeholders and United Nations peacekeeping operations should be involved to create connections between development and humanitarian programming where required.

The key players in the CCS process

- **Government:** The ministry of health (MoH) and other ministries ensure national ownership, relevance and sustainability. They participate in and support the process as well as the monitoring of its implementation. They also endorse and sign the CCS.
- **Three levels of the WHO Secretariat**
  - **Country level:** The HWO leads the CCS process, exercising quality control, with the support of the country office staff and technical backstopping from the RO and HQ.
  - **Regional level:** The responsible unit in the RO provides support, oversight and quality control, to ensure timely initiation and an analytical, holistic, whole-of-Organization approach to the process, including backstopping missions when necessary. The RO reviews drafts of the document and facilitates inputs from the technical programmes at the regional level. In countries where WHO does not have a physical presence, the RO leads the development of the CCS.
  - **Headquarters:** CCU at HQ provides additional technical support and quality control, ensures a corporate, whole-of-Organization approach, reviews drafts of the document and facilitates inputs from the technical programmes.

United Nations system and partners: The UNDG core principles of collaboration for "delivering together" in support of the 2030 Agenda help the CCS process and WHO's collaboration with the United Nations system and other development partners to work towards the national SDG targets.

Signing and launching the CCS

The finalized CCS is endorsed at the RO and HQ levels to become the Organization-wide reference for WHO's work in the country. Modalities for signing and launching the CCS are flexible, the decision being taken by the country offices and ROs. Options have included: signing by the regional director, or co-signing by the minister of health and the HWO, or the regional director and/or WHO Director-General. The trend is towards co-signing to encourage joint ownership of the CCS process.

The CCS document and CCS brief, developed after clearance (see Annex 4), are disseminated across the Secretariat and among partners on the Internet and in hard copy.

2.2 Quick update of the CCS Strategic Agenda

Countries with an expired CCS or one which needs a "mid-course correction" may elect to update strategic priorities and focus areas if they are not in a position to undertake a full CCS renewal.

A CCS should be updated if changes are needed to respond to:

- results and recommendations from the CCS mid-term assessment (see Chapter 5 in Part 3, below);
- changes in the NHPSP;

- country-level action to take forward the SDG agenda – all WHO country offices should align the agreed CCS strategic priorities and focus areas with the national health-related SDG targets (see Annex 15). This ensures the relevance of the CCS to the NHPSP as well as with the mainstreamed national SDGs and other country-level actions.
- the requirement to inform and better position the CCS, in order to influence the PB bottom-up priority-setting process and operationalization during the PB development cycle; and
- the new generation of UNDAFs that support national efforts to implement the SDGs and inform country-level interventions by the United Nations country teams.

Methodology for updating the Strategic Agenda

The HWO leads the process of updating the CCS Strategic Agenda.

- Rapid assessment: the in-depth critical analysis described in Chapter 2 of the CCS document (see Part 3, below) is not expected in updating the Strategic Agenda. A rapid assessment of the current CCS strategic priorities and focus areas is sufficient to: (i) identify major health challenges, risks and gaps not addressed; (ii) determine the continued relevance of the priorities and focus areas to the NHPSP, as well as country-level actions to take forward the SDG agenda, including mainstreaming SDG targets into the NHPSP; and (iii) suggest necessary revisions.

  For countries in fragile situations which are in a position to update the CCS, the rapid assessment should include an analysis of the fragility characteristics (see Annex 1).

  If the Strategic Agenda is being updated during the PB development process, the rapid assessment should ideally be done together with the situation analysis and bottom-up planning for the PB. However, if the country office is not in a position to update the CCS during the PB development process, the PB situation analysis should inform or substitute for the CCS rapid assessment.
- Review of the CCS Strategic Agenda in the context of SDGs – the key issues raised in the checklist in Annex 16 should be addressed in reviewing the CCS strategic priorities and focus areas to determine whether they require updating.
  - **Countries with national sustainable development priorities** – CCS priorities and focus areas should be revised to contribute to and support implementation of these priorities.
  - **Countries that have not yet addressed the SDGs** – the WHO country team should advocate for national adaptation of the SDGs and integration of national sustainable development priorities into the NHPSP and the revised CCS priorities and focus areas.
  - **Countries in fragile situations** may require special support from the country support and planning networks in defining how WHO will provide support.

To maximize the effectiveness of WHO's efforts, technical cooperation with countries should be strategic. Limiting the number of CCS strategic priorities to a maximum of five and focus areas to a maximum of three for each strategic priority will ensure greater focus (Annex 12).

PART 3.

The core features of a CCS document

Part 3. The core features of a CCS document

The two tangible products of the CCS process are:

- the main CCS document that includes the Strategic Agenda mapped against the NHPSP priorities, GPW outcomes, national SDG targets and the UNDAF outcomes; and
- the "CCS at a glance" brief – a two-page summary that communicates the essence of the CCS. The brief should be updated as warranted during the CCS cycle (see Annex 4).

The CCS document should be concise, ideally no more than 30 pages.

Specific guidance is provided in Annexes 1 and 17 for developing a CCS for countries in fragile situations.

Structure of the CCS document

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The Toolbox – Annexes

Executive summary

Suggested length: 1–1.5 pages

- Highlights the country's main health priorities and achievements;
- Captures the focus areas of the CCS consultation process; and
- Summarizes the Strategic Agenda for WHO cooperation.

Chapter 1 • Introduction

Suggested length: 1–1.5 pages

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

- An overview of the WHO policy framework: the GPW, as well as regional and subregional priorities;
- The country context, choices made, timing of the CCS, and the process, including composition of the team, people met and key actions undertaken.

Chapter 2 • Health and development situation

Suggested length: 8–12 pages

This chapter provides a strategic overview of current and anticipated health and development issues that affect the achievement of NHPSP priorities and country-level actions to take forward the health-related SDGs. It provides the issue and evidence base to guide the selection of strategic priorities and focus areas in Chapter 3.

To maintain the strategic nature of the analysis, the focus should be on key issues and challenges affecting the NHPSP and SDGs rather than a broad discussion of every issue affecting the health and related sectors.

In providing a clear and concise statement of key issues and challenges, references can be made to more detailed analytical documents (e.g. Common Country Assessment (CCA) documents, national studies and analyses, academic papers, etc.).

The chapter comprises the following subsections:

2.1 Political, social and macroeconomic context

This section provides a brief description of the political, social and macroeconomic context of the country.

2.2 Health status (burden of disease)

This section analyses the health status of the population, including population health risks and root causes of vulnerability. Trend analysis and projections of burden of disease[1] are encouraged to show progress, remaining and future challenges. Disaggregation by sex and other variables should be used to highlight health-related human rights and gender issues, ensuring that vulnerable populations are not left behind.

A list of essential indicators using statistics from the Global Health Observatory[2] (GHO) as well as graphics to summarize the information should be included (see Annex 5). Significant differences (if any) between GHO data and other sources (i.e. national data), should be noted and sources of information acknowledged.

2.3 Health system response

This section will provide a brief description and analysis of the national health system, in terms of health governance and existing health policies (e.g. on UHC), of health services (public and private), and health resources (human, physical and financial (i.e. public/private domestic sources of revenue including insurance schemes, as well as international sources of finance), programmes of local and international organizations (United Nations, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Gavi (the Vaccine Alliance), bilateral cooperation, philanthropic organizations, NGOs, CSOs, etc.). It should take into account the six building blocks of health systems,[3] focusing on how they address the current and future challenges identified in the subsection on health status and their ability to do so (see Annex 6).

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1 For examples of health situation and trend assessment methods and tools, see http://www.who.int/healthinfo/tools_data_analysis/en/

2 The use of national rather than GHO data should be noted and the source indicated.

3 For criteria for assessing country systems performance, see Monitoring the building blocks of health systems (Geneva: World Health Organization; 2010), Section 3: http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_section3_web.pdf.

An analysis of the capacity of the national health information system and national statistical offices to collect, analyse and report using disaggregated, high-quality health data[1] should be included.

2.4 Cross-cutting issues (equity – "leaving no one behind", gender, human rights, etc.)

An analysis of cross-cutting issues within the broad framework of the NHPSP and the health-related targets under all SDGs (see Annexes 2 and 7) is essential, with a focus on cross-cutting issues that underlie or affect efforts to address the challenges identified in the subsections on health status and health system response.

2.5 Development partners' environment

2.5.1 Partnership and development cooperation – An analysis of the existing and projected roles of all current and potential partners[2] (see Annex 8) for addressing health status and health system challenges and advancing NHPSP priorities and health-related SDGs should be presented in terms of:

- type of relationship with WHO;
- respective mandate, mission or purpose in supporting the government's health and development priorities; and
- respective capacity for decision-making or influencing decision-making in supporting the government's health and development priorities.

A stakeholder mapping should be included in the CCS annexes (see Annex 9).

2.5.2 Collaboration with the United Nations system at country level – This section presents the collaboration of WHO within the United Nations country team. In analysing WHO collaboration, two issues should be considered:

a. How WHO utilizes the expertise of other United Nations agencies in the country[3] to leverage:
   - its convening and coordinating role among partners in health especially in relation to health-related SDG targets;
   - its support to other line ministries important for health outcomes in aligning the work of partners around national priorities and SDG targets; and
   - the communication channels of other United Nations agencies with different ministries to facilitate a whole-of-government approach to addressing health challenges.

b. The relationship between the CCS, CCA and UNDAF – The CCS and the health dimension of the UNDAF, which is developed based on the SDGs, should be harmonized and mutually reinforcing. The health situation analysis of the CCS should inform the CCA and UNDAF and vice versa (Annex 8).

2.5.3 Country contributions to the global health agenda (internationally agreed goals and commitments in regard to global health as embodied in the SDGs) - This subsection is relevant to those countries, generally high-income countries, whose CCSs detail their cooperation with WHO for mutually beneficial collaboration to advance health regionally and globally. It analyses country efforts to be engaged and lead on specific health-related issues at regional or global levels through bi- and multilateral processes (Annex 10).

[1] For criteria for assessing country health information systems performance, see http://www.who.int/healthinfo/tools_data_analysis/en/

[2] Bilateral and multilateral agencies, global health initiatives and international financial institutions, CSOs and NGOs, community groups, academic institutions, WHO collaborating centres, the private sector, and others as appropriate.

[3] In countries with emergencies, there is often a Humanitarian Country Team, led by a Humanitarian Coordinator, in which the HWO participates. For examples of issues to consider in analysing the leveraging of Humanitarian Country Team expertise, see Annex 8.

2.6 Review of WHO's cooperation over the past CCS cycle

This section discusses the implications of recommendations and lessons learnt from the evaluation of WHO's cooperation with the country in the past CCS for the choice of strategic priorities and focuses in Chapter 3.

Chapter 3 • Setting the Strategic Agenda for WHO cooperation

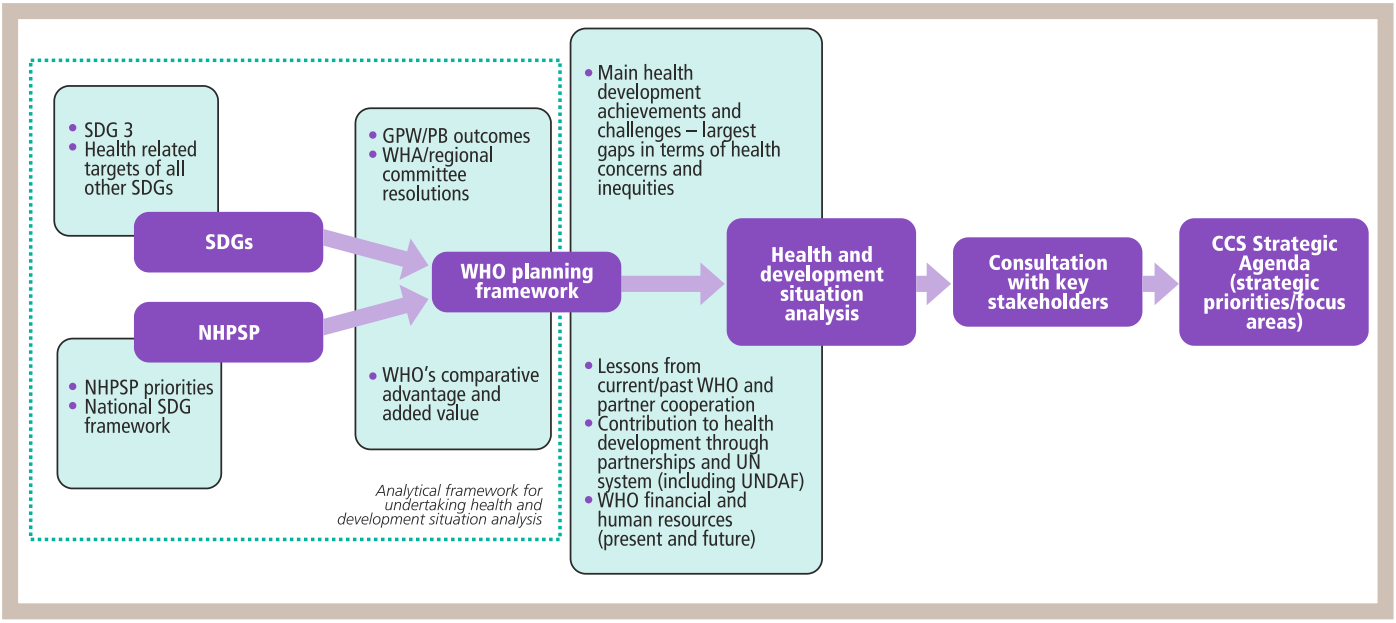
Suggested length: 8–10 pages

The Strategic Agenda is a set of strategic priorities and focus areas for WHO's cooperation with the country to support the NHPSP that is fully aligned with the health-related SDGs. It is based on the analysis in Chapter 2. The Agenda is selected in consultation with the government at the highest level and with partners, especially other United Nations agencies, and jointly agreed with national authorities.

The CCS strategic priorities (maximum of five) constitute the medium-term priorities for WHO's cooperation with the country on which WHO will concentrate the majority (at least 80%) of its resources over the CCS cycle. Each strategic priority contributes to achieving at least one NHPSP priority as well as national health-related SDG targets. The strategic priorities convey the objective of WHO's technical cooperation. Each strategic priority is of equal importance. Their achievement is the joint responsibility of the government and WHO.

The CCS focus areas (maximum of three under each strategic priority) are the "what", reflecting the expected achievements required to realize the CCS strategic priority. Each focus area is of equal importance. They should adopt the SMART format (specific, measurable, achievable, realistic and time-bound). Figure 3 illustrates how the SDGs and NHPSPs and other elements feed into the Strategic Agenda.

***Figure 3.** How elements are employed in the selection of the CCS strategic priorities*



In formulating the Strategic Agenda, it is important to consider:

- the universality of the SDGs and their strong emphasis on equality or "leaving no one behind";
- promoting an intersectoral approach to health, recognizing that health is an important element not only in SDG 3 but in all the SDGs;
- linking with the UNDAF strategic priorities to ensure a more integrated, coordinated and coherent support by the United Nations to countries in the post-2015 era.

Gender and human rights should be mainstreamed into the strategic priorities and focus areas.

Annex 11 provides an example of a priority-setting methodology and decision matrix and issues to consider for selecting from potential strategic priorities and focus areas.

Table 1. An example of a strategic priority within the Strategic Agenda

Strategic priority 1:	**Achieving and sustaining UHC through a revitalized primary health care approach and sustainable service delivery through strengthening of health systems.**
Focus area 1.1:	Strengthened health systems capacity through human resources development, improved health information systems, effective procurement and supply management, and improved regulatory mechanisms and quality assurance of health services.
Focus area 1.2:	Costing and economic analysis and sharing of best international practices in financing health services, based on principles of universal access and equity.
Focus area 1.3:	Increased availability of quality-assured essential medicines and appropriate health technologies.

Each CCS focus area should link directly with at least one NHPSP priority, GPW outcome, health or health-related national SDG target, and UNDAF outcome as shown in Table 2.

Table 2. Validation matrix aligning CCS strategic priorities with national, WHO, United Nations and global priorities

Strategic priorities	Focus areas	NHPSP priorities	GPW outcomes	SDG targets	UNDAF outcomes	Remarks
Strategic priority 1	Focus area 1.1					
	Focus area 1.2					
	Focus area 1.3					
Strategic priority 2	Focus area 2.1					
	Focus area 2.2					
	Focus area 2.3					
Strategic priority 3	Focus area 3.1					
	Focus area 3.2					
	Focus area 3.3					

Formulating a CCS for countries in fragile situations

In countries in fragile situations, the context is more dynamic. The Strategic Agenda will usually have a shorter time frame to address the immediate, priority health-related humanitarian and development needs of the country, based on vulnerability and risk assessments and WHO's functions in emergency situations.

CCSs in countries in fragile situations and disaster-prone countries should include strategic priorities to cover unforeseen acute events or escalation of an ongoing conflict that may require emergency action, including disease outbreaks and natural or human-induced disasters (Annexes 1 and 17).

Formulating a CCS to advance regional and global health agendas

Beyond detailing WHO cooperation with the country, CCSs (particularly in high-income countries) might also identify the country's areas of expertise and resources that may complement those of WHO, and adopt a Strategic Agenda of mutually beneficial collaboration to advance the health agenda in third countries, regionally and globally.

Chapter 4 • Implementing the Strategic Agenda: implications for the Secretariat

Suggested length: 2–3 pages

The CCS Strategic Agenda informs and is implemented through the PB workplans, human resources plan[1] and, if indicated, reprofiling (i.e. changing the skill mix of the country team). If the workplan is already in place, programme changes should be made to ensure consistency between the two.

Once the draft Strategic Agenda has been validated by completing Table 2, the team should consider its implications for the biennial workplan and HR plan.

- Does the country office have the core capacity (in terms of infrastructure, human and financial resources) and other resources needed to implement the Strategic Agenda? If not, what are the implications for the Secretariat to fill the gaps in terms of priority-setting, programming and accountability?
- What shifts will the country office make in its programmatic focus and what broad changes will be made in the skills mix of the country team?
- What partnership support will the country office require to achieve the strategic priorities?

The team should analyse WHO resources at the subregional, regional and global levels and consider resources of other countries, to take advantage of South–South and triangular cooperation opportunities.

The CCS implementation plan should also include an office risk management strategy with measures such as readiness and business continuity plans to address internal and external risks to WHO operations, e.g. financial, security and natural hazards.[2]

[1] Used to plan the positions required by each budget centre to implement the PB; it holds the approved position list of a budget centre, linked, through the salary workplan, to the results to which the staff contribute. Once approved, the HR plan constitutes the authority to staff the budget centre accordingly.

[2] For examples of risk management strategies, see http://www.who.int/management/general/risk/en/

Chapter 5 • Monitoring and evaluation of the CCS

Suggested length: 2–3 pages

This chapter describes:

- how the CCS will be monitored and evaluated during implementation and at the end of the CCS cycle; and
- how the lessons learnt and recommendations from the final evaluation will be shared within WHO and with the government, national stakeholders and development partners.

5.1 Participation in CCS monitoring and evaluation

The country office – under the leadership of the HWO, with the support of the RO and HQ, and with the full participation of and in coordination with the MoH, health-related ministries, national stakeholders and other partners that participated in the CCS formulation – should monitor and evaluate the CCS. This is the first step towards assessing WHO's performance in countries.

5.2 Timing

The CCS is monitored regularly during implementation, evaluated halfway into, and again near the end of, the CCS cycle, coinciding with other national review processes. These exercises should be linked with the biennial workplan, monitoring and assessment of the UNDAF, where feasible.

5.3 Evaluation methodology[1]

The evaluation process is led by the HWO. The HWO designates a CCS evaluation working group drawn from country staff. A consultant may be included and other stakeholders involved, especially in the final evaluation. At the discretion of the HWO, the final evaluation may be undertaken using external evaluators.

5.3.1 Regular monitoring

The focus of regular monitoring is to continuously review whether:

- the CCS priorities and strategic focus areas are reflected in the country's WHO biennial workplan and how priorities and strategies are being carried out; and
- the core staff of the country office have the appropriate core competencies for delivering results in the focus areas.

Regular monitoring is an early warning system to alert the HWO to the need to refocus the biennial workplans and adjust as feasible country office staffing patterns or seek additional technical support through contracting mechanisms or from the RO or HQ.

The specific monitoring framework should be harmonized with other monitoring and evaluation processes.

[1] Guided by the WHO Evaluation practice handbook. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/96311/1/9789241548687_eng.pdf), OECD/DAC criteria for evaluating development assistance (http://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm) and MOPAN 3.0 (http://www.mopanonline.org/GenericPages/Mopan%20Methodology%20Digest%20[4].pdf).

5.3.2 Mid-term evaluation

The focus of the mid-term evaluation is:

- to determine the progress in focus areas (whether the expected achievement(s) is/are on track);
- to identify impediments and potential risks that may require changes to the strategic priorities or focus areas; and
- to identify actions required to improve progress during the second half of the CCS cycle.

The mid-term evaluation is a risk management tool to alert the country office to focus areas that might require special attention, corrective action (including revised guidance for country-level programme budget and resource allocation), or revision of the strategic priorities to which they contribute.

A major emergency or significant change to the country context may require review, revision and renewal of the CCS.

The specific framework for the mid-term evaluation should be harmonized with other monitoring and evaluation processes. Examples of questions to guide the mid-term assessment, based on the Multilateral Organisation Performance Assessment Network (MOPAN) performance assessment criteria,[1] and a sample recommendations template are provided in Annex 13.

5.3.3 Final evaluation

The final evaluation is a more comprehensive assessment than the mid-term review. The focus is:

- to measure the achievement of selected national SDG targets linked to the CCS Strategic Agenda;
- to identify achievements and gaps in implementing the CCS Strategic Agenda and in relation to the MOPAN performance areas (example evaluation questions are provided in Annex 14);
- to determine the extent to which the CCS strategic priorities were incorporated into or influenced the NHPSP and UNDAF and affected the work in country of other development partners towards achieving the SDGs;
- to identify the critical success factors and impediments; and
- to identify the lessons to be applied in the next CCS cycle.

  The final evaluation document should describe the achievements, gaps, challenges, lessons learnt and recommendations.

  The framework for the final evaluation should be harmonized with other monitoring and evaluation processes, such as the UNDAF evaluation.

  The draft document should be shared for comments with the RO and HQ.

  Lessons learnt from CCS evaluations should be shared with other countries, particularly similar countries belonging to, for example, the same country income groups (according to the World Bank classification), within the Secretariat, and with the government and other partners.

[1] Performance areas and performance indicator questions derived from MOPAN 3.0 Generic Indicator Framework (http://www.mopanonline.org/GenericPages/Mopan%20Methodology%20Digest%20[4].pdf).

The Tool box

ANNEXES

The Toolbox – Annexes

Annex 1: Guidance for developing a CCS in countries in fragile situations

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Annex 3: Integrating essential gender, health equity and human rights criteria into the CCS process and document

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Annex 13: Example of a framework for the CCS mid-term evaluation

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Annex 15: Mapping health-related SDG targets against GPW outcomes and WHO PB programme areas

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Annex 17: Guidance for integrating health emergency risk assessment, capacity assessment on emergency risk management for health, and WHO readiness for emergency response into a CCS

Annex 18: Examples of questions related to the SDGS to guide the health situation analysis

Annex 19: CCS clearance process and use of CCS document

Annex 1 – Guidance for developing a CCS in countries in fragile situations

This document provides complementary guidance to WHO CCS teams to develop more responsive and effective CCSs in countries in fragile situations.[1]

1. Defining and analysing fragility

Countries are defined 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".[2] Countries labelled as fragile are heterogeneous and the modalities for interventions need to be adapted to each context, and as situations are often highly dynamic, adapted over time. Countries in fragile situations could be in post-conflict, early recovery, or transition, or faced with recurrent disasters and humanitarian crises, or these different contexts of fragility might exist simultaneously.

2. Characteristics of fragile situations and justification for adapting the CCS

Countries in fragile situations are often characterized by excess mortality and morbidity, crisis-associated disabilities, malnutrition, reduced access to essential life-saving services, and poorly performing health systems in resource-poor and often unstable settings. Many of these countries did not achieve the health-related MDGs, and they are at high risk of not achieving the SDGs. These countries are also at high risk for epidemics and affected by the majority of endemic diseases.

Examples of fragility aspects to consider when developing the CCS include the following:

- Pervasive security problems can lead to restrictions on United Nations staffing or staff movements in country, and result in "remote controlled" programme management.
- Widespread human rights violations, including effects on the right to health and possible exacerbation of pre-existing inequities, such as deliberately excluded or marginalized groups.
- Principles of medical neutrality may be violated. Health facilities, health workers and patients may become targets, or health-care providers may participate in the human rights violations.
- There may be a need to engage in areas that are not under government control, and to adapt approaches to the differences that may exist between regions in the country.

3. Adapted CCS process with countries in fragile situations

a. Preparation

- Composition of the CCS team – One of the team members should have an understanding of the political context and expertise on health systems in countries in fragile situations.

[1] For a list of countries in fragile situations see the World Bank Group's "Harmonized List of Fragile Situations" (http://pubdocs.worldbank.org/pubdocs/publicdoc/2015/7/700521437416355449/FCSlist-FY16-Final-712015.pdf).

[2] Zaidi, N. The fragility of states. Dawn.com. 29 January 2012 (http://dawn.com/2012/01/30/the-fragility-of-states/).

- Choosing appropriate timing and time frame for the CCS – To take into account specific planning cycles linked to fragility and transition planning processes.
- Security briefing – 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 – To undertake a wide consultation, including with humanitarian stakeholders, and engagement with the Humanitarian Country Team, ensuring representation of views of various parties to the conflict.
- Scenario, situation and fragility analysis – To use existing sources to understand the underlying causes of fragility and the political context, country capacity and its resilience, and possible scenarios. And to understand how these may affect health and the health sector.[1]

b. Development

- Conflicts may last decades and even transition periods may take 15 years or more. Therefore, a strategy should take a long-term view, while aiming for short-term, realistic steps.

c. Implementation

- The implementation of the CCS Strategic Agenda may be affected by changes in the country. Emerging from fragility is often not a linear process and implementation of any strategy can therefore face unexpected setbacks when, for example, a conflict (re)escalates.

d. Monitoring and evaluation of the CCS

- The possible shorter time frame, and the frequent significant changes in the context, may call for a shorter period for reviews and the necessary revisions after such reviews.

4. Checklist of the CCS document for countries in fragile situations

The section below shows how and where aspects of fragility can be considered in a CCS.

Chapter 2: Health and development situation

2.1 Political, social and macroeconomic context

- Summary of the context, conflict and/or fragility analyses, scenarios and evolution.

2.2 Health status (burden of disease)

- Analysis of the effects of fragility on the health status of the population, including trends 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 (NCDs).

[1] For example, context and conflict analyses are made by 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/) and the "new deal for peace" initiative (http://www.newdeal4peace.org/new-deal-pilots). For guidance on analysing disrupted health sectors, see http://www.who.int/hac/techguidance/tools/disrupted sectors/en/index.html.

2.3 Health system response

- Analysis of the effects of fragility on:
  - Service delivery – e.g. damaged health infrastructure; unequal access to health services; effects on health-related SDGs.
  - Governance – e.g. interruption of policy process and sector coordination with weak steering role of the (interim) national and subnational health authorities. The multiplicity of actors with diverse agendas may undermine the governance role of the national health authorities and can lead to fragmentation and/or inappropriate policy transfer.
  - Health information system – e.g. fragmented, with challenges faced in validating existing data sets.
  - Human resources for health – e.g. loss of staff, unequal distribution of human resources, untrained staff or uncertified training by various NGOs, task shifting, or diaspora returning.
  - Health financing – e.g. weak financial management capacity and high dependence on external assistance. Additional humanitarian, transition or peace-building funds may be required.
  - Pharmaceutical products – e.g. national production and distribution may be interrupted; absence of regulation for the importation and quality standards for pharmaceutical products.

2.4 Cross-cutting issues (equity – "leaving no one behind", gender, human rights, etc.)

- Analysis of the effects of fragility on determinants of health, including inequity and gender-based violence.

2.5 Collaboration with the United Nations and other partners

- Analysis should be undertaken in regard to the following:
  - The "New Deal" for engagement with countries in fragile situations.[1] The principles of the "New Deal" are reinforced by the call by the United Nations Secretary-General for United Nations support for the "New Deal" in 2012.[2] See also the OECD "Principles for good international engagement in states in fragile situations".[3]
  - The presence of a Humanitarian Coordinator and Humanitarian Country Team, and the role of WHO as Health Cluster lead agency. There may be a regional interagency coordination mechanism outside the country, including coordination for multiple countries affected by the same conflict.

[1] The "New Deal" (signed by more than 40 countries and organizations at the Fourth High Level Forum on Aid Effectiveness in 2011 in Busan, Republic of Korea) 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 United Nations engagement in most countries affected by conflict and crisis. See also http://www.g7plus.org/new-deal-document/

[2] See document A/67/499–S/2012/746.

[3] Conflict, fragility and resilience. In: Development Co-operation Directorate (DCD-DAC) [website]. Paris: Organisation for Economic Co-operation and Development; 2007 (http://www.oecd.org/dacfragilestates/).

- There may be an integrated United Nations presence, including a United Nations peacekeeping or political mission. In principle, there needs to be a clear separation between the peacekeeping and humanitarian mandates. However, in many situations an integrated strategic framework is developed between all United Nations actors (development, humanitarian, peacekeeping).
- Conflict-related recovery planning mechanisms, for example the post-conflict needs assessment supported by the World Bank, the European Commission and the United Nations.
- Contributions of the country to the global health agenda. For example, global health initiatives such as Gavi, the Vaccine Alliance, and the GFATM have strategies adapted to fragile situations; global eradication or elimination programmes often face difficulties in achieving effective implementation and coverage in countries in such situations.

2.6 Review of WHO's cooperation over the past CCS cycle

- Critical analysis of the implications of recommendations and lessons learnt from the evaluation of activities by WHO and other actors and stakeholders to address the consequences of fragility for health-related sectors and how the principles of engagement with countries in fragile situations were taken into account.

Chapter 3: Setting the Strategic Agenda for WHO cooperation

The Strategic Agenda must be responsive to the characteristics of fragility identified in the country, and anticipate changes. The Strategic Agenda will usually have a shorter time frame as the context is more dynamic, and strategic priorities should cover unforeseen acute events or escalation of an ongoing conflict that may require emergency action, including disease outbreaks and natural or man-made disasters. The team must consider the potential role of the health-related sectors and social services in state- and peace-building, and focus on scaling up coverage and quality of service delivery, seeking multiple channels for implementation adapted to the context.

Chapter 4: 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 document that provides guidance on WHO country office structures during emergencies.[1] A similar framework will be finalized in 2016 to guide the work of WHO in countries with protracted emergencies.

[1] http://www.who.int/hac/about/en/

Annex 2 – Detailed description of the process of formulating and evaluating a CCS

Phase	When?[1]	Who?	What?
Initiation			
Initiate the CCS	According to the national planning cycle with the initiation phase beginning [2] months before the preparation phase	HWO leads the process, with country office staff. The regional CSU supports. A focal point from HQ supports the process.	■ Dialogue with national authorities (MoH and other relevant ministries) on the CCS cycle, the intended renewal, and the appropriate timing, taking into consideration key national processes such as renewal of NHPSP, UNDAF, etc. If needed, request support from the RO to advocate for the development of the CCS; ■ Determine whether there is an existing CCS or other planning tools upon which to base the future CCS. Put in place a review of WHO cooperation during the outgoing CCS cycle; ■ Brief the entire country office team on CCS principles, content, process and other key issues (in a half-day internal training session where possible) and inform the RO of how the CCS development/renewal process will be initiated; ■ Identify key documents, such as GPW, NHPSP, documents that indicate country-level actions to take forward the SDGs, and previous CCSs; ■ Ensure that there are sufficient resources for the CCS process, request support from RO and HQ (training or other).
Preparation			
Identify the CCS working group (WG)	Month 0	The HWO leads the process, with country office staff, national counterparts, members of United Nations agencies and other stakeholders. All country office staff participate, though not all staff form part of the WG. A regional CSU focal point supports the process. For countries without HWOs, the WG is organized by the region. A CCU resource person from HQ supports the process.	■ Ensure a balanced team that represents a broad range of stakeholders. A maximum of eight CCS WG[2] members is recommended, one of whom has the appropriate competence in health diplomacy and an understanding of the political context. Appoint a person to take charge of logistics; ■ In countries in fragile situations, and/or disaster-prone countries, ensure that 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 in fragile situations (see Annex 1), and/or humanitarian issues (see Annex 17). Note: A consultant may be appointed for information gathering and drafting but it is essential that the critical analysis and elaboration of strategic priorities be done by the CCS WG.
Draft the roadmap	Month 1	CCS WG	The roadmap lays out: ■ Timing of the CCS process; ■ Roles and responsibilities of WHO and partners; ■ Support required from the RO and HQ; and ■ Costs.

[1] The time frames for initiating the CCS and for each phase of the process are suggestions based on experiences to date. The country will determine its specific time frames for each phase of the process.

[2] To ensure adequate representation and balance among the technical programmes, the Regional Office for Africa and the Regional Office for the Western Pacific include representatives from each cluster in the CCS WG.

Gather and share information among CCS WG members	Month 1	CCS WG	CCS WG collects and shares: ■ National development policies and country-level actions to take forward the SDGs; ■ Health policies, strategies and plans; ■ Annual reports, vital statistics and surveys; ■ External reports on the country, its vulnerable populations, gender, health equity and human rights, International Health Partnership (IHP+) reports; fragility or conflict analyses, all-hazard health emergency risk assessment (refer to Annex 17); ■ Information on regional and global programmatic directions/priorities; ■ International agreements and mandates ratified and/or signed by the country; ■ UNDAF, Integrated Strategic Framework (if relevant) and workplans of relevant United Nations Country Team (UNCT) results/thematic groups; and ■ The final evaluation of the previous CCS.
Analysis[3]			
Country context	Months 2–3	CCS WG	Analyse: ■ Main achievements; ■ Areas to be strengthened; ■ Challenges and gaps, including vulnerable populations; ■ Socio-political situation (for countries in fragile situations see Annex 1); and ■ Emergency and disaster risks to public health and health systems (see Annex 17)
National development and health plan	Months 2–3	CCS WG	Analyse national development and health policies, plans and strategies, including those in health-related sectors, and country-level actions to take forward the SDGs, to determine: ■ Coherence of strategies and plans according to the health situation analysis; ■ Inclusiveness and degree of ownership of the development process; and engagement with all coordinating mechanisms relevant to health; ■ Inclusion of health emergency risk management capacities, including International Health Regulations (2005) (IHR) core capacities; and ■ Inclusion of financing, implementation and management arrangements (including monitoring and reviewing mechanisms). (See Annex 18)

[3] When the formulation of the CCS coincides with the PB bottom-up planning process, the CCS analysis should ideally be done together with the situation analysis for the PB's identification of priorities for WHO technical cooperation at the country level".

WHO priorities	Months 2–3	CCS WG	Analysis of achievements, progress and challenges in relation to WHO priorities, e.g. those identified in the GPW, World Health Assembly and regional committees, etc.
WHO cooperation during previous CCS	Months 2–3	CCS WG with active involvement of partners and all country office team	This involves external and internal reviews where both partners and country office team assess: ■ Degree of implementation of CCS strategic priorities; ■ Resource allocation to the CCS strategic priorities; WHO's contribution to achieving WHO priorities and the national health objectives; and ■ Engagement with the United Nations. (See "monitoring and evaluation" phase, below)
Partnerships and contribution to the global health agenda	Months 2–3	CCS WG	Analyse: ■ Health dimensions of the UNDAF, SDGs and other international platforms (e.g. Busan Partnership for Effective Development Cooperation, Sendai Framework for Disaster Risk Reduction); and ■ The country's contribution to the wider global health agenda.
Development			
Dialogue with RO on potential strategic priorities and focus areas	Months 3-4	CCS WG, regional CCU, RO technical programmes	Dialogue aims to refine potential strategic priorities and focus areas based on situation analysis and technical office input.
Policy dialogue with national counterparts to jointly suggest strategic priorities and focus areas	Months 3–4	CCS WG, with active role of HWO and national counterparts	Taking into consideration the critical analysis of previous steps, the dialogue with Regional office and WHO's comparative advantage and added value, the dialogue aims to: ■ Suggest from among potential CCS strategic priorities and focus areas those to be included in the CCS; and ■ Ensure buy-in from national counterparts.
Development of CCS	Months 4–5	CCS WG, plus HWO, national counterparts, RO, HQ	■ Draft the document; ■ Identify resources and partnerships to implement the CCS; ■ Share the draft document with national authorities and other stakeholders; ■ Ensure clearance from MoH and other relevant ministries, RO and HQ (see Annex 19); and ■ Sign and launch the CCS (Director-General and/or regional director where feasible; HWO and minister of health and other relevant ministers).

Publication and dissemination	Months 5–6	CCS WG, plus HWO, WHO national counterparts, RO and HQ	■ Country office and national counterparts share the CCS widely at country level; ■ Publish the CCS in the Institutional Repository for Information Sharing (IRIS) and on the country office and RO websites and www.who.int, and where feasible the MoH website.
Implementation			
Implementation of CCS	Flexible to align with national planning cycles UNDAF, or to allow for the changing conditions confronting countries in fragile situations	HWO and country office staff (lead) RO and HQ (contribute and support)	■ The CCS is an endorsement by the entire Secretariat of the commitment to pursue the Strategic Agenda in the country (the RO and HQ inform the technical units of the CCS for country missions); ■ The CCS informs the biennial PB, country workplan and human resources plan,[1] which, along with the UNDAF, become the "roadmap" for implementing the CCS; ■ The CCS informs the UNDAF in countries that have adopted Delivering as One (DaO) as well as in other countries.
Monitoring and evaluation[2]			
Regular monitoring	Frequency determined by HWO	CCS WG, plus HWO	Monitor: ■ The country's WHO biennial workplans against the CCS Strategic Agenda to ensure consistency; and ■ Core capacity of the country office against the CCS strategic priorities to ensure consistency.
Mid-term evaluation	Year 2 or 3	HWO and country office; focal point from regional CSU; CCU focal point from HQ	Assess: ■ Process and degree of implementation of the CCS strategic focus areas; ■ WHO's engagement with the United Nations system; ■ Changes in the country's context. According to results and context, consider changes in strategic priorities, focus areas and workplans (see Annex 13).
Final evaluation	Year 4 or 6	HWO and country office; focal point from regional CSU; CCU focal point from HQ	Assess: ■ The achievement of selected national SDG targets linked to the CCS Strategic Agenda: ■ To identify the main achievements and gaps in implementing the CCS Strategic Agenda in terms of its content and in relation to the MOPAN performance areas;[3] ■ To identify the critical success factors and impediments; and ■ To identify the principal lessons to be applied in the next CCS cycle. (See Annex 14) Note: Should be guided by the WHO evaluation practice handbook and MOPAN 3.0. Ideally, partners should be involved in the process.

[1] Used to plan the positions required to implement the workplan; it holds the approved position list ("staffing profile") of a budget centre, linked, through the salary workplan, to the results to which the staff contribute. Once approved, the HR plan constitutes the authority to staff the country office/budget centre accordingly.

[2] The specific monitoring and evaluation frameworks should be harmonized with other monitoring and evaluation processes.

[3] Strategic management – clear strategic direction geared to key functions, intended results and relevant priorities: Operational management – assets and capacities organized behind strategic directions and intended results; Relationship management – engaging in inclusive partnerships to support relevance, leverage effective solutions and to maximize results; and Results – achievement of relevant, inclusive and sustainable contribution to a development result in an efficient way.

Annex 3 – Integrating essential gender, health equity and human rights criteria into the CCS process and document

Gender, equity and human rights criteria
Inclusive dialogue
■ 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.
■ Inclusive dialogues during the CCS process include consultation with national bodies on human rights and national bodies on women.
■ 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: ✓ risk factors, exposures and disease manifestations; ✓ severity and frequency of disease burden and health-seeking behaviour; ✓ access to care and experiences in health care settings; ✓ outcomes and impact in (context-specific) priority health areas.
■ The analysis informing the CCS includes identification of socially excluded or disadvantaged subpopulations.
■ The analysis informing the CCS includes assessment of the (i) availability, (ii) accessibility, (iii) acceptability and (iv) quality of health care services for socially excluded or disadvantaged subpopulations.
■ The analysis informing the CCS health and development challenges takes into consideration recommendations made to the country on the right to health 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.
■ Should advocate for reducing or mitigating the ways in which gender norms, roles or relations negatively affect access to and use of health services.
■ Should advocate for reducing or mitigating inequitable exposure, vulnerability or access of socially excluded or disadvantaged subpopulations.
■ Should advocate for 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 and equity analyses.
■ The CCS report includes reference to international human rights treaties, conventions or standards on the right to health ratified by the country.

Annex 4 – Guidance and template for preparing WHO CCS briefs

Template:	Please use the standardized template for updating the CCS brief. They are available in English, French and Spanish from the CCU Department and can be obtained by contacting countryfocus@who.int
Overview:	The text of the CCS brief should be succinct. The document should be highly analytical, and be based on the content of the latest Country Cooperation Strategy document.
Content and Structure:	The template of the CCS brief has two pages: i. The first page contains the table of a set of key indicators for all countries. The right side of the first page is divided into three sub-sections containing information on the texts of (i) health situation; (ii) health policies and systems; and (iii) cooperation for health. ii. The **second** page presents the CCS Strategic Agenda, including the period of validity, which shows details of the strategic priorities and the CCS focus areas. Only list the main focus areas agreed in the CCS. Please include a heading for each strategic priority. The text of the CCS brief should be succinct, consisting of the current health situation (as relevant, reflecting any work being undertaken to mainstream the SDG agenda), any health-related issues, and the health cooperation situation. The document should be highly analytical, and be based on the content of the most current CCS document. (See the standard template below for proposed contents of each subsection of the CCS brief.)
Indicators	The template contains a set of key health indicators based on the most recent data available from the Global Health Observatory (http://apps.who.int/gho/data/node/cco). If you include any other data in the body of the text, kindly use the most recent data available and ensure that the data sources are quoted. Data that are already in the table should not be repeated unless there is an important health situation that needs to be emphasized.
Length:	The maximum word count for the CCS briefs is 600 words for the first page (200 per section) and 500 words for the second page.
Style:	Use Calibri throughout the brief. The font size for the body text is font size 9. Do not change the font size of the headings or the indicator table. Text should be justified in the boxes. Acronyms should be spelt out in full the first time they are used and subsequently the acronym can be used later in the text; best to be used sparingly as too many acronyms can make reading difficult.
Language:	The brief must be written in English, French or Spanish.
Maps:	Maps are automatically generated by the Global Health Observatory and therefore must not be changed.
Final product:	Once produced, please forward a copy in Word to countryfocus@who.int for final editing, formatting and posting on the global Country Focus website: http://who.int/country-cooperation/what-who-does/strategies-and-briefs/en/

The Department of CCU in Headquarters is ready to provide support to Regional and WHO country offices, if required, in producing the CCS briefs. Do not hesitate to contact us at countryfocus@who.int if you have any queries or require additional assistance.

WHO Country Cooperation Strategy

World Health Organization

Country Cooperation Strategy *at a glance*

Country

WHO region	
World Bank income group	
Child health	
Infants exclusively breastfed for the first six months of life (%) (2007)	
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2014)	
Demographic and socioeconomic statistics	
Life expectancy at birth (years) (2015)	(Both sexes)
	(Male)
	(Female)
Population (in thousands) total (2015)	
% Population under 15 (2015)	
% Population over 60 (2015)	
Poverty headcount ratio at $1.25 a day (PPP) (% of population) (2010)	
Literacy rate among adults aged >= 15 years (%) (2007-2012)	
Gender Inequality Index rank (2014)	
Human Development Index rank (2014)	
Health systems	
Total expenditure on health as a percentage of gross domestic product (2014)	
Private expenditure on health as a percentage of total expenditure on health (2014)	
General government expenditure on health as a percentage of total government expenditure (2014)	
Physicians density (per 1000 population) (2012)	
Nursing and midwifery personnel density (per 1000 population) (2010)	
Mortality and global health estimates	
Neonatal mortality rate (per 1000 live births) (2015)	
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2015)	
Maternal mortality ratio (per 100 000 live births) (2015)	
Births attended by skilled health personnel (%) (2013-2014)	
Public health and environment	
Population using improved drinking water sources (%) (2015)	(Total)
	(Urban)
	(Rural)
Population using improved sanitation facilities (%) (2015)	(Total)
	(Urban)
	(Rural)

HEALTH SITUATION

- Health status of the population, including trends, vulnerabilities and disparities;
- Disease pattern/burden (communicable, non-communicable and re-emerging) and major determinants of health);
- Achievement of the SDGs;
- Key gaps and challenges.

HEALTH POLICIES AND SYSTEMS

- Key health policies and interventions, particularly those supporting the implementation of the 2030 Development Agenda (SDGs);
- Status of achievement of the FCTC and IHR (2005);
- Key features of the health system and delivery mechanism(s).

COOPERATION FOR HEALTH

- to facilitate the implementation of the 2030 Agenda for Sustainable Development;
- Key stakeholders and key processes for cooperation for health, including:
  - UN system partners and delivery mechanisms – DaO, UNDAF & Joint Programming (where applicable);
  - Bilateral donors, non-state actors, and other stakeholders;
  - Partnership framework for development cooperation that country participates in (e.g. GPEDC, IHP+ Every Woman Every Child etc.)
- Country contributions to the global health agenda.

World Health Organization

Country Cooperation Strategy *at a glance*

WHO COUNTRY COOPERATION STRATEGIC AGENDA (20XX-20XX)	
Strategic Priorities	**Main Focus Areas for WHO Cooperation**
1.	• • •
2.	• • •
3.	• • •
4.	• • •
5.	• • •

WHO/CCU/16.03/Country Updated September 2016

Annex 5 – Basic indicators for CCS documents

WHO region	
World Bank income group	
CURRENT HEALTH INDICATORS	
Total population in thousands (year)	
% Population under 15 (year)	
% Population over 60 (year)	
Life expectancy at birth (year) Total, Male, Female	
Neonatal mortality rate per 1000 live births (year)	
Under-five mortality rate per 1000 live births (year)	
Maternal mortality ratio per 100 000 live births (year)	
% DTP3 Immunization coverage among 1-year-olds (year)	
% Births attended by skilled health workers (year)	
Density of physicians per 1000 population (year)	
Density of nurses and midwives per 1000 population (year)	
Total expenditure on health as % of GDP (year)	
General government expenditure on health as % of total government expenditure (year)	
Private expenditure on health as % of total expenditure on health (year)	
Adult (15+) literacy rate total (year)	
Population using improved drinking water sources (%) (year)	
Population using improved sanitation facilities (%) (year)	
Poverty headcount ratio at $1.25 a day (PPP) (% of population) (year)	
Gender-related Development Index rank out of 148 countries (year))	
Human Development Index rank out of 186 countries (year)	

Sources of data:
Global Health Observatory: http://apps.who.int/gho/data/node.cco
If national data are utilized, please indicate source

Annex 6 – Examples of questions related to the health system to guide the health situation analysis

Advancing UHC

More about UHC

Examples of issues to consider in the analysis include:

- Is there any explicit country strategy for implementing or advancing UHC at country level?
- Does the UHC strategy include, at a minimum:
  - an explicit definition of what UHC means in terms of populations covered, services provided and financial protection guaranteed?
  - findings of a 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?
- 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 take (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?
- Is the UHC strategy consistent with the current and future human, technological, and organizational resources available in the country?
- Is the UHC strategy publicly debated?
- Does the UHC strategy take (or in the absence of an explicit strategy, has the NHA taken) steps to improve the country's health information system, with a focus on vital registration?

If the country has a protracted emergency, causing access to health services to be 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?

Implementing the provisions of the IHR

More about the IHR

Examples of issues to consider in the analysis include:

- Is there a national coordinating mechanism to implement the 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?
- Have the core surveillance requirements for IHR been met by the country?
- Does the country have a disease early warning system?
- Have the core response capacity requirements for the IHR been met by the country?
- 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?
- Are bio-risk assessments 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 communication?

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 SOPs for response at designated PoEs available?
- Are the human resources adequately trained to implement the SOPs?

Increasing access to essential, high-quality, effective and affordable medical products

More about essential medicines

Examples of issues to consider in the analysis include:

- Is increasing 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 national 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 the national level?
- Is the legislation implemented and enforced?
- Are the regulatory authorities well equipped to fulfil their duties at national 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 national level?
- Is multidrug resistance or antimicrobial resistance an issue?
- Is a national list of essential medicines currently in use?
- Is rational prescription of medicines a specific priority at national level?
- Is there a specific policy that favours greater use of generic over originator brands?
- Are the procurement and supply management processes and procedures for medical products and technologies currently working efficiently?
- 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 national priority?
- Is the global strategy and plan of action on public health, innovation and intellectual property being implemented in the country?
- Are research and innovation on medical products promoted nationally and regionally, including through networking at the regional level?

Annex 7 – Examples of questions related to cross-cutting issues to guide the health situation analysis

Cross-cutting social, economic and environmental issues

More about social determinants of health

Examples of issues to consider in analysing cross-cutting social, economic environmental issues include:

- 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 national 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 national 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?
- Is nutrition included in the social and economic determinants of health, including school-based healthy diet and nutrition, and are these periodically monitored and the results widely communicated and discussed at the national level?
- Is the country strengthening its capacity to assess and manage impacts of nutritional risk factors and to develop policies and plans on improved nutrition and healthy diets?
- Have intersectoral mechanisms been established to address social determinants of health? (Health in All Policies, Scaling Up Nutrition, United Nations and other coordination platforms.)

Cross-cutting gender, equity and human rights issues

More about gender, equity and human rights

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 gender, health equity and human rights issues 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?

Annex 8 – Examples of questions related to the development partner environment to guide the health situation analysis

Development partner environment
More about development partners

Partnership and development cooperation

The principles for effective development coordination provide the framework for the analysis, i.e.: ownership, focus on results, partnerships, transparency and mutual accountability.[7]

Examples of issues to consider in analysing the roles of WHO and other partners and the programmatic areas they support in the country include:

- the extent to which platforms encourage national ownership, transparency and mutual accountability, encourage division of labour and help to avoid duplication, and foster coherence and cooperation, filling critical gaps;
- the extent to which technical cooperation and health-related sector aid flows are aligned with national policies, strategies, plans and planning cycles, and focus on results;
- monitoring and assessment mechanisms for partnerships and development cooperation, and progress on alignment and harmonization;
- WHO's role in supporting the government to coordinate and monitor partners and external resources (including humanitarian partners and resources where relevant);
- WHO's role in coordination or partnership groups (e.g. does WHO chair or co-chair local development partner coordination partnerships or groups?); and
- WHO's relationship with the cooperation platforms and within the development cooperation effectiveness framework as well as WHO's added value and comparative advantage, including the demands placed on WHO by the government, the United Nations system and other partners.

[1] The Busan Partnership provides key principles for effective development cooperation: (i) ownership of development priorities by countries: countries should define the development model that they want to implement; (ii) focus on results: having a sustainable impact should be the driving force behind investments and efforts in development policy-making; (iii) partnerships for development: development depends on the participation of all actors, and recognizes the diversity and complementarity of their functions; and (iv) transparency and mutual accountability: development cooperation must be transparent and accountable to all citizens (see https://www.oecd.org/dac/effectiveness/Busan%20partnership.pdf).

Collaboration with the United Nations system at country level

The CCS process provides an opportunity to strengthen dialogue with the UNCT on the challenges and opportunities for cooperation in the country. The UNCT is the platform through which WHO can foster a multisectoral response to health challenges and mobilize additional resources to achieve national health goals. In countries with emergencies, there is often a Humanitarian Country Team, led by a Humanitarian Coordinator, in which the HWO participates.

In analysing WHO collaboration with the United Nations system, consider two issues:

1. **Leveraging the expertise of other United Nations agencies in the country. To leverage UNCT expertise and country presence consider:**[8]
   - Which United Nations agencies are part of the UNCT (resident and non-resident)?
   - What is the scope of activities and available expertise in health-related fields such as food and nutrition security, social determinants of health, etc. of other United Nations agencies in the country? (Check the analysis of the comparative advantages of the United Nations agencies in the country. This may have been done as part of the UNDAF preparation process.)
   - If the country adopted the DaO approach, which DaO pillars are implemented?
   - What is the role of the MoH in the Joint National/United Nations Steering Committee?
   - What is WHO's role in the Steering Committee?

   Are there joint programmes dedicated to health-related concerns such as engaging with the labour market sector to ensure that labour conditions are conducive to reducing current and future gaps in the health workforce? What is WHO's role in the joint programmes?
   - Is intersectoral action being considered to address Health in all Policies issues?
   - Has the UNCT established a joint mechanism to mobilize resources for health-related concerns? Is there a Multi-Donor Trust Fund in the country (One Fund in the DaO context, SDG Fund, etc.)?
   - Are there any other United Nations-wide initiatives or processes in the country? (For example, IHP+ or H4+,9 Decade of Action on Nutrition.)

2. **Relationship between the CCS, CCA and UNDAF.**

   Examples of questions the CCS WG might consider to describe the relationship between the CCS, CCA and UNDAF include:
   - To what extent are the health situation analyses of the CCS and CCA shared and harmonized?
   - Does the UNDAF highlight the role of health in the broader development agenda, reinforcing a multisectoral response and addressing key socioeconomic and environmental determinants of health, such as improved nutrition and education?
   - Are there any health-related outcomes in the UNDAF (nutrition, social protection, water and sanitation, specific vulnerable groups or others)?
   - Is WHO contributing to the health-related outputs and outcomes of the UNDAF and is the UNDAF being informed by the CCS strategic priorities?
   - What are the main health-related challenges identified in the country analysis of the UNDAF or DaO programme?
   - Are there health-related thematic groups, such as a nutrition thematic group (these might be called sectoral groups or results groups in the DaO context) e.g. is there a United Nations Interagency Task Force on NCDs?
   - How far does the UNDAF take a multisectoral approach to health and is it aligned with the national health policy?
   - What are the specific outputs agreed upon by health-related thematic groups?
   - What is WHO's role in these groups?

[2] These questions also apply when there is a Humanitarian Country Team. For example, consider the joint humanitarian planning led by the Office for the Coordination of Humanitarian Affairs, through Humanitarian Response Plans, with additional humanitarian funding mechanisms (CERF, humanitarian pooled funds, in some cases transition funds, etc.), and WHO's role as Health Cluster lead agency.

Annex 9 – Sample template for key stakeholder analysis

S/N	Name of agency	Roles fulfilled by development partner	Health-related SDG targets	Major programmatic area of support within country	Net contribution (US$)

Annex 10 – Examples of questions related to country contributions to the global health agenda to guide the health situation analysis

Country contribution to the global health agenda
More about the global health agenda
«Implementing the internationally agreed goals and commitments in regard to global health",[10] as embodied in the SDGs. Examples of issues to consider in analysing the country's contribution to the global health agenda include: • the experiences, knowledge and research in the country, and concrete lessons that can be shared to enhance resilience and contribute to health development in other countries; • the country's financial and technical support to other countries for health development through bilateral or multilateral cooperation, including logistics, human resources, transfer of technologies and research skills; • sharing of experience and cooperation among countries, through: triangular or South–South cooperation, such as in the Greater Mekong subregion, and subregional cooperation on disease surveillance and disaster risk management; and • the country's participation and leadership (if any) in subregional or other inter-country groups that have health agendas, including WHO global and regional governing bodies' meetings.

[1] United Nations Economic and Social Commission. Achieving the global health agenda. New York (NY), United Nations (http:/www.un.org/en/ecosoc/docs/pdfs/achieving_global_public_health_agenda.pdf).

Annex 11 – Example of a priority-setting methodology (refined PAHO-adapted Hanlon Method) and decision matrix and issues to consider for selecting from among potential strategic priorities and focus areas

The analysis of the health and development situation (Chapter 2) lays the basis for the strategic priorities and focus areas. Within that framework each region may select the methodology/framework to be used for identifying strategic priorities and focus areas.

The methodology below is used to establish a hierarchy of priorities to inform planning and resource mobilization and allocation.

1. Refined PAHO-adapted Hanlon Method[1]

This method utilizes a robust approach using the formula outlined below to objectively and systematically rank problems or programme areas to be addressed, based on the analysis of three of the specific components from the original Hanlon Method (A – size of the problem, B – seriousness of the problem and C – availability of effective interventions), and two new components (E – inequity factor and F – positioning/value-added factor), which are intrinsically linked to the values, mission and strategic orientations of the Organization.

$$\text{Basic Priority Rating (BPR)} = \frac{(A+B+E)C}{5.25} \times F$$

Where:

A = Size of the problem (range 0–10 points) – prevalence or incidence for diseases or system or programme deficiency (for non-disease oriented programme areas);

B = Seriousness of the problem (range 0–20) – includes a combination of urgency, severity, economic cost, and negative externality (negative impact on others or ability of the problem to spread and cause other problems). For non-disease programme areas, how essential the system or programme is, and what the consequences of inaction would be, are taken into consideration;

C = Effectiveness of interventions (range 0–10) – availability of cost-effective interventions to address the problem or deficiencies in programmes;

E = Inequity factor (range 0–5) – differential occurrence of disease, access to services or programmes;

F = Positioning factor – PAHO's (WHO's) value-added (range 0.67–1.5) – extent to which PAHO (WHO) is positioned to address the programme areas based on the six core functions of the Organization. As F is a multiplier, if the maximum is 1.5 the minimum is the reciprocal of 1.5 or 0.67.

A division by 5.25 gives the BPR a range of 0–100.

[1] See http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=35730&Itemid=270&lang=en

2. Decision matrix "methodology"

The decision matrix below provides an example of a simple set of criteria/type of methodology that may be considered for selecting from among potential strategic priorities and focus areas.[1]

Decision matrix for selecting from among potential CCS strategic priorities (SPs) and focus areas (FAs)									
For each of the questions indicate "yes" or "no"									
Criteria	SP or FA 1	SP or FA 2	SP or FA 3	SP or FA 4	SP or FA 5	SP or FA 6	SP or FA 7	SP or FA 8	SP or FA 9
1. Is the strategic priority/focus area in alignment with and does it support:									
a. national SDG targets or, if the country has not yet adapted any SDG targets to the country context, whether adopting the FA(s) would encourage the process?									
b. the NHPSP?									
c. achieving GPW outcomes?									
d. the UNDAF outcomes or DaO programme?									
e. emergency and disaster risk management needs, including those for the IHR?									
f. lessons from CCS reviews and the country's experiences?									
2. Does focusing on that strategic priority/ focus area:									
a. address the largest gaps in terms of addressing health concerns and inequities (leaving no one behind and reaching the furthest behind first)?									
b. have the potential to achieve the most rapid progress?									
c. have the ability to produce the highest level of impact?									
d. offer the likelihood of sustainability?									
e. provide a multiplier effect on other areas that should be addressed?									
f. address outcomes of stakeholder consultations?									
g. have the potential to contribute to health development in other countries and globally?									
3. Do enabling conditions and capacities exist:									
a. in the country that facilitate the achievement of results in that area?									
b. within WHO and which are available to the country office (human, financial, time, infrastructural resources – present and future forecasts) to effectively support the achievement of results in that area?									
Total positive responses									

[1] For further examples of methodologies for selecting among potential strategic priorities and focuses, see stakeholder analysis in Lao People's Democratic Republic (http://heapol.oxfordjournals.org/content/early/2016/03/21/heapol.czw010.abstract), and triangle framework for analysis (http://heapol.oxfordjournals.org/content/9/4/353.abstract).

Annex 12 – Country example of linking (validating) CCS focus areas with NHPSP priorities, GPW outcomes, SDG targets and UNDAF outcomes

CCS strategic priorities	CCS focus areas	NHPSP priorities	GPW outcomes	National SDG targets	UNDAF outcomes	Remarks
1: Achieving and sustaining UHC through a revitalized primary health care approach and sustainable service delivery through strengthening of health systems	1.1: Strengthened health systems capacity through human resources development, improved health information systems, effective procurement and supply management, and improved regulatory mechanisms and quality assurance of health services	Ensure adequate staffing of facilities by trained health services personnel	Policies, financing and human resources are in place to increase access to people-centred, integrated health services	Target 3.8: Achieve universal health coverage	Universal access to quality health care services with a focus on the SDGs	Direct link to GPW Category 4 outcome: "Policies, financing and human resources are in place to increase access to people-centred, integrated health services"
	1.2: Costing and economic analysis and sharing of best international practices in financing health services, based on principles of universal access and equity	Develop alternative financing mechanisms to support primary health care	Policies, financing and human resources are in place to increase access to people-centred, integrated health services	Target 3.8: Achieve universal health coverage	Universal access to quality health care services with a focus on the SDGs	Direct link to GPW Category 4 outcome: "Policies, financing and human resources are in place to increase access to people-centred, integrated health services"
	1.3: Increased availability of quality-assured essential medicines and appropriate health technologies	Ensure an adequate supply of essential medicines and equipment to health facilities in rural areas	Improved access to and rational use of safe, efficacious and quality medicines and health technologies	Target 3.8: Achieve universal health coverage	Universal access to quality health care services with a focus on the SDGs	Direct link to GPW Category 4 outcome: "Improved access to, and rational use of, safe, efficacious and quality medicines and health technologies"

2: Scaling up prevention, early detection, monitoring and treatment of NCDs and addressing their determinants through intersectoral collaboration	2.1: Enhanced national capacity and intersectoral action for prevention, early detection and management of NCDs, and for addressing determinants of NCDs	Reduce the prevalence of noncommunicable disease	Increased access to interventions to prevent and manage non communicable diseases and their risk factors	Target 3.4: By 2030 to reduce by 1/3 premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being	Universal access to quality health care services with a focus on the SDGs	Direct link to GPW Category 2 outcome: "Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors"
	2.2: Scaled up response to mental health, alcohol and substance abuse and injury prevention	Ensure the availability of mental health, alcohol and abuse services	Increased access to services for mental health and substance use disorders	Target 3.5: Strengthen the prevention and treatment of substance abuse	Universal access to quality social services with a focus on the SDGs	Direct link to GPW Category 2 outcome: "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			The CCS focus area links to two separate GPW Category 2 outcomes: - "Reduce risk factors for violence and injuries with a focus on road safety, child injuries and violence against children, women and youth" and - "Increased access to services for mental health and substance use disorders" In this case, the CCS focus area should be split in two, one dealing with violence and one dealing with mental health

Annex 13 – Example of a framework for the CCS mid-term evaluation

Each region may develop its own framework/methodology for the mid-term evaluation. At a minimum, frameworks must address:

- progress achieved in strategic focus area (whether the achievement required for meeting the strategic priorities is being realized as expected);
- identification of impediments and potential risks that might demand attention and that might warrant changes in the strategic priorities or focus areas; and
- identification of actions required to mitigate potential risks and improve progress during the second half of the CCS cycle.

The series of questions in the table below, to be applied to each of the strategic focus areas, provides an example of a framework for the mid-term evaluation that could be used to guide the CCS evaluation WG in their review of relevant documents and discussions with country staff and partners and other external stakeholders. The framework is based on the MOPAN performance assessment criteria.[1]

In answering the questions below, it is important not to simply respond "yes" or "no", but to be able to "justify" the response, that is, to elaborate the reasons which led to the response (a written justification is not required). The "justification" will assist in determining the revisions to the Strategic Agenda. In considering the reasons underlying the responses, consideration should be given to factors internal and external to WHO.

Mid-term evaluation questions to guide the CCS evaluation WG in reviewing relevant documents and discussions with country staff, partners and other external stakeholders	
Performance areas	
Strategic management – clear strategic direction geared to key functions, intended results and integration of relevant priorities	Q1. Are the strategic focus areas consistent with the NHPSP objectives, national SDG targets, strategic discussion or country-level actions that have taken place to address unfinished health-related MDGs and take forward the SDG agenda, including mainstreaming SDG targets into the NHPSP? Q2. Are the strategic focus areas consistent with GPW outcomes? Q3. Do the strategic focus areas reflect WHO's comparative advantage in terms of other partners (technical knowledge, convening power, policy dialogue, advocacy, etc.)? Q4. Will the completion of the CCS focus areas contribute to achieving the objective stated in the strategic priority? Q5. Do the CCS focus areas reflect a change or accomplishment for which WHO is willing to be held accountable?
Operational management – Assets and capacities organized behind strategic directions and intended results	Q6. Do the WHO workplans and budget allocations reflect the strategic focus areas? Q7. Are the strategic focus areas being used for advocacy and mobilization of resources for implementing the CCS Strategic Agenda? Q8. Are the mix of competencies and skills in the country office consistent with the strategic focus areas? Are the strategic focus areas being used for adjusting the mix of competencies and skills in the country office?

[1] Performance areas and performance indicator questions Derived from MOPAN 3.0 Generic Indicator Framework (http://www.mopanonline.org/GenericPages/Mopan%20Methodology%20Digest%20[4].pdf).

Relationship management – Engaging in inclusive partnerships to support relevance, to leverage effective solutions and to maximize results	Q9. Are the strategic focus areas providing a platform to mobilize a multisectoral approach to address the NHPSP objectives, national SDG targets, strategic discussion or country-level actions that have taken place to address unfinished health-related MDGs and take forward the SDG agenda, including mainstreaming SDG targets into the NHPSP? Q10. Are the strategic focus areas contributing to increased collaboration with a wider array of partners? Q11. Are the strategic focus areas being used to inform the health priorities of the UNDAF? Q12. Does the approach to the strategic focus areas encourage the leverage of resources and avoid fragmentation? Q13. Is key information related to the strategic focus areas being shared with partners on an ongoing basis?
Results – achievement of relevant, inclusive and sustainable contribution to humanitarian and development results in an efficient way	Q14. Is progress towards the expected achievement reflected in the strategic focus areas as anticipated? Q15. Are the expected achievements reflected in the strategic focus areas having the expected positive benefits for target group members? Q16. Are the strategic focus areas consistent with and contributing to the NHPSP objectives, national SDG targets, strategic discussion or country-level actions that have taken place to address unfinished health-related MDGs and take forward the SDG agenda, including mainstreaming SDG targets into the NHPSP? Q17. Are the strategic focus areas being addressed as part of a coherent response within WHO and among development partners to identified problems/issues related to the NHPSP objectives, national SDG targets, strategic discussion or country-level actions that have taken place to address unfinished health-related MDGs and take forward the SDG agenda including mainstreaming SDG targets into the NHPSP? Q18. Do the strategic focus areas address the largest gaps in terms of health concerns and provide a multiplier effect on other areas that should be addressed? Q19. Are the strategic focus areas being addressed in a resource-efficient and cost-efficient manner?

Based on responses to the above questions, use the template below to describe the actions needed to make progress in each focus area, indicating revisions to the focus areas if necessary.

Actions to improve progress and revisions to the strategic focus areas	
Strategic priority /focus areas	**Actions needed to improve progress and revisions to the strategic focus areas if deemed necessary**
Strategic Priority 1	
Focus Area 1.1 -	
Focus Area 1.2 -	
Focus Area 1.3 -	
Strategic Priority 2	
Focus Area 2.1 -	
Focus Area 2.2 -	
Focus Area 2.3 -	
Strategic Priority 3	
Focus Area 3.1 -	
Focus Area 3.2 -	
Focus Area 3.3 -	
Strategic Priority 4	
Focus Area 4.1 -	
Focus Area 4.2 -	
Focus Area 4.3 -	
Strategic Priority 5	
Focus Area 5.1 -	
Focus Area 5.2 -	
Focus Area 5.3 -	

Annex 14 – Example of a framework for the CCS final evaluation

Each region may develop its own framework/methodology for final evaluation. At a minimum, the framework must:

- measure the achievement of selected national SDG targets linked to the CCS Strategic Agenda:
- identify the main achievements and gaps in implementing the CCS Strategic Agenda;
- identify the critical success factors and impediments; and
- identify the principal lessons to be applied in the next CCS cycle.

The questions in the table below provide the framework for the final evaluation and should be used to guide the CCS evaluation WG in their review of documents from the mid-term evaluation, PB assessment report and discussions with country staff, partners and other stakeholders. The framework is based on the MOPAN performance assessment criteria[1] and theory of change.[2]

In answering the questions below, it is important not simply to respond yes or no, but to be able to elaborate the reasons which led to the response. The "justification" will assist in determining the appropriate recommendations for taking forward the CCS in the next cycle. In considering the reasons underlying the responses, consideration should be given to factors internal and external to WHO.

Final evaluation questions to guide the CCS evaluation WG in reviewing relevant documents and discussions with country staff, partners and other external stakeholders	
Performance areas	
Strategic management – clear strategic direction geared to key functions, intended results and integration of relevant priorities	**Q1**. Was the CCS Strategic Agenda developed on a sound evidence base? **Q2**. Was the CCS Strategic Agenda consistent with the NHPSP objectives, national SDG targets, strategic discussion or country-level actions that have taken place to address unfinished health-related MDGs and take forward the SDG agenda, including mainstreaming SDG targets into the NHPSP? **Q3**. Did the CCS Strategic Agenda support good governance,[3] gender equality and the empowerment of women? **Q4**. Was the CCS Strategic Agenda consistent with GPW outcomes? **Q5**. Did the CCS Strategic Agenda provide a clear medium-term vision and reflect WHO's comparative advantage and added value in terms of other partners (technical knowledge, convening power, policy dialogue, advocacy, etc.)? **Q6**. Are there areas on which WHO should focus, and areas from which it should shift its focus, during the next CCS cycle due to its comparative advantage and added value?

[1] Performance areas and performance indicator questions derived from MOPAN 3.0 Generic Indicator Framework (http://www.mopanonline.org/GenericPages/Mopan%20Methodology%20Digest%20[4].pdf).

[2] The MOPAN theory of change suggests that if a multilateral organization has effective systems, practices and behaviours in place as measured by the performance areas then its activities will be more effectively delivered. Thus if final evaluation indicates that the WHO country office is effective in the performance areas, then, for example, WHO-supported training for midwifes, adaptation of guidelines for preventing neonatal tetanus, and provision of midwife kits can be said to contribute to SDG Goal 3, Target 3.2, "End preventable deaths of newborns and children under 5 years of age»

[3] Peaceful and inclusive societies for sustainable development, reduced inequality, and build effective, accountable and inclusive institutions at all levels (http://www.mopanonline.org/GenericPages/Mopan%20Methodology%20Digest%20[4].pdf).

Operational management – Assets and capacities organized behind strategic directions and intended results	**Q7**. Did the CCS (situation analysis, Strategic Agenda) adequately inform PB preparation? **Q8**. Did the CCS Strategic Agenda inform the WHO country workplans and budget allocations? **Q9**. Was the CCS used for advocacy and mobilization of resources for implementing the CCS Strategic Agenda? **Q10**. Was the CCS Strategic Agenda used for adjusting the mix of competencies and skills in the country office? Was the WHO human resources plan consistent with the competencies and skills required to implement the CCS Strategic Agenda? **Q11**. Was the technical, managerial and administrative support for implementation of the CCS Strategic Agenda from the RO and HQ timely and adequate? **Q12**. Did the information technology and communications infrastructure provide the required support for implementation of the CCS Strategic Agenda?
Relationship management – Engaging in inclusive partnerships to support relevance, to leverage effective solutions and to maximize results	**Q13**. Did the CCS Strategic Agenda provide a platform to mobilize a multisectoral approach and facilitate the mobilization of resources to address the NHPSP objectives, national SDG targets, strategic discussion or country-level actions that have taken place to address unfinished health-related MDGs and take forward the SDG agenda, including mainstreaming SDG targets into the NHPSP? **Q14**. Did the CCS Strategic Agenda contribute to increased collaboration with a wider array of partners, harmonizing WHO's cooperation with that of other development partners and the United Nations development system organizations? Were partnerships based on comparative advantages (technical knowledge, convening power, policy dialogue, advocacy, etc.)? **Q15**. Was the CCS Strategic Agenda used to inform the health priorities of the UNDAF? **Q16**. Did CCS Strategic Agenda encourage the leveraging of resources to health-related sectors and avoid fragmentation? **Q17**. Was key information related to the CCS Strategic Agenda shared with partners on an ongoing basis? Did WHO, national and other development partners participate in the mutual assessment of progress in implementing agreed commitments?
Results – Achievement of relevant, inclusive and sustainable contribution to humanitarian and development results in an efficient way	**Q18**. Were the selected SDG or national SDG targets linked to the CCS Strategic Agenda achieved? What were the WHO biennial workplan outputs that contributed to the achievement of each of the national SDG targets?[2] **Q19**. Were there areas where WHO's contribution was required, but was insufficient to achieve the targets? **Q20**. Did the achievement of the CCS Strategic Agenda have the expected positive benefits for target group members? **Q21**. Did the CCS Strategic Agenda help improve good governance,[3] gender equality and the empowerment of women? **Q22**. To what extent did the achievement of the CCS Strategic Agenda have an effect on NHPSP objectives, national SDG targets, strategic discussion or country-level actions that have taken place to address unfinished health-related MDGs and take forward the SDG agenda, including mainstreaming SDG targets into the NHPSP? **Q23**. Was the CCS Strategic Agenda addressed as part of a coherent response within WHO and among development partners to identified problems/issues related to the NHPSP objectives, national SDG targets, strategic discussion or country-level actions that have taken place to address unfinished health-related MDGs and take forward the SDG agenda, including mainstreaming SDG targets into the NHPSP? **Q24**. Did the CCS Strategic Agenda address the largest gaps in terms of health concerns, and provide a multiplier effect on other areas that should be addressed? **Q25**. Was the CCS Strategic Agenda implemented in a resource-efficient and cost-efficient manner? **Q26**. Were expenditures in the WHO biennial workplan consistent/in line with the CCS Strategic Agenda? **Q27**. Were the tools and resources provided by WHO aligned with the country's needs and with the needs of other relevant country partner organizations?

[1] The selected SDG or national SDG targets, which are linked to specific CCS strategic priorities, are included as a proxy for the success of the Strategic Agenda. As suggested in the MOPAN "theory of change", if WHO has effective systems, practices and behaviours in place (e.g. strategic management, operational management, relationship management) then its interventions/actions will be effectively delivered and thus delivery will achieve relevant, inclusive and sustainable contributions to development results.

[2] Peaceful and inclusive societies for sustainable development, reduced inequality, and the building of effective, accountable and inclusive institutions at all levels (http://www.mopanonline.org/GenericPages/Mopan%20Methodology%20Digest%20[4].pdf).

Annex 15 – Mapping health-related SDG targets against GPW outcomes

SDG targets	Description	Programme area links	Description	GPW outcomes
Health Goal				
3.1	Reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1	Reproductive, maternal, newborn, child and adolescent health	Increased access to interventions for improving health of women, newborn, children and adolescents
3.2	End preventable deaths of newborn and children under 5 years of age	1.5	Vaccine-preventable diseases	Increased vaccination coverage for hard-to-reach populations and communities
		2.3	Violence and injuries	Reduced risk factors for violence and injuries with focus on road safety, child injuries and violence against women, children and youth
		3.1	Reproductive, maternal, newborn, child and adolescent health	Increased access to interventions for improving health of women, newborn, children and adolescents
3.3	End epidemics of AIDs, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	1.1	HIV and hepatitis	Increased access to key interventions for people living with HIV
		1.2	Tuberculosis	Increased number of successfully treated tuberculosis patients

		1.3	Malaria	Increased access to first-line anti-malarial treatment for confirmed malaria cases
		1.4	Neglected Tropical Diseases	Increased and sustained access to essential medicines for neglected tropical diseases
		1.5	Vaccine-preventable diseases	Increased vaccination coverage for hard-to-reach populations and communities
		5.2	Epidemic and pandemic-prone diseases	Increased capacity of countries to build resilience and adequate preparedness to mount rapid, predictable and effective response to major epidemics and pandemics
		5.4	Food safety	All countries are adequately prepared to prevent and mitigate risks to food safety
		5.5	Polio eradication	No cases of paralysis due to wild or type 2 vaccine-related polio virus globally
3.4	By 2030, to reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being	2.1	NCDs	Increased access to interventions to prevent and manage NCDs and their risk factors
		2.2	Mental health and substance abuse	Increased access to services for mental health and substance use disorders
3.5	Strengthen the prevention and treatment of substance abuse	2.2	Mental health and substance abuse	Increased access to services for mental health and substance use disorders

3.6	Halve the number of global deaths and injuries from road traffic accidents	2.3	Violence and injuries	Reduced risk factors for violence and injuries with focus on road safety, child injuries and violence against women, children and youth
3.7	Ensure universal access to sexual and reproductive health-care services	3.1	Reproductive, maternal, newborn, child and adolescent health	Increased access to interventions for improving health of women, newborn, children and adolescents
3.8	Achieve universal health coverage	4.1	National health strategies and plans	All countries have comprehensive NHPSP aimed at moving towards universal health coverage
		4.2	Integrated people centred delivery of health services	Policies, financing and human resources are in place to increase access to people-centred, integrated health services
		4.3	Access to medicines and other health technologies and strengthening regulatory capacity	Improved access to, and rational use of safe, efficacious and quality medicines and health technologies
3.9	Substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination	3.5	Health and environment	Reduced environmental threats to health
3.a	Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	2.1	NCDs	Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors
3.b	Support research and development of vaccines, medicines for communicable and noncommunicable diseases that primarily affect developing countries, and provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health	1.5	Vaccine preventable diseases	Increased vaccination coverage for hard-to-reach populations and communities

		4.3	Access to medicines and other health technologies and strengthening regulatory capacity	Improved access to, and rational use of safe, efficacious and quality medicines and health technologies
		4.4	Health systems information and evidence	All countries have properly functioning civil registration and vital statistics systems
3.c	Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries	4.1	National health strategies and plans	All countries have comprehensive NHPSP aimed at moving towards universal health coverage
		4.2	Integrated people centred delivery of health services	Policies, financing and human resources are in place to increase access to people-centred, integrated health services
3.d	Strengthen capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	5.1	Alert and response	All countries have minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response
		5.2	Epidemic and pandemic-prone diseases	Increased capacity of countries to build resilience and adequate preparedness to mount rapid, predictable and effective response to major epidemics and pandemics
		5.4	Food safety	All countries are adequately prepared to prevent and mitigate risks to food safety
		5.6	Outbreak and crisis response	All countries adequately respond to threats and emergencies with public health consequences

Other goals related to health				
1.3	Implement nationally appropriate social protection systems and measures for all	3.4	Social determinants of health	Increased intersectoral policy coordination to address the social determinants of health
1.5	Build resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other shocks and disasters	3.5	Health and environment	Reduced environmental threats to health
		5.3	Emergency risk and crisis management	Countries have the capacity to manage public health risks associated with emergencies
2.1	End hunger and ensure access by all people to safe, nutritious and sufficient food all year round	2.5	Nutrition	Reduced nutritional risk factors
2.2	End all forms of malnutrition	2.5	Nutrition	Reduced nutritional risk factors
4.5	Eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities	2.4	Disabilities and rehabilitation	Increased access to services for people with disabilities
		3.3	Gender, equity, human rights	Gender, equity and human rights integrated into the Secretariat's and countries' policies and programmes
4.a	Build and upgrade educational facilities that are child, disability and gender sensitive and provide safe, nonviolent, inclusive and effective learning environments for all	2.3	Violence and injuries	Reduced risk factors for violence and injuries with a focus on road safety, child injuries and violence against women, children and youth
		3.3	Gender, equity, human rights	Gender, equity and human rights integrated into the Secretariat's and countries' policies

5.2	Eliminate all forms of violence against all women and girls in the public and private spheres	2.3	Violence and injuries	Reduced risk factors for violence and injuries with a focus on road safety, child injuries and violence against women, children and youth
		3.3	Gender, equity, human rights	Gender, equity and human rights integrated into the Secretariat's and countries' policies and programmes
5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation		Gender, equity, human rights	Gender, equity and human rights integrated into the Secretariat's and countries' policies and programmes
5.6	Ensure universal access to sexual and reproductive health and reproductive rights	3.1	Reproductive, maternal, newborn, child and adolescent health	Increased access to interventions for improving health of women, newborn, children and adolescents
		3.3	Gender, equity, human rights	Gender, equity and human rights integrated into the Secretariat's and countries' policies and programmes
6.1	Achieve universal and equitable access to safe and affordable drinking water for all	3.5	Health and environment	Reduced environmental threats to health
6.2	Achieve access to adequate and equitable sanitation and hygiene for all and end open defecation	3.5	Health and environment	Reduced environmental threats to health
7.1	Ensure universal access to affordable, reliable and modern energy services	3.5	Health and environment	Reduced environmental threats to health
8.5	Achieve full and productive employment and decent work for all	3.4	Social determinants of health	Increased intersectoral policy coordination to address the social determinants of health

8.8	Protect labour rights and promote safe and secure working environments for all workers	3.4	Social determinants of health	Increased intersectoral policy coordination to address the social determinants of health
10.2	Empower and promote the social, economic, political inclusion of all, irrespective of age, sex, disability, race,	3.4	Social determinants of health	Increased intersectoral policy coordination to address the social determinants of health
10.4	Adopt policies, especially fiscal, wage and social protection, and progressively achieve greater equality	3.4	Social determinants of health	Increased intersectoral policy coordination to address the social determinants of health
10.7	Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies	3.4	Social determinants of health	Increased intersectoral policy coordination to address the social determinants of health
11.1	Ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums	3.4	Social determinants of health	Increased intersectoral policy coordination to address the social determinants of health
11.2	Provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety	2.3	Violence and injuries	Reduced risk factors for violence and injuries with focus on road safety, child injuries and violence against women, children and youth
11.5	By 2030, significantly reduce the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations	3.5	Health and environment	Reduced environmental threats to health
		5.3	Emergency risk and crisis management	Countries have the capacity to manage public health risks associated with emergencies
11.7	Provide universal access to safe, inclusive and accessible green and public spaces	3.5	Health and environment	Reduced environmental threats to health
11.b	Substantially increase the number of cities and human settlements adopting and implementing integrated policies and plans towards inclusion, resource efficiency, mitigation and adaptation to climate change, resilience to disasters, and develop holistic disaster risk management	3.5	Health and environment	Reduced environmental threats to health
		5.3	Emergency risk and crisis management	Countries have the capacity to manage public health risks associated with emergencies

Annex 16 – Example of a framework for assessing the quality and relevance of the CCS Strategic Agenda and assessing the need to update the CCS Strategic Agenda

The checklist below provides an example of a framework for assessing the quality and relevance of the strategic priorities and focus areas within the current context and considering: (i) the universality of the SDGs and their emphasis on equality or "leaving no one behind"; (ii) promoting a multisectoral approach to health, recognizing that health is represented in 13 targets under SDG 3 and in 40 additional health-related targets under 14 of the other SDGs.

In responding to the questions, it is important not simply to reply "yes" or "no" but also to be able to "justify" the answer. The justification will assist in determining the relevance of the Strategic Agenda, and, when the Strategic Agenda is being updated, the revisions to be made.

Checklist for assessing relevance of strategic priorities and focus areas when assessing the need to update the CCS Strategic Agenda	
CCS strategic priority	**Q1**. Is the strategic priority clearly linked to any NHPSP objective, national SDG targets, SDG, strategic discussion or country-level actions that have recently taken place to address unfinished health-related MDGs and take forward the SDG agenda?
	Q2. Is the strategic priority supported by the country office's situation analysis?
	Q3. Does the strategic priority address the largest gaps in terms of health concerns? Does it provide a multiplier effect on other areas that should be addressed?
	Q4. Is the strategic priority consistent with the GPW and one or more of the leadership priorities?
	Q5. Does the statement indicate or describe a contribution of WHO that is relevant,[1] address inequities,[2] and is it achievable[3] within the CCS period and sustainable thereafter?
	Q6. Are the strategic priorities comprehensive in that they reflect the full range of objectives for the entire CCS period?
CCS focus area	**Q7**. Are the CCS focus areas linked to any NHPSP objective, national SDG targets, SDG, strategic discussion or country-level actions that have recently taken place to address unfinished health-related MDGs and take forward the SDG agenda?
	Q8. Will the completion of the CCS focus areas contribute to achieving the objective stated in the strategic priority?
	Q9. Are the CCS focus areas backed by the country office's situation analysis?
	Q10. Do the CCS focus areas address the largest gaps in terms of health concerns? Do they provide a multiplier effect on other areas that should be addressed?
	Q11. Are the CCS focus areas linked to SDG targets and GPW outcomes?
	Q12. Do the CCS focus areas reflect a change or accomplishment for which WHO is willing to be held accountable?
	Q13. Are the scopes of the work in the CCS focus areas specific,[4] measurable, achievable, relevant and time-bound,[5] and do they address inequities?

1 Relevant: responds to the country priorities and needs or challenges identified in national policies, strategies and plans, and is within the mandate of the Organization, the GPW, and the regional priorities.

2 Addressing inequities: "leaving no one behind and reaching the furthest behind first".

3 Achievable: realistic given the resources likely to be available.

4 Specific: identifies the nature of the expected achievements or changes; the target should be as detailed as possible without being wordy.

5 Time-bound: can be achieved within the CCS period.

Annex 17 – Guidance for integrating health emergency risk assessment, capacity assessment on emergency risk management for health, and WHO readiness for emergency response into a CCS

1. Introduction

All countries from the community to the national levels are at risk of emergencies or disasters arising from a range of hazards, which can affect public health, health infrastructure, health-related 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 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 annex has been developed to provide brief guidance to WHO CCS teams on how to integrate the outcomes of these three assessments into 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. The HERA consists of four components: context analysis; risk identification (hazard and vulnerability analyses); risk analysis; and risk evaluation.

Capacity assessment on emergency risk and disaster risk management for health (EDRM-H)

EDRM-H provides information on the strengths of, and gaps in, the country's "systems for health" (health-related systems) to manage the risks of emergencies, implement the IHR 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 United Nations and bilateral agencies at country level. This includes WHO's ability to fulfil its responsibilities under the IHR, the Inter-Agency Standing Committee (IASC) Transformative Agenda and as Global Health Cluster lead agency.[1]

[1] For an example of other benchmarks being used to assess the health aspects of country capacity to manage natural disasters, see Benchmarking Emergency Preparedness: http://www.eird.org/isdr-biblio/PDF/Benchmarking%20emergency%20preparedness.pdf

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 integrate the outcomes of the assessments 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, IHR and WHO readiness for emergency response in the CCS consultations;
- **Health and development situation analysis** – solicit answers for the HERA, capacity assessment on EDRM-H, and WHO response readiness.

(b) The CCS document

The framework in the table below shows how and where to briefly integrate the outcomes of the HERA, capacity assessment on EDRM-H and assessment of WHO emergency response readiness into the CCS document.

Integrating outcomes of assessments into CCS document

Sections in the CCS document	Key elements to include
Chapter 1: Introduction	
Chapter 2: Health and development situation	
Macroeconomic, political and social context	○ The risk of political instability (civil war, adverse regime change, ethnic conflict), including history of emergencies in the country
Other major determinants of health	○ Outcome of all-hazard analysis and the potential consequences for the health status of the people, health infrastructures, health systems and services
Health status of the population	○ Outcome of vulnerability analysis: differential effects and vulnerabilities to emergencies across the population and subpopulations
National responses to overcoming health challenges	○ Outcomes of capacity assessments of national multisectoral capacities, strengths and gaps in managing risks to health ○ Outcome of assessment of country IHR capacities
Health systems and services, and the response of other sectors	○ Outcomes of assessment of health systems capacities, challenges, gaps at country level for EDRM-H including for prevention, preparedness, response and recovery
National contribution to and role in global health	○ Role of the country in regional and global activities in EDRM-H, IHR, cross-border, regional and international agreements and arrangements ○ Good practices in EDRM-H, including risk assessment, which could be shared with other countries
Evaluation of WHO cooperation during the past CCS cycle	○ Outcomes of internal and external review of WHO cooperation in strengthening national EDRM-H and WHO readiness for response and recovery

Chapter 3: Setting the Strategic Agenda for WHO cooperation	
Definition of strategic priorities	○ Based on the outcomes of the three assessments; if required, include a strategic priority for strengthening WHO readiness for emergency response in country, and developing national capacities on EDRM-H, including for the IHR
Chapter 4: Implementing the Strategic Agenda: implications for the Secretariat	
Approaches to implementation	○ State briefly the related implications in cases where a strategic priority related to the HERA has been selected as part of the Strategic Agenda

Annex – 18 Examples of questions related to the SDGs to guide the health situation analysis

SDGs
More about the SDGs

The 2030 Agenda for Sustainable Development was adopted in September 2015 to ensure follow-up on the implementation of the MDGs and provide a global framework for integrated and coherent action on sustainable development until 2030. The 17 SDGs are already influencing the work of the United Nations 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 for implementing the SDGs, including relevant indicators; and to develop a CCS Strategic Agenda that supports those national actions. The SDGs contain one health-specific goal: SDG 3 (ensure healthy lives and promote well-being for all at all ages), which has 13 targets. However, all 17 SDGs have health-related targets.

The following questions should be considered in undertaking the situational analysis.

- Is there a specific national coordination mechanism to ensure follow-up and achievement of the SDGs? Do the SDGs have a high priority on the political agenda, i.e. do they influence the public policies of the country? How can the SDGs help reach long-term national development objectives?
- What were the health priorities identified at national and subnational levels? Which health indicators will the country monitor?
- Do existing national development plans and strategies, including sectoral plans and strategies and other related plans, reflect the SDG areas? Are any of the SDG targets considered a priority, have they been adapted as national SDG targets (e.g. on premature mortality from NCDs, mental health, road safety, prevention of substance abuse, UHC, improved nutrition, etc.)?
- What interventions are identified as priorities (e.g. providing free access to health care to pregnant women, mothers and children, emergency obstetrics, immunization, effective integration of nutrition services for mothers, infants and young children in health service delivery, nutritional supplementation programmes)? 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 intersectoral approach and do they include a "system for health" (health-related systems) strengthening component?
- What were the main successes and challenges in achieving the MDGs? Are there established mechanisms for collaboration on the achievement of the unfinished MDGs (e.g. improving maternal health, including sexual and reproductive health, as well as newborn and child health, etc.)? Can these be applied to the SDGs and supported and facilitated through a CCS Strategic Agenda?
- Which mechanisms are in place that address the national SDG agenda multisectorally?
- Are there specific strategies to prepare local governments for the "localization" of SDGs at subnational level? Does the situation/do the conditions allow for these strategies be supported and facilitated through a CCS Strategic Agenda?
- Is the support of the United Nations system in the implementation of the SDGs at the national and subnational levels discussed in the UNCT?
- Is WHO leading the work on identifying nationally relevant SDG health targets and indicators?
- Are the SDGs being monitored and are a system for evaluation and a mechanism to publicize the evaluation results in place?

Annex 19 – CCS clearance process and use of CCS document

	Action	Country office	RO	HQ
1.	Final review by RO and HQ	X	X	X
2.	Clearance by MoH, other relevant ministries, RO and HQ		X	X
3.	Agree on the process for publishing the CCS with the RO, ensuring the proper use of WHO logo and publishing standards	X	X	
4.	Signature and launch of the CCS by the MoH, other relevant ministries and HWO*	X		
5.	Widely disseminate the CCS to all country office staff, the government and other partners. Publish the CCS on the country office website	X		
6.	Upload the CCS to the regional IRIS			X
7.	Use CCS priorities to revise workplans, inform the biennial workplan and budget, define and shape the health component of the UNDAF and other partnership platforms	X		
8.	Use the CCS for advocacy and resource mobilization for health	X	X	X
9.	Widely disseminate the CCS and the CCS brief to all WHO departments and divisions, and other stakeholders		X	X
10.	Ensure that technical interactions between country offices and governments are consistent and based on the CCS priorities	X	X	X
11.	Ensure that CCS priorities are the basis for the preparation of strategic and operational plans, including budgets and resource allocation	X	X	X
12.	Ensure CCS mid-term evaluation with support from RO	X	X	
13.	Ensure CCS final evaluation with support from HQ	X	X	X
14.	Back the approved priorities with relevant resources	X	X	X

* This could include the regional director or a representative from HQ depending on the circumstances

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