

# COUNTRY COOPERATION STRATEGY GUIDE 2020

Implementing the Thirteenth General  
Programme of Work  
for driving impact  
in every country



Country cooperation strategy guide 2020: implementing the Thirteenth General Programme of Work for driving impact in every country

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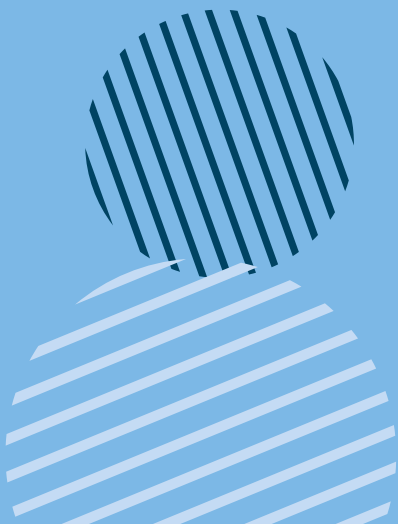


# ABBREVIATIONS

<b>AIDS</b>	ACQUIRED IMMUNODEFICIENCY SYNDROME
<b>CCA</b>	COMMON COUNTRY ASSESSMENT
<b>CCS</b>	COUNTRY COOPERATION STRATEGY
<b>CCS/HQ</b>	DEPARTMENT OF COUNTRY STRATEGY AND SUPPORT
<b>CSO</b>	CIVIL SOCIETY ORGANIZATION
<b>CSU</b>	COUNTRY SUPPORT UNIT
<b>DAC</b>	DEVELOPMENT ASSISTANCE COMMITTEE
<b>DAO</b>	DELIVERING AS ONE
<b>DCO</b>	WHO DEPARTMENT OF COMMUNICATIONS
<b>DG</b>	WHO DIRECTOR-GENERAL
<b>ERF</b>	EMERGENCY RESPONSE FRAMEWORK
<b>EDRM-H</b>	EMERGENCY AND DISASTERRISK MANAGEMENT FOR HEALTH
<b>FCTC</b>	FRAMEWORK CONVENTION ON TOBACCO CONTROL
<b>FENSA</b>	WHO FRAMEWORK OF ENGAGEMENT WITH NON-STATE ACTORS
<b>GAP</b>	GLOBAL ACTION PLAN ON SUSTAINABLE DEVELOPMENT GOALS
<b>GAVI</b>	FORMERLY GLOBAL ALLIANCE FOR VACCINES AND IMMUNIZATIONS, NOW GAVI, THE VACCINE ALLIANCE
<b>GFATM</b>	GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA
<b>GHO</b>	GLOBAL HEALTH OBSERVATORY
<b>GPW13</b>	THIRTEENTH GENERAL PROGRAMME OF WORK
<b>GSM</b>	GENERAL SERVICES MODULE
<b>HDI</b>	HUMAN DEVELOPMENT INDEX
<b>HERA</b>	HEALTH EMERGENCY RISK ASSESSMENT
<b>HIC</b>	HIGH-INCOME COUNTRIES
<b>HQ</b>	WHO HEADQUARTERS
<b>HWO</b>	HEAD OF WHO OFFICE IN COUNTRIES, TERRITORIES AND AREAS
<b>IAEG</b>	INTER-AGENCY EXPERT GROUP FOR SDGS
<b>IHP+</b>	INTERNATIONAL HEALTH PARTNERSHIP
<b>IHR</b>	INTERNATIONAL HEALTH REGULATIONS (2005)
<b>IOS</b>	INTERNAL OVERSIGHT SERVICES
<b>ISF</b>	INTEGRATED STRATEGIC FRAMEWORK (UN)
<b>JEE</b>	JOINT EXTERNAL EVALUATION
<b>MOH</b>	MINISTRY OF HEALTH
<b>NAPHS</b>	NATIONAL ACTION PLAN FOR HEALTH SECURITY
<b>NCD</b>	NONCOMMUNICABLE DISEASE
<b>NGO</b>	NONGOVERNMENTAL ORGANIZATION
<b>NHA</b>	NATIONAL HEALTH AUTHORITY
<b>NHPSP</b>	NATIONAL HEALTH POLICY, STRATEGY AND PLAN
<b>OECD</b>	ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT
<b>PB</b>	PROGRAMME BUDGET
<b>PBPA</b>	PROGRAMME BUDGET PERFORMANCE ASSESSMENT
<b>RD</b>	WHO REGIONAL DIRECTOR
<b>RO</b>	WHO REGIONAL OFFICE
<b>SDGS</b>	SUSTAINABLE DEVELOPMENT GOALS
<b>SMART</b>	SPECIFIC, MEASURABLE, ACHIEVABLE, REALISTIC AND TIME-BOUND
<b>SOP</b>	STANDARD OPERATING PROCEDURE
<b>SP</b>	STRATEGIC PRIORITY
<b>SPAR</b>	STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING
<b>UHC</b>	UNIVERSAL HEALTH COVERAGE
<b>UNAIDS</b>	JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
<b>UNCT</b>	UNITED NATIONS COUNTRY TEAM
<b>UNDAF</b>	UNITED NATIONS DEVELOPMENT ASSISTANCE FRAMEWORK
<b>UNDG</b>	UNITED NATIONS DEVELOPMENT GROUP
<b>UNFPA</b>	UNITED NATIONS POPULATION FUND
<b>UNICEF</b>	UNITED NATIONS CHILDREN'S FUND
<b>UNRC</b>	UNITED NATIONS RESIDENT COORDINATOR
<b>UNSDCF</b>	UNITED NATIONS SUSTAINABLE DEVELOPMENT COOPERATION FRAMEWORK
<b>WCO</b>	WHO COUNTRY OFFICE
<b>WG</b>	WORKING GROUP
<b>WHA</b>	WORLD HEALTH ASSEMBLY
<b>WHE</b>	WHO HEALTH EMERGENCY
<b>WHO</b>	WORLD HEALTH ORGANIZATION
<b>WR</b>	WHO REPRESENTATIVE

# CONTENTS

6	Foreword
8	Introduction
10	What's new?
11	What is unique about WHO's Country Cooperation Strategy?
13	How to use this guidance document
14	The six stages of the CCS cycle
14	<b>Stage 1 – Analyse</b>
18	1. ANALYSING THE COUNTRY CONTEXT
20	2. ANALYSING THE HEALTH AND EQUITY SITUATION Using the GPW13: Impact Framework to guide systematic analysis of a country's health situation
40	3. ANALYSING THE NATIONAL HEALTH AND DEVELOPMENT AGEND
43	4. ANALYSING THE PARTNERSHIP ENVIRONMENT
46	5. EXPRESSING NATIONAL PRIORITIES IN THE CCS
50	<b>Stage 2 – Conduct dialogue</b>
51	1. KEY STAKEHOLDERS TO CONSIDER
53	2. SETTING THE STRATEGIC AGENDA ON JOINT PRIORITIES FOR COLLABORATION
54	3. DEVELOPING AN AGREED COUNTRY IMPACT/ RESULTS FRAMEWORK
56	<b>Stage 3 – Draft the CCS</b>
57	PROPOSED CCS DOCUMENT STRUCTURE
60	<b>Stage 4 – Launch the CCS</b>
61	INNOVATIVE IDEAS FOR LAUNCHING THE CCS
62	<b>Stage 5 – Implement the CCS</b>
62	ALIGNMENT WITH OPERATION PLAN (CSP)
64	<b>Stage 6 – Monitor and evaluate the CCS</b>
64	MONITOR IMPLEMENTATION, CCS EVALUATION: MIDTERM AND FINAL EVALUATION
66	Annex 1. Concept note for CCS evaluation
74	Annex 2. Evaluation steps
75	Annex 3. WCO Evaluation Manager's terms of reference



# FOREWORD

WHO's 13th General Programme of Work (GPW13) puts countries at the centre of our work. In practice, this means our efforts must be directed towards these three goals:

- **Focusing** on measurable impacts to improve people's health;
- **Prioritizing** our work to drive public health impact in countries and demonstrate how resources will be aligned with delivery of these impacts; and
- **Aligning** and building synergies to deliver the work of the three levels of the organization.

The WHO Country Cooperation Strategy (CCS) is a medium-term corporate strategic framework designed to address the priorities of GPW13. Through the CCS, WHO identifies key priorities for technical cooperation with Member States, taking into consideration national context, to facilitate coordination with the United Nations Country Teams and other partners. The CCS guides dialogue, priority setting, and implementation of WHO's work at country level for achieving the "triple billion" targets, and the health-related Sustainable Development Goals.

The WHO Country Cooperation Strategy Guide 2020: Implementing the GPW13 for driving impact in every country will support the development, implementation and evaluation of a new generation of country cooperation strategies. It provides a step-by-step guide on how to develop each chapter of the CCS and highlights key checklists.

The mid-term and end of the CCS evaluation will assess which priorities were implemented through the country support plan and whether targets and indicators from the WHO impact framework were achieved.

I urge everyone across the three levels of WHO to contribute to the development of the CCS and use it to strongly align and better coordinate implementation to maximize WHO's impact at the country-level. It will enable you to identify countries where your area of work will be required for technical cooperation, and to provide tailor-made, differentiated country support, through policy dialogue, strategic support, and technical cooperation or services.



Dr Tedros Adhanom Ghebreyesus  
**Director-General**  
**World Health Organization**





# INTRODUCTION



The Country Cooperation Strategy (CCS) is WHO's strategic framework to guide the Organization's work in and with a country. It responds to that country's National Health and Development Agenda<sup>1</sup> and identifies a set of agreed joint priorities for WHO collaboration, covering those areas where the Organization has a comparative advantage in order to assure public health impact. The CCS is WHO's corporate framework strategy to implement the Thirteenth General Programme of Work (GPW13) with a response to country needs and priorities and addresses the Sustainable Development Agenda in health-related Sustainable Development Goals (SDGs).

As the public expression of WHO's results chain at the country level, the CCS sets out clearly defined impact targets for each of the agreed priorities. It also provides input to the process of formulating key elements of WHO's operational instruments such as the Country Support Plan (CSP), which is linked to the Programme Budget (PB) GPW13. The CCS brings corporate value to WHO as both a **process** and an **instrument**. It is recommended that each CCS should be aligned with the GPW13 and United Nations Sustainable Development Cooperation Framework (UNSDCF<sup>2</sup>). Wherever applicable the CCS should serve as the starting point for WHO work in that country. This will allow WHO and the Member State to deliver priorities through the CCS strategic framework and measure impact at country level, and to track health-related SDGs.

<sup>1</sup> "National Health and Development Agenda" is used throughout this text to describe all of a given country's health-related priorities which are typically drawn up by the Government in the form of strategies, policies, plans and vision documents. These often include National Health Policies and Plans, Sustainable Development Plans and other sectoral policies and plans that may have an influence on health and related aspects of the UNSDCF.

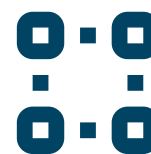
<sup>2</sup> [https://undg.org/wp-content/uploads/2019/06/UN-Cooperation-Framework-Internal-Guidance-25\\_June-2019.pdf](https://undg.org/wp-content/uploads/2019/06/UN-Cooperation-Framework-Internal-Guidance-25_June-2019.pdf)



As a **process**, CCS development provides a country-level platform for intensive, wide-ranging dialogue on a country's health needs and aspirations, while sensitizing partners to WHO's General Programme of Work (GPW) and global and regional goals. It is a unique opportunity to renew and deepen the collaboration between WHO and MoH, as well as other key sectors and partners.

As an **instrument**, CCS is:

- **a strategic vision towards public health impacts and outcomes.** A functioning CCS supports implementation of the GPW13 at the country level, and monitoring of results. It spells out WHO's jointly agreed priorities and their alignment with the national context and needs, specifically the health and development agenda, as well as opportunities for collaboration and interaction between various partners and stakeholders. The CCS can provide a steadfast focus on a given country's priorities and public health impact despite changes in the political agenda.
- **a means to support WHO's results-based management framework and contribute to internal and external assessments** such as the planned IOS reviews and WHO Country Office evaluation as set out in WHO Evaluation Practice Handbook.
- **a political instrument to promote national ownership and intersectoral approaches to achieve all health-related SDGs.** The CCS sets out the needs of the population and Government commitments to raise awareness of key issues, even beyond the traditional health agenda.
- **a mechanism to ensure strategic coherence, complementarity and coordination among UN entities** with mandates relevant to health and to boost the standing of health in the development agenda. CCS priorities provide major input to development of the health component of the United Nations Sustainable Development Cooperation Framework (UNSDCF)<sup>3</sup> and can serve as a policy accelerator for the health agenda in the UNCT through GAP for SDG3.
- **a tool to mobilize resources** at the country level. It can also serve as a tool for countries to demonstrate the support they provide to other countries and to global and regional health agendas.
- **a platform for increasing WHO's visibility** in terms of communication and advocacy. It can draw attention to WHO's work with specific Member States and enhance opportunities for resource mobilization.
- **a key contributing factor to WHO's transparency in the responsible use of international aid.** In 2016, WHO joined the International Aid Transparency Initiative (IATI) which registers aid flows and compares WHO to other international agencies based on a range of factors including the availability of a valid CCS.



*As the public expression of WHO's results chain at the country level, the CCS sets out clearly defined impact targets for each of the agreed priorities.*

<sup>3</sup> The United Nations Sustainable Development Cooperation Framework (UNSDCF) is replacing the UNDAF.





## What's new?

The GPW13 challenges WHO to transform into a **country-focused** and **impact-orientated** Organization. WHO's country planning and implementation are being reorganized for the 2020–2021 biennium and the country operating model is being strengthened. To ensure that the CCS reflects the strategic priorities and shifts of the GPW13 as well as opportunities arising through the new United Nations Sustainable Development Cooperation Framework (UNSDCF), a new generation of country cooperation strategies is needed.

### The new CCS should:

- support implementation of the GPW13 triple billion targets, based on countrywide strategic priorities and the WHO Global Action Plan for healthy lives and well-being for all;
- be more strategically focused on results, with targets and milestones based on outcome indicators from CCS so as to achieve impact during the CCS in line with longer-term goals, e.g. health-related SDGs;
- serve as the basis for all WHO's strategic cooperation work in Member States and provide a direct link with the WHO Country Support Plans (CSP) on how, when and at which level (HQ, RO or CO) WHO support should be provided to a given country: the CCS should serve as a template for the CSP and indicate how all three levels of the Organization can contribute towards clearly defined priority outcomes and targets defined at country level (and thereby also promote a coherent "One WHO" approach);
- remain aligned with National Strategic and Development Plans and the United Nations Sustainable Development Cooperation Framework (UNSDCF), being updated as and when required to reflect changes at the national and global levels;
- include a clear results chain designed as a country-level impact framework which includes targets (milestones) related to expected outcomes and the triple billion index of GPW13 and the SDGs;
- provide an opportunity to identify and engage a wider partnership environment to achieve the SDGs and country-specific implementation and innovation factors related to the WHO Global Action Plan for healthy lives and well-being for all;
- recognize the relevance of working with the UN system to encourage its reform, and the need to provide more coherent support for achieving SDGs that bring the CCS into line with the UNSDCF, wherever possible;
- contain an overview of requisite and available resources as well as probable shortfalls so that the Organization can mobilize future resources more fully, and address priorities identified in the CCS in a more-timely manner;
- contain a detailed map of academic stakeholders and civil society organizations (CSO) for each Member State, defining areas of synergy and planned engagement and setting priorities for monitoring via a CSO engagement road map.



**WHO's country planning and implementation are being reorganized for the 2020–2021 biennium and the country operating model is being strengthened.**

The Country Cooperation Strategy (CCS) informs and supports the development of WHO's programme budget and operational planning (Country Support Plans) and yet, as a strategic process and instrument, goes well beyond operational planning and budgeting. It adds unique value to WHO's work in six main ways.

- 1. CCS development facilitates broad dialogue and strengthens partnerships based on the country's full national health and development agenda, including priorities beyond GPW13 outcomes and impacts.** Strategic policy dialogue is undertaken with key government sectors and partners in addition to the MoH on all of a country's health and development needs and aspirations. It presents a unique opportunity to renew and deepen the collaboration between WHO and partners.
- 2. CCS provides a clear strategic rationale for WHO's work to guide planning processes.** Its situation analysis offers a strategic rationale informed by the national context for WHO's work in and with a country and partners.
- 3. CCS sets out WHO's role and contribution to the UN system at the country level.** Since it is more detailed than the UNSDCF, it can influence development of the health component of the UNSDCF and serve as a policy accelerator for health within the UN at country level. It can provide direct input to the Common Country Assessment (CCA) of the UNSDCF, enabling the WHO Representative in the Country Office (WR) to take a leading role in the health section of UNSDCF. The CCA can serve as a basis for prioritization exercises for both CCS and UNSDCF on health issues, under WR leadership. The CCS operates as WHO's framework for country engagement and provides direct input to the UNSDCF for those countries with a UNCT. The timing of the CCS is ideally aligned to the UNSDCF. If the new UNSDCF is not yet developed and the CCS is up for renewal, timeframes should be matched, when possible.
- 4. CCS promotes country ownership in achieving health-related SDGs.** Jointly identified priorities are negotiated, agreed, endorsed and monitored through the CCS by senior Government and WHO officials.
- 5. CCS evaluation goes beyond measuring WHO outcomes and impact.** Assessment focuses on the country's progress (in collaboration with WHO and partners) towards joint priorities and impact targets set by the country itself.
- 6. As a public product, CCS boosts the visibility and accountability of WHO operations and results.** Unlike internal planning tools and documents, CCS can be used for external communication, resource mobilization and greater advocacy for priority issues in the country.

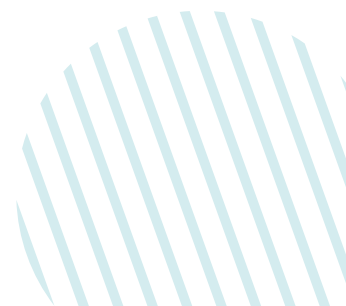
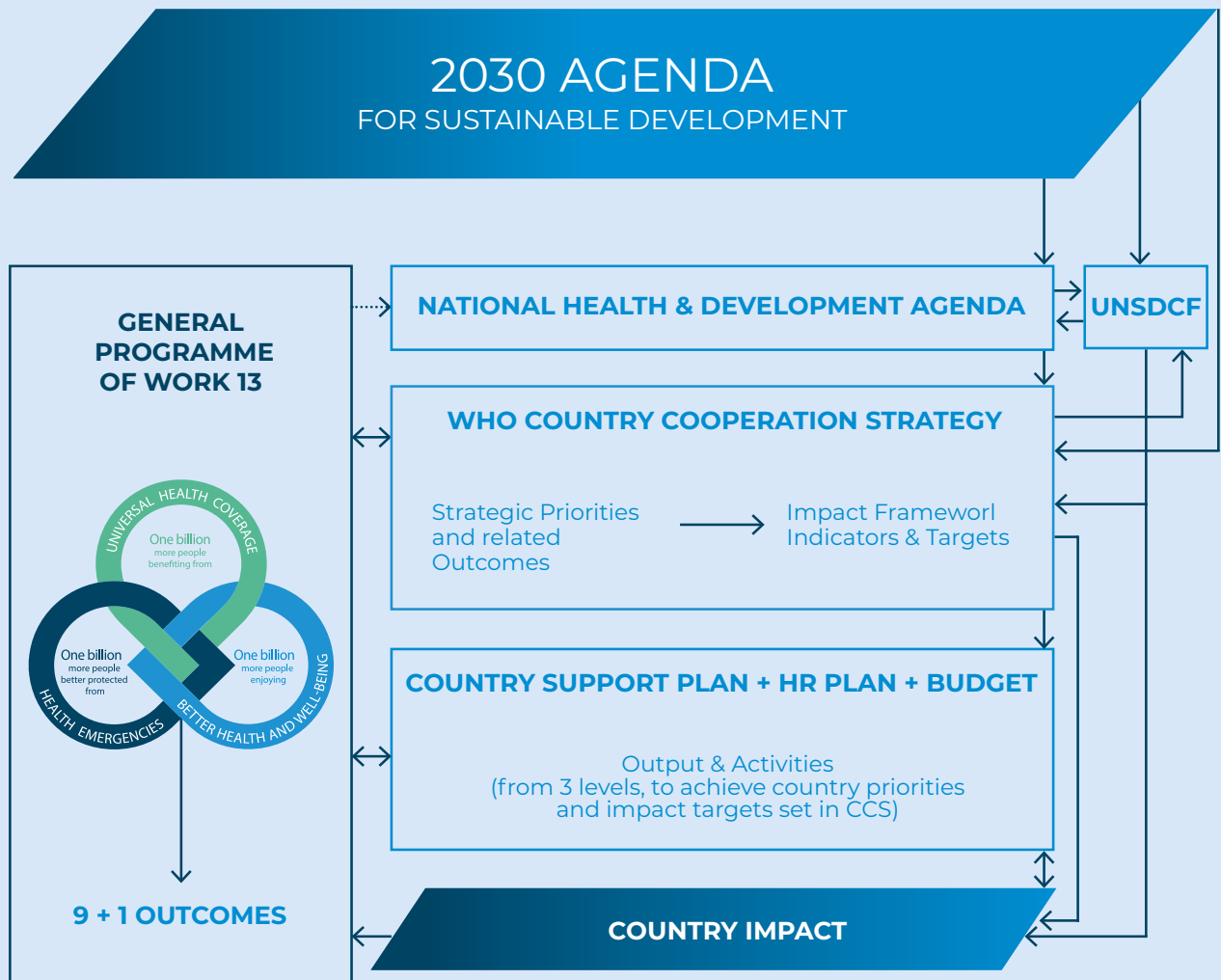


Fig. 1 – CCS as a tool to implement the GPW13, guide WHO's strategic cooperation, and drive impact at the country level



## How to use this guidance document

The Country Cooperation Strategy Guide (2020) is designed to be a practical tool kit, providing a step-by-step approach to the development process and setting out the key components for producing a concise and evidence-based CCS. This guidance document has been developed to assist all stakeholders involved in drawing up the CCS. The six stages for successful development, implementation and evaluation of the CCS are described in Fig. 2 below and explained in this CCS Guide. A CCS prototype document is available as a companion to the CCS Guide and can be used as a template to assist countries in developing their own CCS.

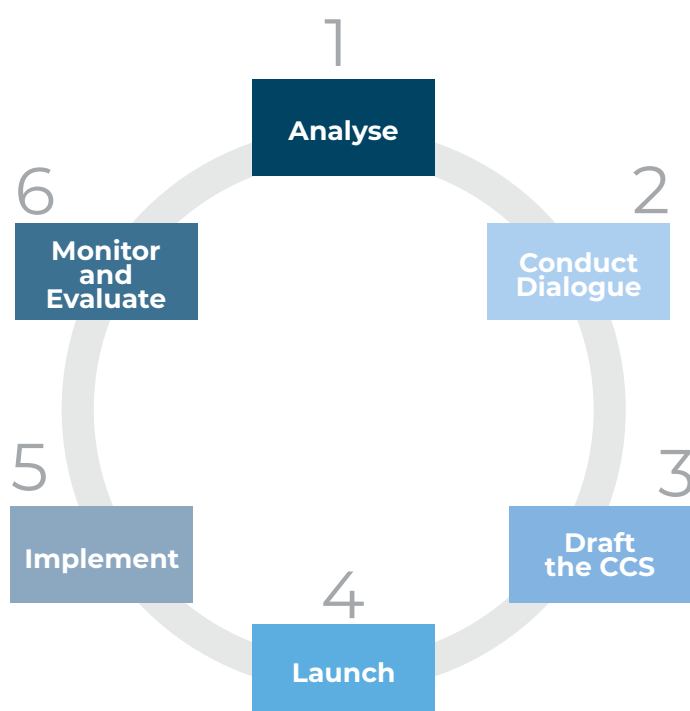
This CCS Guide applies to all countries for which WHO provides technical assistance, regardless of whether the Organization has a dedicated Country Office or provides support from another country or Regional Office. It is flexible enough to allow countries in conflictual and fragile situations as well as high-income countries to follow a similar approach.

If you have feedback or questions regarding the guide, please contact: [countryfocus@who.int](mailto:countryfocus@who.int)



***This CCS Guide applies to all countries for which WHO provides technical assistance.***

*Fig 2. The six stages for successful development, implementation and evaluation of the CCS*



# THE SIX STAGES OF THE CCS CYCLE

## Stage 1 Analyse

### Estimated time required: 1 month.

The CCS should reflect priorities for a given country which are linked to the GPW13. It should be aligned with the UNSDCF timeframe and ideally provide input for the health component of the Country Common Analysis (CCA) and UNSDCF. Ideally, the CCA/UNSDCF would inform the CCS.

This phase is closely connected with the evaluation process.



### ESSENTIAL TO KNOW:

#### ***Where a WCO exists, the CCS should be led by the WR***

The WHO Representative (WR) is responsible for supervising and delivering a high-quality CCS as well as implementing, monitoring and reporting its results. All three levels of the Organization should be involved in CCS development, the WR owns and takes an active role throughout the entire process. If a UNCT is operational in the country, the WR should liaise proactively with the UNRC to include CCS priorities in the UNSDCF.

In countries **without** a WCO, the CCS should be initiated and led by the Regional CSU Office, with assistance from technical units for each agreed strategic area of collaboration, and from HQ CSS when needed.

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### Key considerations when preparing a new CCS:

- Key findings from evaluation of the latest CCS. UNSDCF evaluation can also be used as an input. The evaluation phase details how input can be provided into the development of the CCS.
- Country context, including the feasibility of developing the CCS and the presence of any immediate competing government priorities, e.g. forthcoming election, acute political instability, civil unrest or humanitarian crisis.

- Timeline of national health and SDG-related plans and policies as well as UNSDCF. The CCS can be considered a UN instrument insofar as it is an authentic expression of UNSDCF outcomes plus additional standard-setting activities not prioritized in the UNSDCF.
- Country office capacity for undertaking CCS development and whether additional expertise and/or resources are needed.

### Important early actions

- Hold initial discussions to involve WCO staff, regional CSUs and CSS/HQ. Key players in technical units and departments (HQ and regional offices) should also be consulted.
- Discuss informally with MoH and other relevant ministries for input and prepare other key stakeholders including relevant UN agencies/ Resident Coordinator and other health and development partners for active involvement in the process.
- Establish a CCS working group (size will depend on country's capacity) and identify additional capacity and expertise if required.
- DON'T FORGET – network with the regional CSU and CSS/HQ department as soon as a new CCS is proposed in order to acquire more information, resources, guidance and recent learning and best practices.
- The first action is to analyse each of the key areas listed below to identify key issues that will help guide development of the CCS and strategic priorities. A strong evidence base is crucial to development of a CCS that most effectively meets the country's needs and helps it achieve its health-related SDG targets. It will ensure that the priorities selected and type of support provided are relevant and focused on the country's specific needs and challenges. Recent and disaggregated data are particularly important to ensure that health-related human rights and gender issues are given proper consideration, and that vulnerable populations are not left behind.



### Alignment of the CCS and the UNSDCF

- **Ideally the UNSDCF is to be developed first and inform the CCS.**
- **If not the latter, CCS and UNSDCF can be developed in parallel.**
- **The prerogative lies with the country. WHO will ensure to fit to the needs in the country context and UN process at country level.**





### **CHECKLIST:**

#### ***Stakeholders to consider for the CCS working group:***

- ✓ WHO Representation from all 3 levels
- ✓ MoH/key health agencies
- ✓ Representatives from other sectors relevant to health sector
- ✓ Representatives from UN agencies/ development partners working towards SDG-related health targets
- ✓ NGO/CSOs including those defending marginalized groups
- ✓ If warranted, a health expert for fragile states who knows the country

#### ***Key information to share among working group members:***

- ✓ National development policies/national SDG plans
- ✓ NHPSP, annual reports, vital statistics and surveys
- ✓ External reports on GER, IHP+, fragility/ conflict analyses, ISF, emergency risk assessment
- ✓ Country's current functional and programme reviews
- ✓ UNSDCF, UN Vision 2030, Common Country Analysis (CCA), workplans of relevant results groups
- ✓ Final evaluation of previous CCS







## Key areas for analysis

### 1

#### **Country context**

Including key political, social, demographic and economic factors.

### 2

#### **Health and health equity situation**

Country burden of disease and root causes.

### 3

#### **National health and development agenda**

Policies, plans and reforms across sectors.

### 4

#### **Partnership environment**

UN and other relevant partners in health and development.

### 5

#### **The final step**

Once the national context has been fully analysed, GPW13-related priorities and impact targets identified in the planning and budgeting process should be reviewed to ensure that they are properly aligned as well as to identify any major gaps not addressed by WHO, Government or partners.

All five areas for analysis are explored in detail below.



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# 1. Analysing the country context

Overview of key political, social, cultural, demographic, environmental, economic, technological and other factors and determinants with important implications for health. Areas to cover may include:

- **the main drivers for progress in population health and development;**
- **important topics to address;**
- **persistent challenges;**
- **key health achievements and areas of global and regional interest;**
- **identifying particularly vulnerable populations; and**
- **the legislative and policy environment affecting health, including non-health sectors.**

For countries where UNCT is operational, the country context analysis can be mapped from the Common Country Assessment (CCA), specifically the section dealing with the national context. Cross-cutting issues (e.g. equity, gender, human rights) should be analysed, especially when they complicate or impinge on efforts to address key health challenges which have been identified. Further guidance is provided in the analysis of health and equity below.

Like the CCA (if available), this assessment should provide a strategic overview of the most significant government policies and critical gaps in the policy architecture.



Table 1. Cross-cutting themes in the country context<sup>4</sup>

Themes	Elements
Socio-economic situation	<ul style="list-style-type: none"> <li>• Economic situation and drivers for growth</li> <li>• Trends in poverty reduction and international development assistance</li> <li>• Social determinants of health: housing, education and work</li> <li>• Population demographics</li> <li>• Population distribution, density and trends, e.g. urbanization</li> <li>• Religious factors</li> </ul>
Political situation	<ul style="list-style-type: none"> <li>• Government structure</li> <li>• Public participation in governance</li> <li>• Financial structures</li> <li>• Influence of the country on the subregional, regional and global development agenda</li> </ul>
Climate and environment	<ul style="list-style-type: none"> <li>• Country-specific and emerging risks or threats</li> <li>• Environmental determinants of health (water, sanitation, pollution)</li> <li>• Resilience and climate action mitigation and adaption actions</li> </ul>
Peace-humanitarian-development nexus (if relevant)	<ul style="list-style-type: none"> <li>• Disaster risk reduction</li> <li>• Conflict and displacement risks</li> <li>• Humanitarian response</li> <li>• Activities for sustainable development</li> </ul>

<sup>4</sup> The cross-cutting themes in Table 1 are mapped with cross-cutting themes from the CCA for the UNSDCF.



## 2. Analysing the health and equity situation

The GPW13 should serve as the conceptual framework for undertaking a robust health situation analysis. A CCS can be deployed to track the joint efforts of WHO and its Member States to meet GPW13 targets in alignment with the strategic priorities defined by the country itself. Every WHO Country Office should have access to baseline data for all indicators: these should be examined at inception along with data from other sources. Where available, the national databases used for the national health policy, strategy and plan can provide insight on baseline data for health as well as be used to project or map CCS priorities, provided the data meet **WHO data quality standards**.

To ensure WHO's work can adequately address issues of **gender, equity and human rights (GER)**, all data should, wherever possible, be disaggregated for analysis (sub-nationally and by sex) in order to detect priority inequalities and/or vulnerable groups. Disaggregated data strengthens effective and evidence-based interventions that can be implemented at population, subpopulation and individual levels. Data also provide insight into the gender-responsiveness, human rights-based and equity-oriented (GER) approach currently present in the country and guide the analysis of evidence needed for GER mainstreaming in the CCS.



***Every WHO Country Office should have access to baseline data for all indicators.***



Table 2. GER analysis for the CCS

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## Evidence and analysis of GER

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- Data are disaggregated by sex and at least two other inequality dimensions (e.g. age, disability, economic status, education, place of residence (urban/rural) and subnational geography (where applicable). If disaggregation by sex is not feasible, a clear explanation should be provided
  - Populations experiencing disadvantage or discrimination and processes leading to exclusion are identified
  - Analysis of policies and laws include a gender, equity and rights analysis of the evidence
- 

## Reducing inequities

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- Analysis of strategic documents with respect to proposed actions and interventions to reduce gender inequalities, health inequities and discrimination
  - Analysis of technical assistance in place to support planning and development of actions to reduce and monitor health inequities, including gender inequalities and discrimination
  - Analysis of stakeholders' participation in the design, implementation and evaluation of actions to reduce health inequities
- 

## Accountability for GER mainstreaming

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- Analysis of actions and/or plans in place to build national capacities on mainstreaming gender, equity and human rights in health that can sustain this mainstreaming approach in the implementation of the CCS.
-



## CHECKLIST:

*The following items are all essential to present a complete picture of health indicators.*

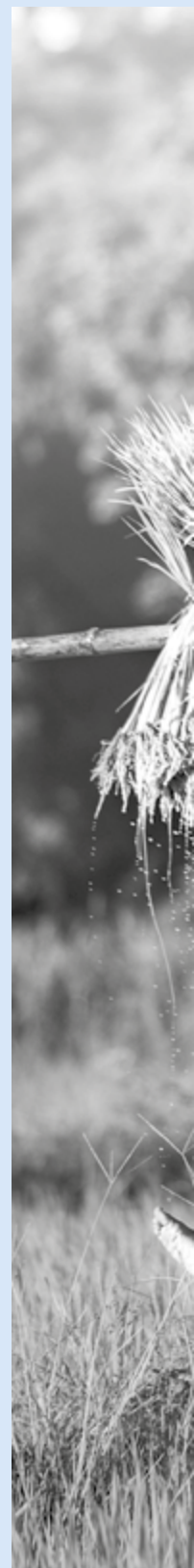
- ✓ In addition to reviewing the country's health situation for each of the GPW13 targets, **review its top ten causes of death/burden of disease.**
- ✓ **Disaggregate data** by sex, age, income, geography, etc., wherever possible to reveal inequities, health-related human rights and gender issues.
- ✓ **Prepare trend analyses and projections** of the burden of disease to display progress and remaining and future challenges.
- ✓ Once data have been analysed, "spotlight" key indicators in the CCS with a **breakdown of root causes and identify any key actions being taken to address the issue at the country level.**

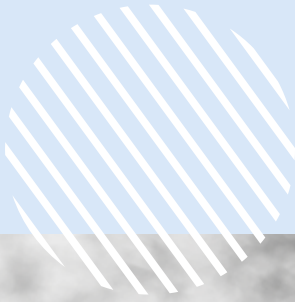


## KEY DATA SOURCES:

*Data for health situation analysis can be accessed from:*

- World Health Statistics data visualizations dashboard – monitoring health for the SDGs: <https://apps.who.int/gho/data/node.sdg>
- Country-level data for all 46 programme indicators compiled from the UNSD SDG database (38 SDG indicators) and from the WHO Global Health Observatory (8 non-SDG indicators): <https://amitprasad.shinyapps.io/gpw13-data>
- Global Burden of Disease Foresight – data visualizations and projections: <https://vizhub.healthdata.org/gbd-foresight>
- WHO Country Presence Data on the country presence portal: <http://apps.searo.who.int/cpd/Home/Index>
- Global Health Observatory: <http://www.who.int/gho/en>
- Life expectancy (LE) and healthy life expectancy (HALE) data source: [http://www.who.int/gho/mortality\\_burden\\_disease/life\\_tables/en](http://www.who.int/gho/mortality_burden_disease/life_tables/en)
- Global Burden of Disease: <http://www.healthdata.org/gbd>
- World Health Surveys: <http://www.who.int/healthinfo/survey/en>
- SDG Indicators – Department of Economic and Social Affairs/Statistics Division UN: <https://unstats.un.org/sdgs/indicators/database>





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Using the GPW13 Impact Framework to guide systematic analysis of a country’s health situation

The GPW13 goal is to reach the triple billion target by 2023. The CCS, as a joint WHO-Member State instrument, is intended to facilitate the implementation of GPW13: its triple billion target stands in alignment with priorities based on the country’s own needs and which can be measured by the defined outcome indicators and milestones set out in the CCS.

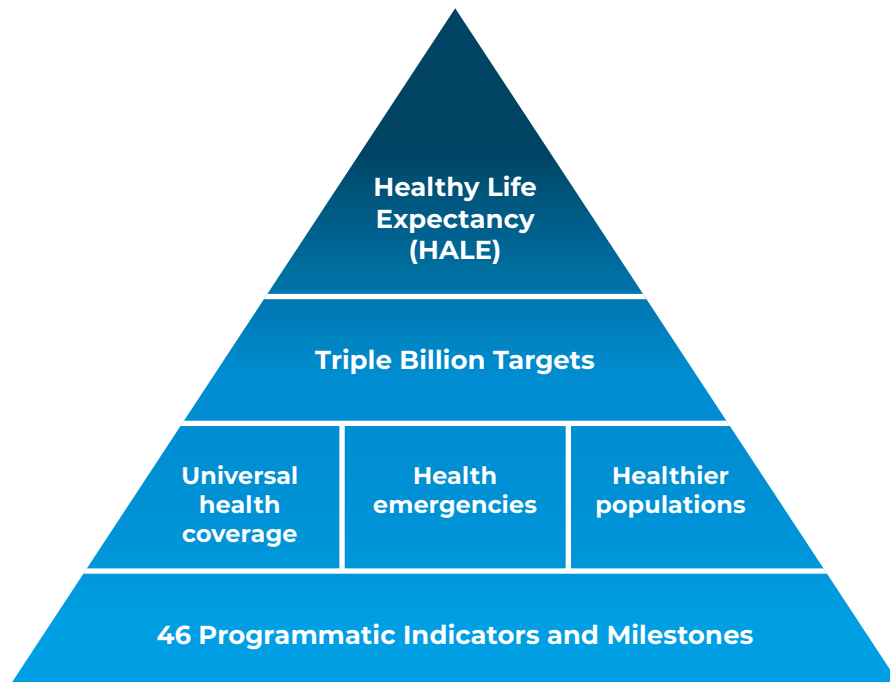
The CCS defines, for each outcome, the country’s strategic priorities and indicators (SDG and others) to measure progress and impact. The country itself, working together with the WHO Country Office, decides which specific targets and indicators will be chosen to track and evaluate a milestone (target). Tracking methods are set out below and are linked to the WHO Impact Framework outlined in Fig. 3, as measured by Healthy Life Expectancy (HALE), the triple billion indices<sup>5</sup> and programme outcomes.

Presenting quantitative results alongside qualitative stories about CCS implementation will allow the WR to report on GPW13 and SDG outcomes and present a holistic view of WHO’s impact at the country level.



**The country itself, working together with the WHO Country Office, decides which specific targets and indicators will be chosen to track and evaluate a milestone (target).**

Fig. 3. WHO Impact Framework



<sup>5</sup> The triple billion indices are under development and will be presented to Member States at the WHA in 2020.



The impact framework is a measurement system with three layers:

- **46 programme indicators and milestones (also known as outcome indicators in the 2020–2021 PB)** covering a range of health issues and providing a set of indicators to measure outcomes in the programme budget (PB). They include 39 SDG indicators together with 7 non-SDG indicators that address priorities identified by member states: antimicrobial resistance; polio; risk factors for noncommunicable diseases; and emergencies. The 46 programmatic indicators are associated with 40 2023 global milestones. Each milestone is tracked by one or more indicators, which are aligned with the SDGs. Indicators and milestones apply for the entire period of the GPW13 (2019–2023). Countries will select their priorities from within this set of 46 programme indicators and targets, and track progress towards selected targets using the related indicators. In other words, not every country will track every target or indicator: priorities will be defined in the CCS. Indicators will be disaggregated by key inequality measures (such as sex, age and location).
- **The triple billion targets are:** 1 billion more people benefiting from universal health coverage, 1 billion more people better protected from health emergencies and 1 billion more people enjoying better health and well-being. The goal is to achieve the triple billion targets by 2023. Each of the triple billion targets will be measured using composite indices. Each billion will be measured at the global and regional levels, and the contribution made by the CCS at the national level.
- **Healthy life expectancy (HALE)**, as set out in the GPW13, is considered to be a good summary measure for overall population health and a means of determining overall progress towards SDG3. The general health analysis should describe the country's life expectancy (LE) and, wherever possible, healthy life expectancy at birth (HALE). HALE is an extended, complementary estimation of the more commonly used indicator, life expectancy. Where life expectancy measures solely the length of life, HALE measures both the length and quality of life. It is therefore a more comprehensive indicator which is more closely aligned with SDG targets and GPW13 milestones.

Under the heading of each billion, the following pages explain how the CO can use and integrate GPW13 Impact Framework measurements in its CCS health situation analysis as a basis for prioritization.



The **46**  
programmatic  
indicators are  
associated with  
**2023**  
global milestones.



### Achieving Universal Health Coverage (UHC) – 1 billion

Universal health coverage means that all people receive the health services they need, including promotive, preventive, treatment, rehabilitation and palliative care of sufficient quality to be effective, while ensuring that the use of these services does not expose the user to financial hardship. In keeping with the spirit of UHC expressed in SDG 3, GPW13 incorporates both service coverage and financial protection in counting one billion more people receiving UHC by 2023.



The index was approved by the Inter-agency Expert Group for SDG indicators (IAEG-SDGs), a group of National Statistical Offices created by the UN Statistical Commission to monitor the SDGs. The universal health coverage index is a combined measure of health service coverage and related financial hardship. Health service coverage will be measured using the service coverage index approved by IAEG-SDGs, and consists of 14 indicators (five of which are SDG indicators and nine of which involve SDG inputs or fall within the 46 programme indicators). It is recognized however that the current measure of health service coverage focuses on “crude” coverage and does not capture “effective” coverage, and the Secretariat is working on an updated service coverage measurement to be pilot-tested in 2019–2020 in selected countries. In terms of financial protection, SDG indicator 3.8.2 set two thresholds for “large” health-related household expenditure in order to decide what ought to be considered a “catastrophic” out-of-pocket payment for a health intervention: 10% and 25% of total household expenditure or income.

## UHC

*The universal health coverage index is a combined measure of health service coverage and related financial hardship.*

<sup>6</sup> The triple billion indices will be presented to Member States at the WHA in 2020.

Given the importance of UHC to achieving health as a human right, UHC (or a specific component of essential services and/or health protection) should be a priority issue in all country cooperation strategies. The GPW13 outcome indicators in Table 3 are aligned with the SDGs (or WHA resolutions in a few cases) and be used to identify priorities and track progress towards UHC, especially indicators 11 (essential services) and 18 (household expenditure). The wider set of indicators in the table reflect different aspects of service coverage and quality and can be used as a menu, with items being chosen according to their relevance to the country context. The CCS is therefore not required to define all UHC outcome indicators listed below; they can be summarized in an annex in the CCS assessment/analysis phase, allowing it to focus on those indicators linked to the strategic priorities as agreed by the country and WHO.



Table 3. UHC outcome indicators

<b>Indicator</b>	<b>2023 milestone</b>	<b>GPW13</b>	<b>SDG/WHA</b>
1. Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	20% relative reduction in the premature mortality (age 30–70 years) from noncommunicable diseases (cardiovascular diseases, cancer, diabetes or chronic respiratory disease) through prevention and treatment	1.1	SDG 3.4.1
2. Suicide mortality rate	Reduce suicide mortality rate by 15%	1.1	SDG 3.4.2
3. Proportion of women of reproductive age (aged 15–49 years) whose family planning needs are met with modern methods	Increase the proportion of women of reproductive age (aged 15–49 years) whose family planning needs are met with modern methods to 66%	1.1	SDG 3.7.1
4. Tuberculosis incidence per 100 000 population	Reduce by 27% the number of new tuberculosis cases per 100 000 population	1.1	SDG 3.3.2
5. Maternal mortality ratio	Reduce the global maternal mortality ratio by 30%	1.1	SDG 3.1.1
6. Hepatitis B incidence per 100 000 population	Reduce hepatitis B incidence to 0.5% for children aged under 5 years	1.1	SDG 3.3.4
7. Number of new HIV infections per 1000 uninfected population, by sex, age and key population groups	Reduce number of new HIV infections per 1000 uninfected population by sex, age and key population groups by 73%	1.1	SDG 3.3.1

Indicator	2023 milestone	GPW13	SDG/WHA
8. Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure of >140 mmHg and/or diastolic blood pressure >90 mmHg) and mean systolic blood pressure	20% relative reduction in the prevalence of raised blood pressure	1.1	WHA 66.10
9. Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders	Increase service coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders to xx <sup>7</sup>	1.1	SDG 3.5.1
10. Health worker density and distribution	Increase health workforce density, with improved distribution	1.1	SDG 3.c.1
11. Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)	Increase coverage of essential health services	1.1	SDG 3.8.1

<sup>7</sup> Milestone to be revised.

<b>Indicator</b>	<b>2023 milestone</b>	<b>GPW13</b>	<b>SDG/WHA</b>
12. Proportion of births attended by skilled health personnel	Reduce the global maternal mortality ratio by 30%	1.1	SDG 3.1.2
13. Under-five mortality rate	Reduce the preventable deaths of newborns and children aged under five years by 17% and 30%, respectively	1.1	SDG 3.2.1
14. Neonatal mortality rate		1.1	SDG 3.2.2
15. Proportion of the target population covered by all vaccines included in their national programme	Increase coverage of 2nd dose of measles vaccine to 85%	1.1	SDG 3.b.1
16. Number of people requiring interventions against neglected tropical diseases	Reduce by 400 million the number of people requiring interventions	1.1	SDG 3.3.5
17. Malaria incidence per 1000 population	Reduce malaria case incidence by 50%	1.1	SDG 3.3.3
18. Proportion of population with large household expenditures on health as a share of total household expenditures or income	Prevent an increasing number of people suffering financial hardship (defined as out-of-pocket spending exceeding ability to pay) in accessing health services	1.2	SDG 3.8.2
19. Proportion of total government spending on essential services (education, health and social protection)	Increase the share of public spending on health by 10%	1.2	SDG1.a.2

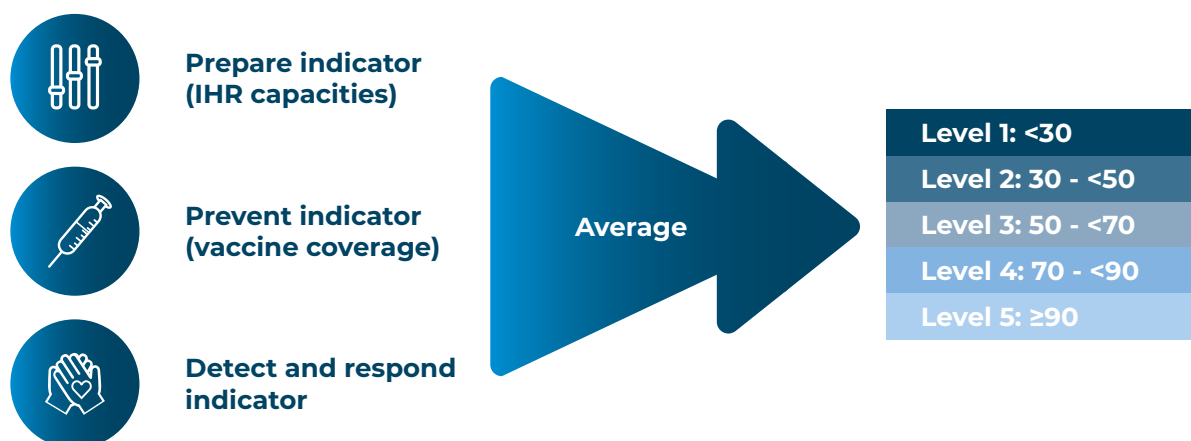
<b>Indicator</b>	<b>2023 milestone</b>	<b>GPW13</b>	<b>SDG/WHA</b>
20. Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis	Increase the availability of essential medicines for primary health care, including those free of charge, to 80%	1.3	SDG 3.b.3
21. Patterns of antibiotic consumption at national level	ACCESS group antibiotics at $\geq 60\%$ of overall antibiotic consumption	1.3	WHA 68.7

This table can help to define what aspects should be foregrounded in the health analysis part of the CCS in relation to UHC. If data are available, provide a succinct description of the health workforce and its breakdown in terms of sex, age and the urban/rural divide.

### Addressing health emergencies – 1 billion

Goal 2 is to ensure that 1 billion more people are more effectively protected against health emergencies. To achieve this goal, data available for analysis of the health emergency context can be incorporated in the CCS in order to guide strategic priorities. When analysing emergencies at the country level, three steps should be borne in mind: “prepare” (measuring IHR), “prevent” (measuring routine and emergency vaccination) and “detect and respond” (measuring timeliness in detecting and responding to potential health emergencies).

Fig 5. Health emergencies index



The health emergencies index consists of three tracer indices that capture activities associated with preparing for, preventing, and detecting and responding to health emergencies. The overall **health emergencies index** is the **average of the three preparedness, prevention, and detect and respond indicators**. The health emergencies index ranges from 0 (no protection) to 100 (perfect protection) and is banded into five levels. Priority indicators for the health emergencies index are displayed in Table 4. These indicators will be combined to produce the overall index to measure the health emergencies billion.



Table 4. World Health Emergencies (WHE) outcome indicators

<b>Indicator</b>	<b>2023 milestone</b>	<b>GPW13</b>	<b>SDG/WHA</b>
1. International Health Regulations (IHR) capacity and health emergency preparedness	Increase in Member States' International Health Regulations capacities	2.1	SDG 3.d.1
2. Vaccine coverage of at-risk groups for epidemic or pandemic prone diseases	Increase immunization coverage for cholera, yellow fever, meningococcal meningitis and pandemic influenza	2.2	WHE
3. Number of cases of poliomyelitis caused by wild poliovirus (WPV)	Eradicate poliomyelitis to zero cases of poliomyelitis caused by wild poliovirus and establish a clear timetable for the global withdrawal of oral polio vaccines in order to stop outbreaks caused by vaccine-derived poliovirus	2.2	WHA68.3
4. Number of deaths, missing persons and directly affected persons attributed to disasters per 100 000 population	Reduce the number of deaths, missing persons and persons affected by disasters per 100 000 population	2.3	SDG 1.5.1
5. Proportion of vulnerable people in fragile settings provided with essential health services	Increase the number of vulnerable people in fragile settings provided with essential health services to at least 80%	2.3	WHE

It is important to note that every country has its own profile with regard to health emergencies, whether in terms of preparedness, prevention, detection and/or response. In countries in a fragile situation, the context is more dynamic. A CCS strategic agenda will usually have a shorter timeframe in which to address a country's immediate health-related humanitarian and development priorities, based on assessment of its vulnerability and risks and WHO's role in emergency situations. A CCS for a fragile or disaster-prone country should include strategic priorities to cover unforeseen acute events or escalation of an ongoing conflict that may require emergency action, including managing disease outbreaks and natural or human-induced disasters. A major emergency or significant change in a country's situation may require review, revision and renewal of the CCS.

The role of WHO as health cluster lead agency should be detailed in the CCS and information provided on whether a humanitarian coordinator and country team are present in the country. The CCS should identify the cluster organization and individual roles, so that should an emergency occur applicable mechanisms and hierarchies can be followed in line with the principles set out in the Emergency Risk Framework. For WHO, this approach raises issues concerning capacity, resource pooling and the application of standard operating procedures (SOPs) in emergencies. The WHO Emergency Response Framework provides procedural guidance to WHO Country Offices in emergencies.



### **Key elements for integrating health emergencies in the CCS :**

- Include key stakeholders responsible for multisectoral and health emergency risk assessment and management, IHR and WHO operational readiness for emergency responses in the CCS consultation. Note that some key emergency stakeholders may be based outside the Ministry of Health - it is important to get them involved in the CCS from the start.
- IHR core capacities (SPAR tool report) and National Action Plan for Health Security (NAPHS), based on a One Health for all-hazards, whole-of-government approach. The "NAPHS for all" country implementation guide can be linked to the CCS, if applicable.
- Joint External Evaluation (JEE) may be a priority if not yet completed. Where JEE has been completed, the CCS can be used along with NAPHS to address gaps and implement its recommendations.

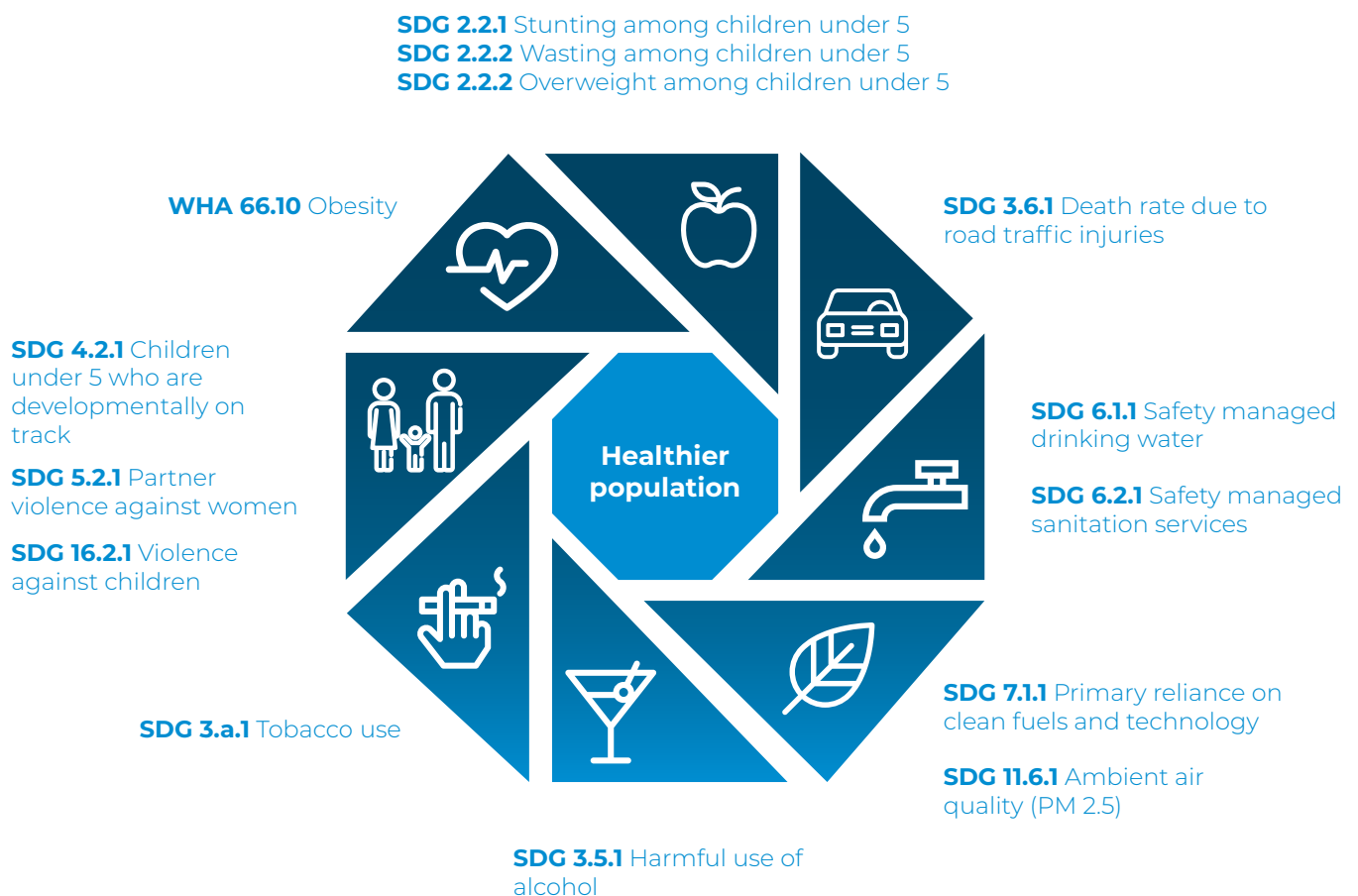


## Promoting a healthier population – 1 billion

The healthier population billion aims to address factors influencing people's health that lie outside the direct control of the health sector, and which can be influenced by multisectoral action, legislation and policy. What are the major determinants of poor health in the country? What major risk factors exist that need to be addressed through multisectoral action, health in all policies and health-setting interventions?

This healthier populations index focuses on measuring the impact of multisectoral interventions influenced by policy, advocacy and regulatory approaches stewarded by the health sector. Priority indicators have all been selected from programme outcome indicators and are listed in Table 5.

Fig. 6. Healthier population index<sup>9</sup>



The main criteria for selecting the indicators for the healthier population billion are that they should focus on health and well-being and lie outside the direct control of the health sector properly speaking. Fig. 6 shows the 14 indicators that have been selected for inclusion in the index. All but one are SDG indicators.

<sup>9</sup> The triple billion indexes will be presented to Member States at the WHA in 2020.

Table 5. Healthier population outcome indicators

<b>Indicator</b>	<b>2023 milestone</b>	<b>GPW13</b>	<b>SDG/WHA</b>
1. Mortality rate attributed to household and ambient air pollution	Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.1	SDG 3.9.1
2. Prevalence of malnutrition (weight-for-height $\geq 2$ or $\leq 2$ standard deviations from the median value of the WHO Child Growth Standards) among children aged under 5 years (overweight)	Halt and begin to reverse the rise in childhood overweight (0–4 years)	3.1	SDG 2.2.2
3. Proportion of children aged under five years who are developmentally on track in health, learning and psychosocial well-being, by sex	Increase the proportion of children aged under five years who are developmentally on track in health, learning and psychosocial well-being to 80%	3.1	SDG 4.2.1
4. Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month	Decrease the number of children subjected to violence in the past 12 months, including physical and psychological violence by caregivers in the past month, by 20%	3.1	SDG 16.2.1
5. Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	Decrease the proportion of ever-partnered women and girls aged 15–49 years subjected to physical or sexual violence by a current or former intimate partner in the previous 12 months from 20% to 15%	3.1	SDG 5.2.1

Indicator	2023 milestone	GPW13	SDG/WHA
6. Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	Increase the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care to 68%	3.1	SDG 5.6.1
7. Death rate due to road traffic injuries	Reduce the number of global deaths and injuries from road traffic accidents by 20%	3.1	SDG 3.6.1
8. Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)	Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.1	SDG 3.9.2
9. Mortality rate attributed to unintentional poisoning		3.1	SDG 3.9.3
10. Proportion of population with primary reliance on clean fuels and technology	Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.1	SDG 7.1.2
11. Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (weighted population)		3.1	SDG 11.6.2
12. Proportion of population using safely managed drinking water services	Provide access to safely managed drinking water services for 1 billion more people	3.1	SDG 6.1.1

<b>Indicator</b>	<b>2023 milestone</b>	<b>GPW13</b>	<b>SDG/WHA</b>
13. Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water	Provide access to safely managed sanitation services for 800 million more people	3.1	SDG 6.2.1
14. Prevalence of stunting (height-for-age $\leq 2$ standard deviations from the median value of the WHO Child Growth Standards) among children aged under five years	Reduce the number of stunted children aged under five years by 30%	3.1	SDG 2.2.1
15. Prevalence of malnutrition (weight-for-height $\geq 2$ or $\leq 2$ standard deviations from the median value of the WHO Child Growth Standards) among children under 5 years of age (wasting)	Reduce the prevalence of wasting among children aged under five years to less than 5%	3.1	SDG 2.2.2
16. Age-standardized prevalence of current tobacco use among persons aged 15 years and older	25% relative reduction in prevalence of current tobacco use in persons aged 15 and older	3.2	SDG 3.a.1
17. Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol	7% relative reduction in the harmful use of alcohol, as appropriate within the national context	3.2	SDG 3.5.2

<b>Indicator</b>	<b>2023 milestone</b>	<b>GPW13</b>	<b>SDG/WHA</b>
18. Percentage of people protected by effective regulation on trans fats	Eliminate industrially produced trans fats (increase the percentage of people protected by effective regulation)	3.2	WHA 66.10
19. Prevalence of obesity	Halt and begin to reverse the rise in obesity	3.2	WHA 66.10
20. Percentage of bloodstream infections due to antimicrobial resistant organisms	Reduce the percentage of bloodstream infections due to selected antimicrobial resistant organisms by 10%	3.2	WHA67.25, WHA 68.7

### 3. Analysing the national health and development agenda

#### Analysis should include several crucial factors

- Examine priorities and goals set out in National Health Policies, Strategies and Plans, national development and SDG plans, and any other sectoral policies that have an impact on health.
- The UNCT Country Situational Analysis should serve as the initial matrix. Consider initiating a Common Country Analysis (CCA)<sup>10</sup> as part of the 2030 commitment, since it may strengthen the analysis.
- Are strategic plans coherent enough to address the needs identified in the health situation analysis? Identify and record any major gaps not being addressed.
- Look into national health financing and governance arrangements (including monitoring and review mechanisms) and any health sector reforms planned or undertaken and their implications.
- Consider specific health-related or SDG targets being monitored at the national level.
- Read the voluntary national reviews reported to the annual high-level political forum on SDG implementation.

As recommended in the CCA, analysis of the health and development agenda should have both vertical (alignment with national priorities and SDG action plan) and horizontal (interconnectedness of targets, indicators and 2030 agenda and GPW13 data) dimensions.

Analysis should make every effort to identify gaps relating to the country context which could be addressed and bridged by the CCS, as a source of added value and support. Tools recommended for gap assessment are the Reference Guide for UN Country Teams on mainstreaming the 2030 agenda<sup>11</sup> and the consolidated annexes to the Cooperation Framework Guidance<sup>12</sup>.

Strategic priority setting for the health and development agenda should follow from this analysis and provide the evidence base for chosen priorities.



**Analysis should make every effort to identify gaps relating to the country context which could be addressed and bridged by the CCS.**

<sup>10</sup> <https://undg.org/wp-content/uploads/2017/06/UNDG-UNDAF-Companion-Pieces-2-Common-Country-Analysis.pdf>

<sup>11</sup> <https://undg.org/document/mainstreaming-the-2030-agenda-for-sustainable-development-reference-guide-for-un-country-teams>

<sup>12</sup> <https://undg.org/document/consolidated-annexes-for-cooperation-framework-guidance>



### ***Step 1: Data review***

- Are data available for health and development based on the analysis in the country context and health chapters? Can data be disaggregated by vulnerable groups and sex?
- Are data available for national, subnational and/or regional level analysis?
- Does the dataset correspond to WHO GPW13 data and SDG target indicators?
- Can projections be made from the data to support future trends?
- What national obligations under WHO treaties and resolutions has the country signed up for?

### ***Step 2: Data assessment***

- Which are the most vulnerable groups in the country? Do national health and development policies already exist to support those groups?
- What is the gender equality situation? What are the structural and immediate causes of social and health inequities, including gender inequalities and discrimination?
- To what extent is the county committed to implementation of global and regional health agreements?

### ***Step 3: Data analysis***

- Conduct the final comparative analysis with data mapped from the GPW13 at outcome level, SDG national priorities and priorities derived from the national health policy, strategy and plan.



**COUNTRIES IN FRAGILE SITUATIONS - Additional health and context analysis is recommended.**

- Summary of context, conflict and/or fragility analyses, scenarios and likely changes.
- Analysis of the effects of fragility on the health status of the population.
- Pervasive security problems including restrictions on UN staffing or staff movements in the country – are there any “remote-controlled” programmes?
- Egregious human rights violations, including effects on the right to health and worsening of pre-existing inequities, e.g. deliberately excluded or marginalized groups.
- Violations of medical neutrality e.g. targeting of health facilities, workers and patients, or involvement of health-care providers in human rights violations.
- Analysis of the effects of fragility on health determinants including inequity and gender-based violence.
- Analysis of the effects of fragility on:
  - » **service delivery** – e.g. damaged health infrastructure or unequal access to health services;
  - » **governance** – e.g. interruption of policy process and sector coordination with weak steering role of (interim) national and subnational health authorities, multiple actors with diverse agendas and policy fragmentation and/or inappropriate transfer;
  - » **health information system** – e.g. fragmented, with challenges to validate existing data sets;
  - » **human resources for health** – e.g. loss of staff, unequal distribution of human resources, untrained staff, task shifting or returning diaspora;
  - » **health financing** – e.g. weak financial management capacity and high dependence on external assistance with need for additional humanitarian, transition or peace-building funds;
  - » **pharmaceutical products** – e.g. stockouts in national production and distribution, absence of import regulations and quality standards for pharmaceutical products.



**For more information:**

For fragility analysis, use existing sources to understand the underlying causes of fragility and the political context, country capacity and resilience, and likely future scenarios, especially insofar as these affect health and the health sector. Context and conflict analyses are published by:

- International Crisis Group ([www.crisisgroup.org](http://www.crisisgroup.org));
- The Economist Intelligence Unit ([www.eiu.com/index.asp?&rf=0](http://www.eiu.com/index.asp?&rf=0));
- Centre for Research on the Epidemiology of Disasters ([www.cred.be](http://www.cred.be)); and
- “New Deal for Peace” Initiative ([www.newdeal4peace.org/new-deal-pilots](http://www.newdeal4peace.org/new-deal-pilots)).

**For guidance on analysing disrupted health sectors, see:**

- [www.who.int/hac/techguidance/tools/disrupted\\_sectors/en](http://www.who.int/hac/techguidance/tools/disrupted_sectors/en)



## 4. Analysing the partnership environment

### Analysis should include several factors

- The role of all current and potential partners (including their respective mandate, mission or purpose in supporting the government's health and development priorities).
- The respective capacity of partners for contributing to or influencing decision-making in support of Government health and development priorities.
- The type of relationship each partner enjoys with WHO: consider potential areas for new or stronger strategic partnership relations.
- Platforms and mechanisms for partner coordination in which WHO has a role to play such as South-South and Triangular Cooperation.

### With specific reference to UN partners, the following questions are relevant

- Are there opportunities to leverage UN agency access to and strategic collaboration with non-health ministries or sectors in order to encourage a whole-of-government or "health in all policies" approach?
- Can the UNSDCF/Common Country Analysis (CCA) be used to inform the CCS and vice versa? The CCS should reproduce all UNSDCF outcomes and include additional outcomes.
- If the country has expressed interest in the Global Action Plan for Healthy Lives and Well-being for All (GAP) for strengthening collaboration among multilateral health organizations to accelerate country progress on health-related SDGs, assess the 12 agencies<sup>13</sup> at presence and/or engagement at country level and discuss priorities for closer collaboration (on the 7 accelerators themes) and the linkages to the CCS. Can they work on any of the CCS-linked drivers?
- Which effective mechanisms are in place to strengthen the work of the UN Country Team in addressing key health issues to deliver the SDGs, e.g. joint programmes, health-related theme groups



**12 multilateral health, development and humanitarian agencies have committed to better supporting countries to accelerate progress on the health-related SDGs and to deliver on other major commitments to health (including UHC and PHC).**

<sup>13</sup> The 12 global agencies are: Gavi, Global Financing Facility for Women, Children and Adolescents, Global Fund to Fight AIDS, TB and Malaria, UNAIDS, UNDP, UNFPA, UNICEF, Unitaid, UN Women, World Bank, World Food Programme and WHO.

With the launch of the Global Action Plan for Healthy Lives and Well-being for All at the UN General Assembly in September 2019, 12 multilateral health, development and humanitarian agencies have committed to better supporting countries to accelerate progress on the health-related SDGs and to deliver on other major commitments to health (including UHC and PHC). In [country x], the CCS will take the GAP forward to coordinate implementation with the UN agencies and partners in one of the key commitment outlined below.

The Global Action Plan is based on four key commitments by the heads of the signatory agencies to:

- **Engage** with countries better to identify priorities in health and plan and implement together;
- **Accelerate** progress in countries through joint action under specific programmatic themes and on gender equality and the delivery of global public goods;
- **Align** in support of countries by harmonizing their operational and financial strategies, policies and approaches; and
- **Account**, by reviewing progress and learning together to enhance shared accountability.

The Global Action Plan broadly complements the United Nations System-wide Strategic Document, which describes the work of the United Nations Development System as a whole to support implementation of the 2030 Agenda for Sustainable Development.



## 5. Expressing national priorities in the CCS

The CCS is a joint WHO-Member State instrument to facilitate the implementation of GPW13: the triple billion target stands in alignment with priorities based on the country's own needs and which can be measured by the defined outcome indicator and milestones set in the CCS.



### ***NEW DEVELOPMENTS: CCS and UNSDCF***

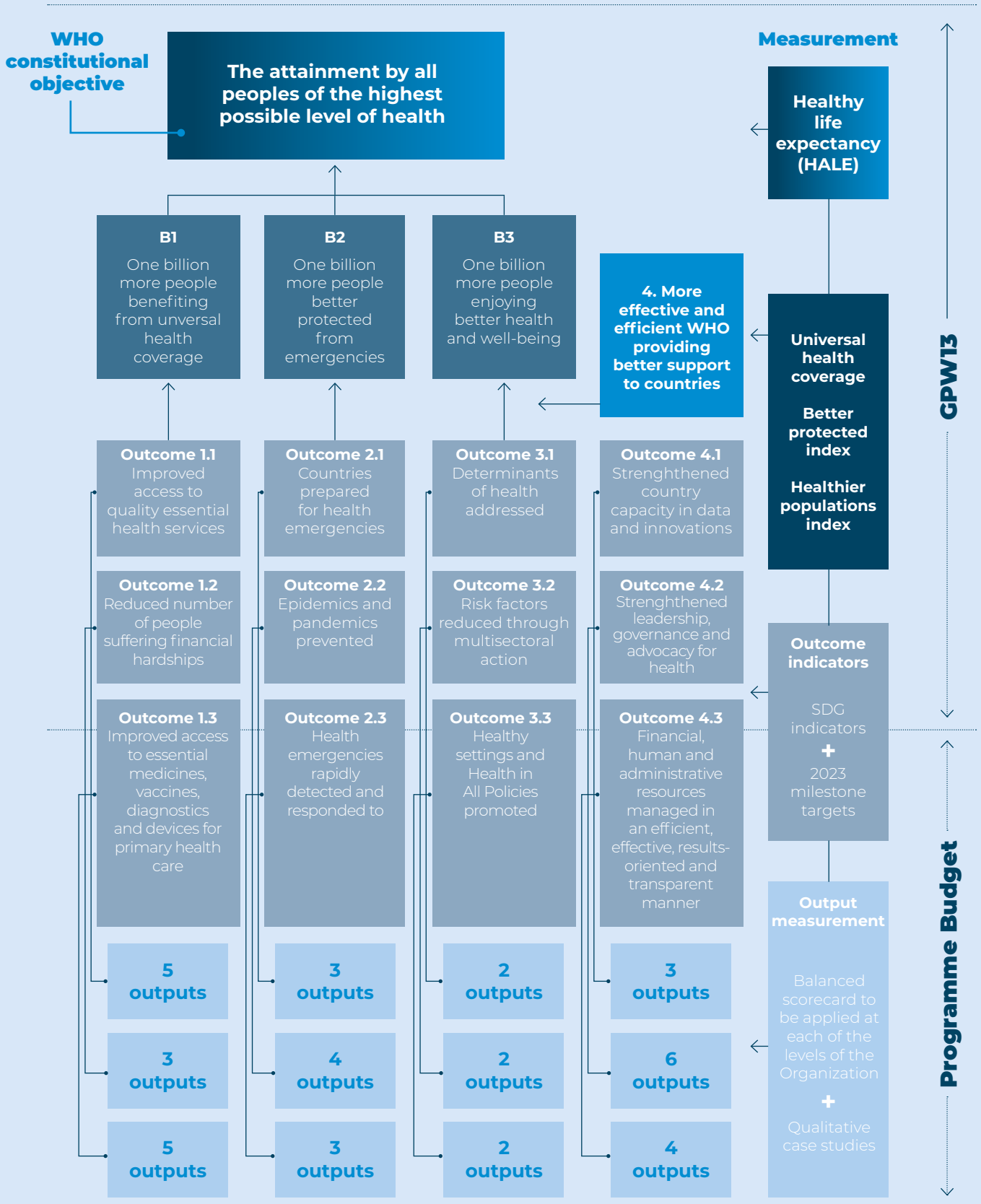
The CCS informs and reinforces the health dimension of the UNSDCF. It serves as the main instrument for harmonizing WHO's activities in a given country with the work of other UN agencies and development partners to deliver the SDGs. Owing to specific WHO technical mandates, the CCS sets out strategic priorities which exceed those of the UNSDCF.

As an aspect of ongoing UN reform, the UNSDCF is the most important instrument for delivery of United Nations development activities in any given country under the terms of the 2030 Agenda (A/RES/72/279).

The UNSDCF in each Member State is underpinned by a robust CCA and provides programme cue points for UN agency programmes. Owing to the planned high political profile of the UNSDCF, all the health issues it addresses will enjoy greater political visibility and therefore be more likely to attract funds from donors who adopt the UNSDCF as a basis for funding UN activities in a country.

The WCO should align the CCS with the UNSDCF as much as possible. The WCO should make use of the UNSDCF to ensure that health issues have top priority in government agendas, to guarantee policy coherence among UN agencies and to leverage support and additional resources from the UN and partners. WHO Representatives and UN Resident Coordinators are responsible for increasing the priority of health issues in the UNSDCF.

Fig. 7. GPW13 Results Framework and measurement system.

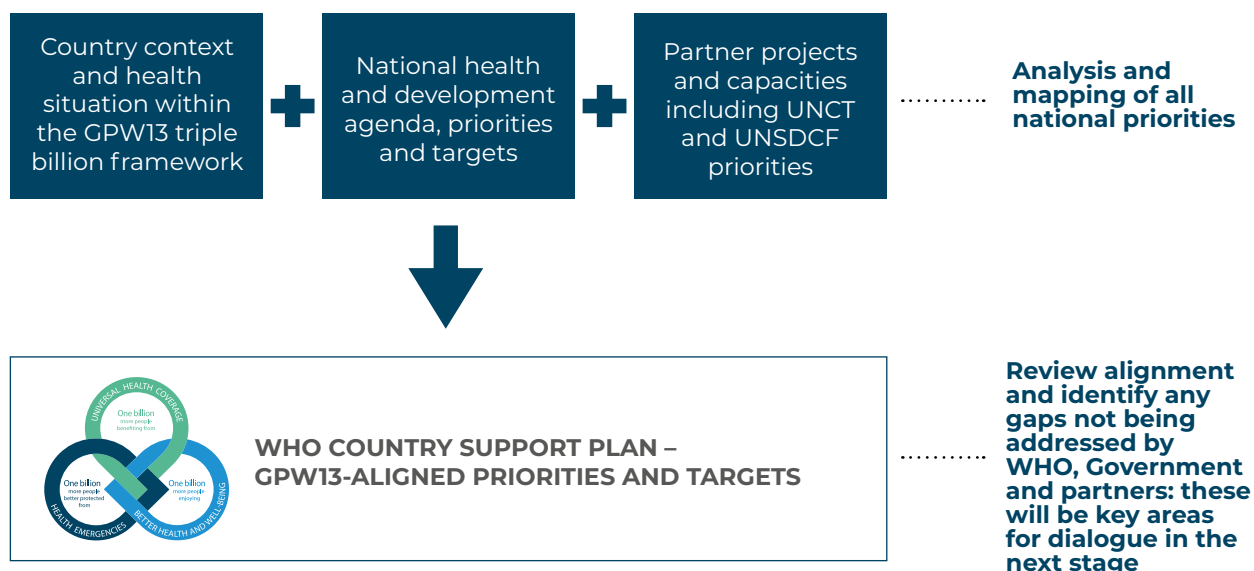


A new CCS is never developed ex nihilo: there will always be existing priorities and programmes. The process of developing a new CCS presents an opportunity to refine and improve current or previously agreed priorities for collaboration so as to ensure that they are strategically apt and appropriately supported by WHO.

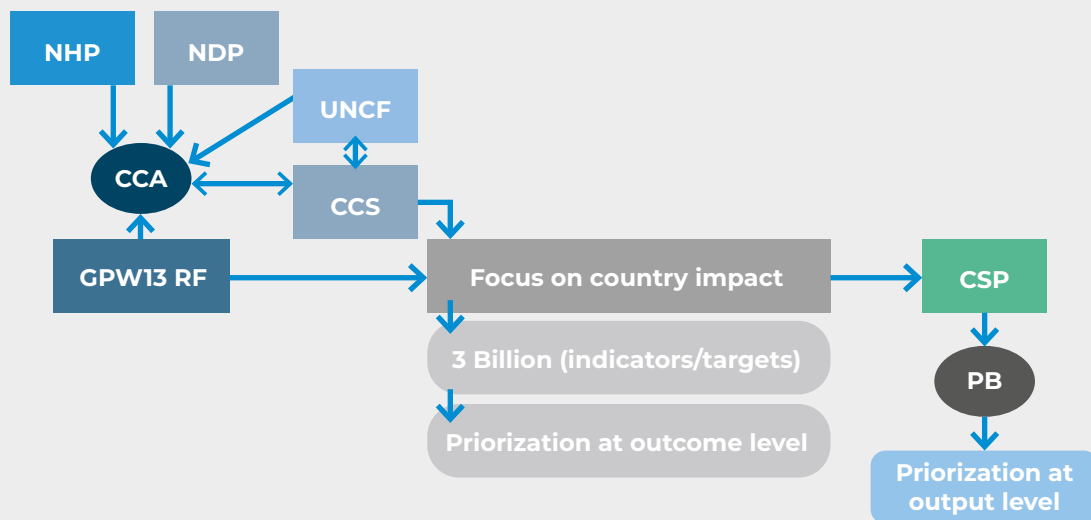
**The final step in the analysis stage, before heading into dialogue with Government and partners is** to review current work and priorities (e.g. previous CCS or current CSP) in terms of their alignment to GPW13 and the National Health and Development agenda.

1. Check that current work and priorities are fully aligned with national needs and priorities.
2. Ensure that there is no duplication or overlap with partners and that WHO is best positioned (i.e. at a comparative advantage) to deliver in the priority area.
3. Determine how much other partners are likely to deliver in priority areas.
4. Identify any major gaps not addressed by WHO, Government or partners.
5. Highlight opportunities for innovation or partnerships.

*Fig. 8. Analysing and mapping flowchart for aligning national priorities with previous CCS.*







### CHECKLIST:

- ✓ Main health development challenges, gaps in health outcomes, national capacities and priority outcomes and priority interventions identified in the national health plan or UNSDCF.
- ✓ Binding international commitments (i.e. IHR, FCTC, etc.).
- ✓ Contribution to regional or global targets (i.e. GPW impact framework, SDGs).
- ✓ Target country for regional or global plans.
- ✓ WHO's comparative advantage (policy dialogue, strategic support, technical assistance and service delivery). Who will fill the breach and when if WHO decides not to use its comparative advantage?
- ✓ Cross-cutting issues such as human rights, equity and gender high on the national agenda.
- ✓ Health emergency in country and grade.
- ✓ Lessons from current/past WHO and partner cooperation projects.
- ✓ WHO's human and financial resources (present levels and future forecasts so that country priorities are more realistic, etc.).

## Stage 2

# Conduct dialogue

### **Estimated time required: 1 month.**

Dialogue is guided to a large extent by the outcomes of the analysis stage. It takes the form of strategic high-level discussions, particularly at ministerial level, along with a series of meetings, briefings, and workshops with a more technical focus which may involve a wider audience. CCS dialogue in high-income countries includes representatives of foreign affairs/development assistance bodies, academic institutions, WHO Collaborating Centres and key international organizations working in the country to ensure alignment and identify potentially innovative ways for a mutually beneficial cooperation with WHO.



# 1. Key stakeholders to consider

## Key stakeholders to consider for policy dialogue:

- WHO representative and working group to represent WHO from all three levels
- MoH and other government sectors (Finance, Planning, Environment, Development, Education,...)
- Key health agencies and institutions
- National human rights bodies
- UN agency representatives including the Resident Coordinator
- Development partners working towards SDG 3 targets
- NGO/CSOs including those defending marginalized or vulnerable groups
- If warranted, a health expert for fragile states who knows the country.

An increasing number of non-state actors, including from the private sector and civil society, play an important role in health at the country level and need to be included in dialogue. FENSA is the appropriate reference guide.





## **Dialogue has one main objective and eight secondary objectives:**

### **Main objective**

To engage key stakeholders and foster consensus on strategic priorities for WHO's collaboration with the country in the medium term, with input from the Secretariat on how to implement these priorities and the framework and mechanisms for measuring impact.

### **Secondary objectives**

- To share WHO's proposed country priorities and their contextual/ evidence base with key stakeholders. The dialogue phase of the CCS process provides an opportunity to refine and enhance these priorities in order to ensure that they are strategically apt and appropriately supported by WHO.
- To discuss any areas identified that need additional attention from partners, Government and WHO.
- To explore and determine the comparative advantages of encouraging different actors to address priority areas, and roles and responsibilities when working in close cooperation. This implies being consistent in the terminology used for the national health strategy, UNSDCF, GPW13 and CCS.
- To link WHO's planned contribution via the country support plan with higher-level strategic priorities as defined in the CCS.
- To review impact targets and ensure they are sufficiently ambitious, realistic and relevant to the country situation, and to cooperate in joint monitoring and evaluation of ongoing CCS impact.
- To review good practices and lessons learnt during previous work on priorities.
- To highlight any key issues and risks that may hinder implementation of the CCS and prevent targets being reached, e.g. liaising with other sectors may bring to light policy barriers that need to be addressed.
- To foster consensus and trust among key country stakeholders.

## 2. Setting the strategic agenda and agreeing on joint priorities for collaboration

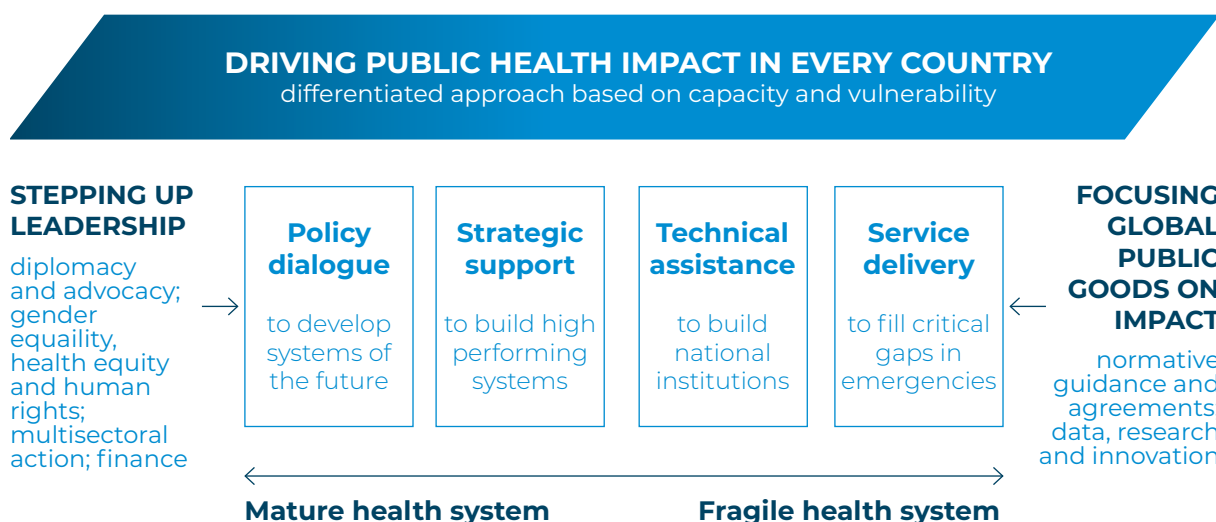
Each strategic priority is the joint responsibility of the Government and WHO. They should adapt the SMART format (specific, measurable, achievable, realistic and time-bound). Each strategic priority chosen through dialogue should support achievement of the relevant GPW13 outcome(s) while responding to the key aspects of the national health agenda.

The strategic prioritization process ought to consider the type of support needed in the country based on factors such as country capacity and health system maturity and stability. For each jointly agreed priority, it should be clear what is expected of all three levels of WHO in terms of the Organization's support to government and collaboration with partners. The diagram below adapted from GPW13 summarizes WHO's working strategy: it applies to all levels, all programme areas and all country contexts.



**Each strategic priority is the joint responsibility of the Government and WHO.**

Fig. 9. WHO Strategic shifts for delivering the triple billion goal.



### 3. Developing an agreed country impact/results framework

One of the main outputs of dialogue should be agreement on indicators and targets to measure impact and results for each of the priorities. WHO and MoH will be the main partners for development of the impact framework in the CCS, although other stakeholders may be involved in discussions. Wherever possible, selected indicators should be aligned with national health indicators, the GPW13 metrics framework (previously referenced along with [hyperlink](#), and already coherent with the SDGs) and any health-related indicators in the UNSDCF.

As recommended by the WHO Impact Framework, the CCS should interlock with the triple billion targets, focusing on UHC, health emergencies and a healthier population. Programme targets and related indicators at the country level should be mapped out for implementation of the CCS. Each of the triple billion targets in the GPW13 will be measured using composite indices: the UHC billion will be measured with a UHC index, the health emergencies billion with a health emergency protection index and the healthier population billion with a healthier population index. These indicators are aligned with the SDGs.



*Example: A Country Impact Framework showing alignment with GPW, UNSDCF and National Health Plan indicators*

<b>Country impact framework indicator</b>	<b>Baseline (year)</b>	<b>Target (2023)</b>	<b>Indicator alignment</b>
<b>Priority 1 – Ensure more people benefit from UHC</b>			
Number of people receiving UHC	X	X	GPW, UNSDCF, NHP
Number of people receiving essential health service coverage	%	%	GPW, UNSDCF, NHP
% population suffering financial hardship in accessing health care (10% or more of household income)	%	%	GPW, UNSDCF, NHP
% increase in availability of essential medicines for PHC	%	%	GPW, NHP
<b>Priority 2 – Boost health system resilience to protect health and mitigate effects of emergencies</b>			
Number of IHR core capacities implemented	X	X	GPW
Government spending on emergency preparedness and response	\$	\$	UNSDCF, NHP
% vulnerable population provided with essential health services	%	%	GPW
<b>Priority 3 - Improve child and maternal health</b>			
Maternal mortality ratio (per 100 000 live births)	X	X	GPW, UNSDCF, NHP
% children aged under five years with stunting	%	%	GPW, UNSDCF, NHP
% women (aged 15–49) experiencing physical or sexual violence in past 12 months	%	%	GPW, UNSDCF, NHP
<b>Priority 4 - Reduce mortality from climate related diseases and environmental causes</b>			
% population with access to safely managed sanitation	%	%	GPW, UNSDCF, NHP
Climate change vulnerability index rating	X	X	UNSDCF
Mortality rate attributed to household and ambient air pollution	%	%	GPW, UNSDCF, NHP

## Stage 3

# Draft the CCS

### Estimated time required: 1 month.

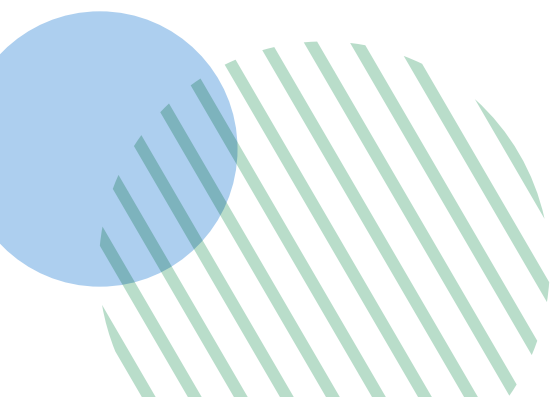
The CCS is an important corporate instrument. Although there is room for flexibility, the CCS should be structured as far as possible in a consistent format with the same type of sections and information categories.

The CCS should be drafted by the core working group established as above, adopting a One WHO approach. When a WHO Country Office exists in the country, it should be owned and led by the WR, and if no country office is in place by the regional CSU. The CCS should be drafted internally with the WR as core leader, supported by the WCO team, regional CSU and HQ CSS. The regional CSU and HQ CSS will facilitate input from all relevant technical and operational units at their respective offices. The prototype attached to this CCS Guide can be followed and used as a template for setting out a given country's CCS.

The CCS should be evidence based, concise, visually appealing and clearly focused on implementation and results. Unnecessary background or contextual information which is not specifically linked to WHO work or its current advocacy messages will make the document less appealing and probably reduce its effectiveness. Lengthy country contexts and analyses that are readily available in other documents do not need to be repeated. They can be included as references, if needed. **The CCS itself should not be more than about 30–40 pages.**



***Tip: the purpose of the CCS is to convey a concise, powerful message about the health needs of a given population and the work WHO has committed to undertake in partnership with the Government and all relevant actors in the pursuit of specific and explicit health outcomes at the country level.***





# Proposed CCS document structure

1. **Cover page:** usually contains a photo or graphic from the country.
2. **Signature page:** refer to Stage 5 for conventions concerning signatories.
3. **Contents**
4. **Abbreviations**
5. **Executive summary (one page maximum):** provides information on the new strategic agenda for WHO cooperation focusing on implementation and results.
6. **Introduction:** sets out the role of the CCS in the wider health development landscape and usually contains an overview of WHO policy framework, GPW13 and regional and subregional priorities; the country context, strategic joint priority areas for collaboration; and the CCS development process including actions taken and key stakeholders involved.
7. **Health and development situation:** refer to Stage 2 for content, structure and examples.
8. **Partnership Environment:** refer to Stage 2 for content, structure and examples.
9. **Collaboration between WHO and the country:** describes the key functions of WHO support, technical focus of recent WHO work in country.

Includes the country's contribution to the regional and global health agenda, including financial and technical support to other countries (including through South-South cooperation); and participation and/or leadership in global, regional, sub-regional or other inter-country groups with health agendas.

10. **Strategic priorities:** lists agreed priorities following analysis and dialogue with corresponding impact targets along with a brief description of focus areas.
11. **Implementation:** outlines contributions from all three levels of the Organization in support of the strategic priorities outlined in the CCS, with a more detailed version to be included in the Country Support Plan.

Includes WHO's key implementation partners and whether any specific contribution is expected from them in pursuit of each of the strategic priorities.

Consider including a section on "Financing the Strategic Priorities" if there are significant opportunities for mobilizing resources at the country level.

Special reference should be made to the CCS/UNSDCF linkage in order to ensure that the UN system approach is coherent in the implementation stage and interconnected with the GAP.

12. **Monitoring and evaluation:**

Includes key milestones for monitoring and evaluation activities for the entire CCS cycle and highlights how impact will be quantitatively and qualitatively measured.

13. **Annexes** (wherever possible, use electronic annexes to minimize document size):

May include full stakeholder mapping and capacity analysis; a matrix of health-related priorities in National Health Policies, Strategies and Plans; GPW, UNSDCF; and the budget estimation methodology for implementing priorities.

**STRUCTURE OF THE CCS FOR HIGH-INCOME COUNTRIES:**

A flexible approach should be adopted when determining the CCS structure since various aspects of the standard document will not be appropriate for high-income countries (HIC), such as the partnership environment and/or UNCT presence.

In HIC, the CCS is often initiated and led by the regional office (RO) CSU. The RO CSU should assume prime responsibility for regular monitoring and follow-up of outcomes, assisted by the technical units for each agreed strategic area of collaboration. A monitoring and evaluation plan can be developed jointly with the country.

The CCS ought to outline the country's global health interest and support to other countries as a potential health donor. This support should however be described in greater detail in other tools such as WHO's partnership framework agreements.

WHO's role as a facilitator in North-South and triangular cooperation may also be included in the CCS, if appropriate. The key components of the agreed mutual cooperation should be presented in clear graphic form as shown in the example below.

*Example - WHO Country Cooperation Strategy (year-year)*

<b>Aim</b>	To strengthen and guide cooperation between country X's health portfolio agencies and WHO in areas of mutually agreed priority in order to improve the health of all populations in X Region		
<b>Foundations of Country X-WHO cooperation</b>	1. WHO contributes to the health of all people in country X	2. Country X contributes to the health of the Region	3. Country X and WHO work in partnership to promote better health in Region X
<b>(Technical) strategic priority areas</b>	<ul style="list-style-type: none"> <li>a. Enhancing health security</li> <li>b. Promoting people-centred health systems and UHC</li> <li>c. Regulatory strengthening</li> <li>d. Supporting WHO in efforts to achieve organizational excellence</li> </ul>		
<b>Principles of cooperation</b>	Technical contribution, agenda shaping, information exchange, multisectoral approach, prioritization of vulnerable groups, open communication, regional capacity building		



## Stage 4 Launch the CCS

Once endorsed at the WHO Regional Office and Headquarters, the finalized CCS will become the reference document across the Organization for WHO's work in a given country. CCS signing modalities are flexible. To ensure joint ownership however, the CCS should be co-signed by a representative of the national Government (e.g. Minister of Health or other official) and a WHO representative (e.g. Director-General and/or Regional Director, and WR where there is WHO country presence).

Launching the CCS is a prime opportunity to increase the visibility of work and goals in any given country and help it to achieve its health objectives, including national SDG targets. Consideration should be given to establishing a launch committee with clear TORs so that WHO and MoH can use the occasion to generate maximum visibility and engagement. The goal is to reach the widest possible audience and make it aware of the CCS and what it aims to accomplish. Thought should be given to the different audiences at local, regional and global levels and the key take-home messages for participants, e.g. government ministries, head of state, parliamentarians, UNCT, bilateral and multilateral partners, potential donors, private sector, academic institutions, civil society and the general public – the ultimate beneficiaries of WHO support!



***The goal is to reach the widest possible audience and make it aware of the CCS and what it aims to accomplish.***



# Innovative ideas for launching the CCS

- Hold a launch event and invite all important contributors and partners who will be essential for implementing strategic priorities.
- Consider inviting VIPs such as high-level government and parliamentary officials, local celebrities, RD and DG to attend for a country visit.
- Engage local and national media: liaise with them in advance of the launch to kindle their interest, encourage buy-in and make a newsworthy story.
- Consider assembling a panel of experts to discuss priority areas and raise their profile in the general population.
- Print and give away WHO merchandise (make it relevant and attractive).
- Launch a campaign to kick-start work in a particular area or encourage the government to make a public commitment or pledge to the population about their access to health care.
- Use social media intensively to create a buzz around the launch and any subsequent event.
- Develop common public messaging that is catchy, memorable and sums up what WHO is aiming to do in the CCS.
- Get WHO technical units from Regional and HQ offices involved.
- Ask CCS to deliver a global document launch (throughout WHO) via WebEx with speakers from the MoH, Country Office and Regional Office.
- Consider translating the CCS or a brochure-style summary into the local language for wider hard-copy dissemination to key stakeholders.



**Tip: Work with teams at country, regional and HQ levels early on to discuss your ideas!**



# Stage 5 Implement the CCS

## Alignment with Operation plan (CSP)

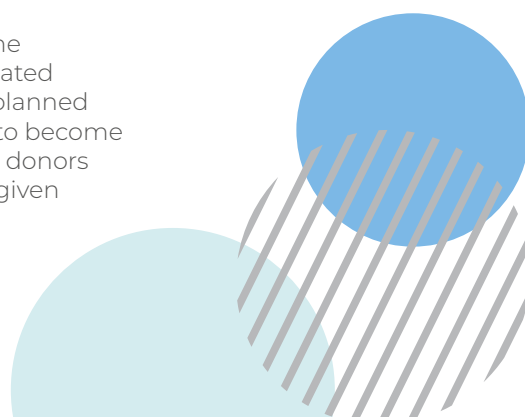
**Ensure alignment:** the first step in implementing the CCS is to **ensure that the operational plans (CSP) are aligned with the CCS**. Operational plans must be reviewed and adjusted if necessary. Specific regional operational guides should provide adequate information to allow realignment and support coming from RO and HQ is coordinated.

The second step is to **review**, and if necessary **redescribe** resources at the country level in order to respond to the priorities identified in the CCS.

**Use the CCS to generate strategic partnerships for health.** The CCS should also be used as an advocacy and planning tool to **create strategic partnerships** and mobilize necessary resources. Since the CCS clearly spells out its aims and how to accomplish them, it can be used to show development partners how mutually beneficial collaboration works, encourage their active support and lead to a better delivery of results.

The CCS process also provides an opportunity to strengthen collaboration with UN agencies on cooperation challenges and opportunities in the country: the tangible contributions that UN partners make to advancing the strategic agenda can be made explicit in the CCS. When developing the UNSDCF, WHO should ensure that it includes as many CCS priorities as possible. This enables WHO to generate a multisectoral response to CCS priorities, since many of the issues (e.g. health security) also entail actions from outside the health sector proper. In addition, UN partners are actively engaged in many issues related to the social determinants of health, and the CCS can provide important information to shape planned interventions. UN partners may also be asked to use their convening power to influence sectors where WHO's relationships are not so strong.

Furthermore, it is likely that by extending the evidence base in the CCS a case can be made to use common UN funds for health-related interventions and vouchsafe a win-win approach. In view of the planned higher visibility of the UNSDCF, all its key health issues are likely to become more prominent politically and thereby attract funds from other donors using the UNSDCF as a basis for supporting UN activities in any given country.





# Stage 6 Monitor and evaluate the CCS

## Monitor implementation, CCS Evaluation: midterm and final evaluation

The Country Impact Framework<sup>14</sup> in the new-generation CCS will greatly enhance monitoring and evaluation of progress and results as the strategy develops. These critical processes will also contribute significantly when reporting on WHO's contribution and impact in delivering GPW13 targets at the regional and global levels.

While CCS monitoring is the responsibility of the WHO Country Office, it should be done in collaboration with the Government, and involve all three levels of the Organization (where appropriate) to encourage joint ownership of results. The country involved can also consider being more efficient by jointly monitoring and measuring strategic priority progress within the UNSDCF evaluation process. Wherever feasible, both processes should be interlinked.

Progress in CCS implementation should be reviewed at country level at least once every year. The CCS should also be reviewed whenever there are significant changes at the country level, e.g.:

- a new government in office or other major government reforms affecting health and national priorities;
- a change in health situation and risks, i.e. humanitarian crisis or outbreak;
- a new UNSDCF is developed; or
- new evidence or information comes to light concerning national public health needs or statistics.



***Progress in CCS  
implementation  
should be reviewed  
at country level at  
least once every  
year.***

<sup>14</sup> [https://www.who.int/docs/default-source/documents/about-us/proposed-methods-for-gpw13-impact-measurement-v-1-2-0.pdf?sfvrsn=cecdc802\\_2](https://www.who.int/docs/default-source/documents/about-us/proposed-methods-for-gpw13-impact-measurement-v-1-2-0.pdf?sfvrsn=cecdc802_2)



**Monitoring CCS implementation:**

- ensures that CCS priorities are being carried out in a timely and efficient manner;
- provides an early warning system to identify any problems related to implementation of the strategic priorities and related activities;
- offers an opportunity to re-evaluate, update and adjust any necessary aspects of the strategy; and
- monitors CCS implementation by assessing how the respective operational plans are accomplished using the instruments available at the regional level. These cumulative periodical reviews serve as input for the midterm and final CCS evaluation.

**CCS evaluation**

The evaluation process is led by the WR, often in tandem with a CCS evaluation working group drawn from WHO Country Office staff: it should include a staff member from the Regional CSU or CSS/HQ. Liaise with CSU and CSS staff since they can provide guidance, templates, offer recent best-practice examples and provide support in the midterm and final evaluation working group drawn from Country Office staff, regional CSU and HQ CSS.

The main focus of the evaluation is to measure whether targets identified in the country results framework have been achieved and determine whether the CCS has contributed towards GPW13's triple billion goals. A proposed Terms of Reference can be found as a concept note in Annex 1 to this section.

The country balance scorecard is a tool to be used for CCS midterm and evaluation purpose. Detailed guidance will be worked out in 2020.

**Midterm evaluation**

Midterm evaluation of the CCS should take place halfway through its implementation: it will help to adjust priorities and/or contextual needs in the country concerned. The focus of the midterm evaluation is:

1. to determine whether implementation of the strategic priorities is progressing (whether expected achievements are on track) with reference to the country result framework; and if not
2. to identify impediments and potential risks that may require changes to the strategic priorities, actions to speed up progress in the second half of the CCS cycle or strategic priorities that need revising, especially if there has been a significant event in the country such as a major emergency.

**Final evaluation**

The final evaluation is a more conclusive and comprehensive assessment than the midterm review; it should describe the achievements, gaps, challenges, lessons learnt and make recommendations for future collaboration between WHO and the Member State. Some WCOs may elect to have the final evaluation conducted by an independent evaluation team, although this will be dependent on the WCO context and budget. Final evaluation should start when CCS implementation comes to an end and feed directly into the development of a new CCS.

# ANNEX 1.

## CONCEPT NOTE FOR CCS EVALUATION

### Introduction

The Country Cooperation Strategy (CCS) is the WHO's key instrument to guide its collaboration in and with a country, in support of the country's national health agenda and contribution to the 2030 Agenda for Sustainable Development and WHO's General Programme of Work. The CCS is developed through an extensive and broad consultation process, with the participation of staff from WHO, UN agencies and representatives of the Government, development partners, academia and civil society.

As defined by the UN Evaluation Group (UNEG), "evaluation" is an assessment, as systematic and impartial as possible, of an activity, project, programme, strategy, policy, theme, sector, operational area or institutional performance. It focuses on expected and achieved accomplishments, examining the results chain, processes, contextual factors and causal links, in order to understand achievements or the lack thereof. It aims at determining the relevance, impact, effectiveness, efficiency and sustainability of the interventions and contributions of UN system organizations. Any evaluation should provide evidence-based information that is credible, reliable and useful, enabling findings, recommendations and lessons to be integrated expeditiously into the decision-making processes.<sup>15</sup>

The goal of CCS evaluation is to contribute to a broader assessment of WHO's contribution to, and influence on the national health development agenda seen in the light of the agreed joint strategic priorities set out in the CCS. It is a structured, decentralized<sup>16</sup> evaluation process conducted by all three levels of the Organization.

The overall objective of the evaluation is to assess the effectiveness, efficiency and quality of WHO's work as its input towards improving the health outcomes of the population of a given country. It also feeds into the development of new CCS. CCS evaluation, although part of WHO's broader accountability framework, is distinct from other functions in its supervisory remit. Where audit and the internal control framework focus on compliance, CCS evaluation focuses on results, on understanding and documenting what works, why and how. Evaluation also differs from Programme Budget monitoring and performance assessment, since it examines not only whether expected results are being achieved but looks more widely at issues of relevance, context, causality and eventual impact and sustainability. CCS evaluation is an independent exercise.



**The overall objective of the evaluation is to assess the effectiveness, efficiency and quality of WHO's work as its input towards improving the health outcomes of the population of a given country.**

<sup>15</sup> As defined by the UN Evaluation Group (UNEG) United Nations Evaluation Group's Norms and standards for evaluation, 2016 <http://www.unevaluation.org/document/detail/1914>

<sup>16</sup> Decentralized evaluations are managed, commissioned or conducted outside the central HQ Evaluation Office.

## Evaluation principles

CCS evaluation should be conducted strictly in conformity with WHO's five interlinked key evaluation principles of impartiality, independence, utility, quality and transparency. In addition, three overarching principles – a human rights-based approach, mainstreaming a gender perspective and equity in health – underpin the evaluation design.

## Objectives

### General objective

Evaluate the <year> CCS for <country> to substantiate WHO's contribution to achieving results. CCS evaluation should also generate recommendations that influence policy, management and operational decisions at the country level.

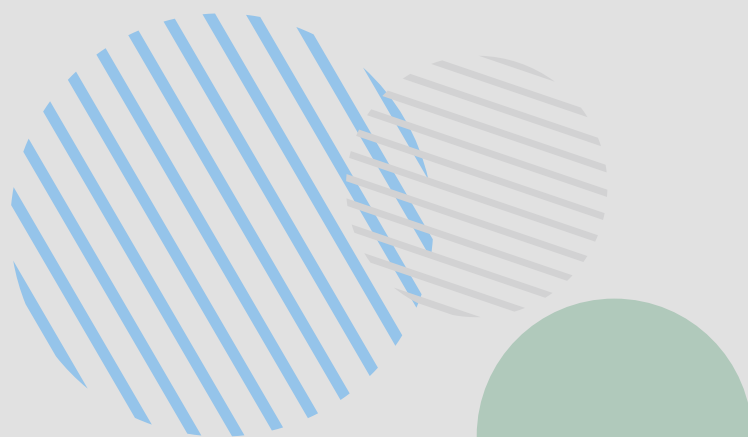
### Specific objectives

CCS Evaluation has five specific objectives that stem from the scope of its five priorities:

1. review the progress, process, outputs and outcomes of CCS priorities;
2. examine the alignment of CCS priorities with those in the Government's health agenda;
3. determine the impact of WHO's work in the current CCS on the country's health outcomes;
4. analyse the harmonization of WHO's work with other UN agencies through UNSDCF; and
5. identify lessons learnt from planning and implementing the current CCS for developing the next CCS.

The results of CCS evaluation should provide information and reflect on:

<b>Target objective</b>	<b>Evaluation parameters</b>
<p><b>Objective 1</b> review progress of CCS priorities</p>	<p><b>Effectiveness and timeliness of CCS priority interventions</b> relevance, effectiveness, efficiency, impact and sustainability</p>
<p><b>Objective 2</b> examine alignment of CCS priorities with those in Government's health agenda</p>	<p><b>Correspondence between CCS priorities and the country's health agenda</b> relevance, effectiveness, efficiency, impact and sustainability</p>
<p><b>Objective 3</b> determine the impact of current CCS on the health outcomes</p>	<p><b>Impact of WHO's work towards CCS priorities on health outcomes</b> relevance, effectiveness, efficiency, impact and sustainability</p>
<p><b>Objective 4</b> analyse the harmonization of WHO work with UN</p>	<p><b>Coordination and collaboration with UN System Organizations</b> relevance, effectiveness, efficiency, impact and sustainability</p>
<p><b>Objective 5</b> development of the next CCS</p>	<p><b>Critical success of and factors impeding WHO cooperation</b> relevance, effectiveness, efficiency, impact and sustainability</p>



## Beneficiaries

The WHO Representative, staff from WHO Country Office, WHO Regional Office and HQ and the Ministry of Health are the key beneficiaries of the evaluation since they can extrapolate the findings in their work and accelerate efforts towards improving population-based health outcomes. For WHO in particular, CCS evaluation may identify opportunities for exploring and scaling up WHO leadership beyond the health sector, e.g. offer more intensive engagement with sectors that deal with the socioeconomic and environmental determinants of health.

The target audience should also include the national Government, UN Resident Coordinator, including the UNCT and other staff from UN agencies work in the health sector of <country>, international and national developmental partners, representatives of academia and civil society that are directly or indirectly involved in health sector-related programs.

## Methodology

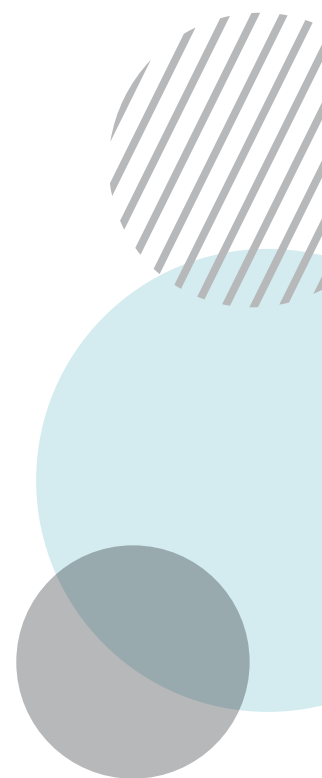
CCS Evaluation is an internal implementation evaluation that follows 2016 UN Evaluation Group norms and standards and WHO corporate evaluation policy and practice guidance.<sup>17</sup> The evaluation methodology relies on a hybrid approach, including desk reviews, stakeholder interviews and a participatory approach.

## Evaluation questions

Stemming from the strategic priorities as identified in the current CCS, evaluation questions should review the logic of the CCS theory of change and assess whether its result framework is credible. Responses should describe accomplished outputs, outcomes and impacts in comparison to planned results. Proposed questions include:

1. Quantitatively and qualitatively, what progress was made and to what extent can these changes be attributed to the priority interventions undertaken by WHO?
2. What did WHO do, and with whom? (Identify key contributions in various domains: policy dialogue, strategic support, technical assistance, service delivery with partners. Include support at all three levels and highlight any multisectoral actions undertaken).

<sup>17</sup> Including: a. [WHO Evaluation Policy](#) (2018) approved at the 114th Session of the Executive Board on 29 May 2018, (EB143(9) Agenda item 4.3) b. [WHO Evaluation Practice Handbook](#), WHO 2013; c. [The WHO Framework for Strengthening Evaluation and Organizational Learning in WHO](#)



3. To what extent did the implementation of CCS priority interventions:
  - a. make it easier for health services users to claim their rights and service providers to fulfil their obligations?
  - b. contribute to gender mainstreaming and promote equal access to health services by children, women and men?
  - c. contribute to empowering and addressing the needs of indigent and vulnerable populations, and improve their access to health services?
4. Did WHO align operational instruments and country office capacity to meet the priorities? Were the required financial and human resources mobilized as planned, for smooth implementation of current CCS priority interventions?
5. Was WHO's work effective? Suggestions for improvement? (Cite the external views of Government and partners).
6. What were the challenges and lessons learnt? What could have been done differently to achieve a better outcome?
7. What were the missed opportunities? What was the key WHO contribution to health development according to the Ministry of Health and other partners?
8. What work is left to do in the area? Is the priority still an area to be included in a new CCS?

### **Data collection and analysis**

The CCS evaluation team should adopt a three-phase qualitative and quantitative data collection method:

- a desk review of relevant national and partner documents<sup>18</sup> collected before the field mission as well as GSM data to assess the intervention logic with examination of the results chain and contextual and causal factors that could account for achievement (or not) of the expected results;

<sup>18</sup> i) Country Common Analysis and ii) United Nations Sustainable Development Cooperation Framework (UNSDCF), iii) National Health Development Plans, iv) National Health Financing Strategy, v) GPW13 strategic results notes, vi) most recent Country Cooperation Strategy, vii) workplans, budgets, HR plans, biennial PB assessments and Country Support Plan, viii) data, estimates and evidence, and ix) review of existing published documents: policies, reports, success stories.

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- qualitative data collections through interviews and focus group discussions with key beneficiaries and other stakeholders involved in implementing CCS priority interventions; and
- feedback sessions with senior national health authorities and other persons involved in implementing health sector priority interventions.

### **Stakeholder involvement**

The CCS evaluation is participatory. The following stakeholders should be engaged in the process, from report inception through to validation: i) national health authorities, ii) UN System organizations participating in the UNFSDC, iii) bilateral development cooperation partners involved in the health sector, iv) persons from academia and v) civil society organizations (non-state actors) involved in the health sector. Interviews, testimonies and quotations (with permission) should be sought from these parties.

### **Evaluation period**

The evaluation will be conducted during <period>.

### **Evaluation team**

The WR in WHO Country Office in <country> is the commissioner of the CCS evaluation.

The Evaluation Management Team (EMT), chaired by the senior manager or technical lead, should be set up to oversee the evaluation and ensure it follows the evaluation criteria, methodology, allocated timeline and budget. The evaluation manager, appointed by the WR, and the evaluation team lead, appointed by the WHO Regional Office, support the WR. The evaluation manager liaises between the evaluation commissioner and evaluation team lead who, in turn, supervises the work of the evaluation team and monitors the evaluation process throughout its cycle.

The CCS Evaluation Management Group (EMG) should be made up of representatives from all three levels of the Organization. Participants should be selected on the basis of the following criteria: i) leadership, technical and sectoral expertise, ii) experience of quantitative and qualitative evaluation methodology, iii) credibility, iv) impartiality and v) interpersonal and communication skills.

### **Evaluation report**

The evaluation report should provide clear answers to the evaluation questions asked and set out the evidence underpinning the conclusions, lessons learnt and recommendations for the next round of CCS development. The evaluation report ought to include an executive summary, methodology, findings and recommendations. It should be prepared and submitted to senior management at the RO and HQ.



### **Communication of evaluation outcomes**

A debrief will be organized by the WR, as evaluation commissioner, at the end of the field visit to ensure that important points are captured in the report and to discuss nuanced findings and areas for inclusion in later evaluations. The report will be printed and distributed to stakeholders involved in the evaluation process and other beneficiaries identified by the WR.

The CCS evaluation may be discussed at regional and global management forums and governing body meetings at the discretion of WHO senior management.

For internal learning purposes, a global webinar/seminar may be organized by the CSS in collaboration with the regional CSU and WR to share the experience and findings across the Organization. In accordance with WHO disclosure policy, the evaluation report and management responses may be published on the country, regional or global website. The CCS evaluation report will also be shared with the Evaluation Office for follow-up, where necessary, or to inform future WCO evaluations.

### **Resource implications**

The budget of the CCS review process should be included in the country biennial workplan or the respective WHO Regional budgets.

### **Additional guidance**

#### [Accessible from the WHO Evaluation Practice Handbook](#)

Checklist for compliance with the WHO evaluation policy: p. 89

Roles and responsibilities – management responses to evaluations: p. 91

Evaluation workplan: criteria for selection of evaluation topics: p. 109

Checklist for evaluation terms of reference: p. 113

Core competencies for evaluators: p. 123

Evaluation workplan template: p. 125

Typology of in-depth interviews: p. 127

Checklist for evaluation reports: p. 131

Glossary of key terms in evaluation: p. 139

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## ANNEX 2.

# EVALUATION STEPS

<b>Evaluation step</b>	<b>Activity</b>	<b>Timeframe</b>	<b>Person in charge</b>	<b>Estimated cost</b>
<b>Preliminary phase</b>	Development of the terms of reference (ToR)			
	Appointment of evaluation team			
	Development of the evaluation work plan and budget			
<b>Field mission</b>	Documentary review			
	Data collection and analysis			
	Feedback session			
<b>Evaluation report</b>	Development of the evaluation draft			
	Incorporation of the WHO country team inputs			
	Validation and dissemination of the evaluation report			

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## ANNEX 3.

# WCO EVALUATION MANAGER'S TERMS OF REFERENCE

- Develop the terms of reference and evaluation plan.
  - Inform the Country Office/WR about the evaluation and its requirements, and obtain their cooperation.
  - Commission an external consultant if needed (following WHO procurement rules) and manage the contractual arrangements, budget and evaluation personnel.
  - List key stakeholders and inform them of their area of expertise and scope of their collaboration.
  - Work with the evaluation team on selecting stakeholders to survey/ interview.
  - Schedule local meetings with key informants.
  - Arrange for relevant WHO staff to brief the evaluation team on the local situation and conditions.
  - Provide administrative and logistic support to the evaluation team.
  - Gather basic documentation for the evaluation team.
  - Liaise with and respond to stakeholders.
  - Ensure that the evaluation advances in line with the schedule set by the ToR.
  - Compile comments for the evaluation team on the draft report.
  - Ensure that the final draft meets quality standards.
  - Draft a management response to the final report.
  - Supervise final administrative and financial matters, including payments.
  - Arrange for an evaluation team debriefing before completing the field visit.
  - Circulate the evaluation findings internally and externally in line with a clearly defined dissemination strategy.
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