HEALTH DIVISION DOCUMENT 2002:4

Sweden's Development Co-operation with WHO

– a Strategy for the Period 2002–2005

Sida

SWEDISH INTERNATIONAL DEVELOPMENT
COOPERATION AGENCY

Department for Democracy
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Health Division

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1. Foreword

The world has seen unprecedented human and health development during the last fifty years. But new challenges have emerged.

The United Nations, including its various funds and programmes, plays a crucial role in leading the global community towards the achievement of the Millennium Development Goals, which include halving the proportion of people living in extreme poverty by 2015 and have a strong focus on health outcomes. WHO is the key organisation in the promotion of health and development.

Multilateral development co-operation is a vital element of Sweden's official development assistance. We believe that the political support that we might be able to lend to the UN development organisations is just as important as our financial contribution. Together with other member states, Sweden is deeply engaged in the reform and the governance of the different UN organisations. A rich and rewarding partnership has been established with development practitioners at headquarters, as well as in the field.

This strategy framework translates Sweden's development related support to WHO into guidelines for the medium term. Forward-looking, its objective is to reconfirm our commitment to work together with other member states of the United Nations to strengthen the development efforts of the UN.

The strategy was approved by the Swedish Government in April 2002.

Anders Nordström
Head
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2. Mandate

The World Health Organisation, founded in 1948, is the United Nations' specialist agency in the health field.

The basic texts of WHO state that WHO shall act as the directing and co-ordinating authority on international health work. In its mandate, WHO uses a broad definition of health, and does not limit itself to measures in the health sector, rather seeing health issues in a broader development perspective.

Since the 1970s, WHO has increasingly involved itself in normative work, concentrating on the dominant global health problems found mainly in low- and middle-income countries, and technical support for these countries for the development of national health programmes. In some countries, WHO functions as the operative organisation for development programmes. This is especially marked in Latin America, where WHO's Regional Office, Pan American Health Organisation (PAHO), plays a more operative role. In addition, WHO often plays an active role in disaster aid.

WHO supports extensive research in fields of importance to the countries with which Sida co-operates, in particular the special research programmes on reproductive health and tropical diseases. The child health and vaccine development programmes also include important research components.

WHO began its humanitarian activities as late as 1993, and has not yet clearly defined its role in humanitarian issues. A humanitarian identity is taking shape, where WHO is assuming the role of co-ordinator and technical adviser rather than that of operative organ.

The position of WHO as the leading global organisation in the health field was to a certain extent called into question in the mid-1990s, mainly because of lack of confidence in WHO leadership. One result of this was that the World Bank assumed a more dominant role, for example in the issues of health system development and funding.. Since Gro Harlem Bruntland became Director General however, WHO has greatly strengthened its position as the central normative health actor at global level. Over the last few years, WHO has also been successful in bringing health issues onto the international political agenda and clarifying the links between health and development.

The Swedish Position

Sweden has a positive view of the mandate held by WHO as the global normative health organisation, and of its role as the leading global health agency. Swedish views may be summarised as follows:

WHO's main role should be normative, i.e. that of working to develop technical standards, collating, analysing and providing information, and supporting the development of guidelines within all fields of relevance to health.

1. It is important that WHO uses its broad mandate to clarify the link between health and development, both globally and nationally.

2. The work of WHO in medical issues of a technical nature must be supplemented with further development of its normative role in the public health field, and the task of developing health systems.
3. WHO plays an important role in health research. In order to maintain its normative role, WHO must have a broad interface with health-related research and knowledge development. WHO should to be able to identify and promote areas requiring research. WHO should also play an active role in promoting national research as an integral part of a country's health system.
4. In the humanitarian area, WHO's role should primarily be a comprehensive normative one, and in the field, that of a co-ordinator in collaboration with OCHA, UNICEF, NGOs etc.
5. WHO should only function as an operative organisation where the organisation has a clear comparative advantage. PAHO has been used by Sida as the operative organisation for regional programmes in Central America. Bilateralisation of these programmes is desirable, and is under way.

3. Governance

WHO is a membership organisation with 191 member countries. Sweden is a member of the European region. There are three formal organs: the World Health Assembly (WHA), the Regional Committees (RC) and the Executive Board (EB).

The World Health Assembly

The World Health Assembly is the supreme decision-making body of WHO, and consists of delegations from all member countries. It meets once a year. The Swedish delegation, which is usually headed by the Minister of Health and Social Affairs, includes representatives of various interests such as the Ministry of Foreign Affairs, Sida, the National Board of Health and Welfare, the National Institute of Public Health, the Institute for Control of Infectious Diseases, the Swedish Medical Association and the Swedish Association of Health Professionals. Because of its scope, its size and its working practices, the WHA is a clumsy instrument for the member countries' control of WHO operations.

Regional Meetings

The Regional Committees meet once a year and function as control organs with the right to make decisions on regional issues.

The Executive Board

WHO's Executive Board consists of 32 members who meet twice a year. The board members are appointed for three-year terms. Board members have previously acted in a personal capacity but now act as representatives of their respective countries. It has been accepted practice in the board that the Nordic countries are represented on a rotating basis. Sweden currently has a seat on the board, for the period 2000–2002. Today, the Board does not exercise strategic control of priorities, resource allocation and organisational change. This would be desirable in the Swedish view.

Other Control

Within the framework of the overall control exercised by the WHA, the RC and the EB, the organisation is run by the Director General through the Secretariat and the Regional Directors. Beyond this, the donors of the voluntarily funded part of the budget exert a not inconsiderable influence through annual meetings concerning their earmarked contributions, and through the annual "Meeting of Interested Parties" for each of the 35 Areas of Work. One interesting recent development has been that the donor group, which previously largely consisted of

national aid organisations, has been extended to include large private contributors from foundations and from the business sector.

The Swedish Position

1. The Board should have more influence over the long-term orientation, goal development, priorities, and resource allocation of the organisation. This requires, among other things, changes in the Board's way of working.
2. The strategic two-year budget must function as the organisation's main instrument of control, and the link between priorities and total resources must be made clearer.
3. Follow-up of the activities is a basic requirement for control. Systems for reporting and analysing results and carrying out evaluations need improvement.

4. Organisation – Administration – Management

WHO's Secretariat consists of the Geneva Headquarters, Regional Offices, and Country Offices, and employs about 3,800 people in total.

The Geneva HQ is organised into 8 Clusters, which are in turn divided into Departments and Teams (see attached organigram). There is a Regional Office in each region: EURO (Europe), EMRO (Eastern Mediterranean), SEARO (South East Asia), AMRO/PAHO (North, Central, and South America), AFRO (Africa) and WPRO (Western Pacific).

Great changes have been made since the appointment of Gro Harlem Bruntland as Director General, particularly in the organisation of the Secretariat in Geneva. There is a pronounced ambition to create a more effective and coherent organisation. The goal is to reduce fragmentation within the organisation and create "one WHO". There is however no clear strategy for the continued reform of the organisation.

WHO's evaluation systems are poor. Nor are evaluations used as the strategic instruments of control they should be. Reporting and analysis of results is also poor.

The Regional Offices for Latin America (PAHO) and Europe (EURO) differ greatly from the others in that they work more independently. The African Regional Office is considered to have the greatest problems at present. The future role of the Regional Offices is a key issue for WHO. In Sweden's view, the combined resources of Headquarters and the six Regional Offices are not put to optimal use in developing the work of WHO at country level.

The Country Offices often function poorly. A 1997 evaluation of the work of WHO at country level identified the greatest problem as insufficient links between the needs of the country and WHO's activity in that country. Staff skills are deficient (limited medical skills and lack of skills in economy and management), and the offices are often characterised by lack of resources and authority.

WHO has initiated long-term efforts to develop coherent programmes at country level (country operational strategies) which are intended to achieve more selectivity and reduce the operative work.

WHO has an unwieldy recruitment procedure, where geographical considerations are among the most important selection criteria. At country level, recruitment is practically always from within the organisation. An overview of personnel policy is under way in order to create a better overall personnel policy, greater mobility within the organisation (above all between regions and country offices and headquarters), greater staff development opportunities, fewer short-term contracts, more women and better regional distribution. Today, 60% of newly recruited staff are women.

Nine Swedes currently work within WHO, of which 2 are APOs. This means that only 7 Swedes have permanent professional contracts, which is fewer than

in previous years. The quota for the number of Swedes lies somewhere between 9 and 15 persons.

Despite a well-developed Swedish resource base within several of WHO's prioritised areas, such as health systems, sexual and reproductive health and rights, and child and youth health, few Swedes are recruited to WHO and few Swedish experts or consultants are contracted for short assignments.

A new modus operandi is necessary to deal with the under-representation of Swedish personnel within WHO. Sweden and WHO have begun collaboration with the aim of developing practical means to ensure that interested Swedes with relevant skills apply for posts where external recruitment is taking place. If such persons are deemed to objectively meet WHO's requirements for a post, and are considered suitable by Sweden, they will receive active Swedish support.

The Swedish Position

1. The current leadership's work of "one WHO" with clear operational priorities deserves support.
2. The work of rationalising and improving the efficiency of WHO's administration must continue. A clear strategy for the ongoing reform of the organisation – an institutional and organisational development plan – should be produced by WHO.
3. The work of the Country Offices must be better adapted to the country's needs and to the UN-coordination through CCA/UNDAFF. Together with Headquarters, the Regional Offices must more effectively support the work at country level. The initiative of developing country operational strategies should be supported.
4. Contacts between WHO and the Swedish resource base should be stimulated to contribute to the activity of the programmes, and to facilitate the recruitment of Swedish experts to WHO.
5. In the light of the large Swedishco-operation with WHO, efforts should be made to increase the recruitment of Swedish experts to WHO, with an indicative target of 15. This should be able to be achieved during the current strategy period.
6. Over and above this, Sweden should annually fund 4–5 APOs within WHO.

5. Budget and funding

Budget

WHO's budget is met through assessed contributions from the member states and voluntary contributions. The Swedish assessed contribution is administered by the Ministry of Health and Social Affairs and is currently 40 million SEK per year.

The 2000–2001 WHO budget was 1,800 million USD, which is an increase of 9.3% compared to 1998–1999. Assessed contributions are expected to amount to 842 million USD in 2000–2001, and voluntary contributions to 958 million USD. The entire increase is due to voluntary contributions, with the budgeted assessed contributions remaining unchanged. 33% of the total budget pertains to work based at the Geneva Headquarters, 27% to the Regional Offices and 40% to work at country level. (Part of the budgeted funds for Geneva and the Regional Offices is used for activity at country level.)

WHO's dependence on voluntary contributions has steadily increased since the 1970s. Today, somewhat more than half of the total WHO budget is met by voluntary contributions, which are largely earmarked for various programmes and departments.

The 2000–2001 budget adopted by the World Health Assembly in May 1999 includes both voluntary contributions and assessed contributions from the member states and is divided into areas of activity corresponding to the new organisational division into Clusters. The budget also shows main Areas of Work, goals, and expected results for each Cluster. The budget adopted by the WHA can thus be regarded as a basis for the donors' discussions with WHO concerning the need for contributions, and can also function as a basis for follow-up of the operations.

In the proposed budget for 2002–2003, the text for the General Programme of Work, 2002–2005 has also been added to the policy section, which further marks the central role of the budget as an instrument of control.

Mobilisation of Resources

A new strategy for mobilisation of resources was presented in May 1999 for WHO's Executive Board and has been discussed during 2000 with the donors at a number of Meetings of Interested Parties, which were organised at Cluster level instead of, as previously, at programme level. This, however, has not entailed any change in WHO's relationship to donors of voluntary contributions. WHO has defined 35 Areas of Work that will be the basis of both the budget process and contacts with the donors through Meetings of Interested Parties.

Swedish Financial Support

Voluntary programme support from Sweden to WHO began in the early 1970s with support for the special programme for research into human reproduction (HRP). Its initial aim was to produce new improved contraception for use in developing countries. Sida also supported the development of a special research programme for tropical diseases (TDR).

At present, most of Sida's voluntary programme support to WHO is regulated in an agreement between WHO and Sida (the exception is support to humanitarian work). The agreement is drawn up jointly by DESO/Health and SAREC. For the period 2000–2001, the agreement comprises programme support of 160 million SEK. There is also a special agreement with PAHO for collaboration in Central America for the period 1999–2001, amounting to 155 million SEK. Humanitarian support is 20–30 million SEK per year.

The Swedish Position

1. The budget is to be an instrument of management and is to include both voluntary contributions and assessed members' contributions.
2. There should be a clearer link between the goals and priorities of the organisation and the financial resources, a "result-controlled budget".
3. WHO today is greatly dependent on voluntary contributions. Co-operation with donors must be developed in such a way that donors are not permitted to exercise inappropriate control over the work of the organisation by dint of their financial strength. One possible mechanism for this is for donors to have a more coherent negotiation procedure with the organisation concerning voluntary contributions, with the 2-year budget as a basis (negotiated contributions). Sweden should begin a dialogue with WHO and other donors in this area.
4. The dialogue between WHO and the donors is not only to be seen as a way of mobilising financial resources. It is also an important opportunity for WHO to disseminate knowledge of its work and to obtain important ideas and impressions from outside the organisation.
5. The Swedish contribution to WHO should have as little earmarking as possible. Research support should continue to be earmarked however, since most of this goes to the special research programmes, outside but associated with WHO, and because WHO's role in research has not yet been satisfactorily defined. Support to each research programme is to continue as basic support. Humanitarian support will continue to go to projects defined by WHO disaster unit.

6. Co-ordination issues

Sweden

It is important that Sweden's action with respect to WHO be consistent and co-ordinated. To this end, a consultation system has been in existence since the 1980s between the main parties involved – the Ministry of Health and Social Affairs, the Ministry of Foreign Affairs, the National Board of Health and Welfare and Sida (DESO/Health Unit and SAREC). Regular consultation meetings are held prior to meetings of WHO's Board and WHA, and prior to the annual consultations with WHO concerning voluntary programme support.

This has produced a very close and trusting collaboration between these actors, and Sweden has been able to conduct a co-ordinated policy, something which was particularly important during the years when WHO was experiencing a crisis of confidence.

The nature of humanitarian aid has thus far not permitted the degree of co-ordination referred to in the above consultation system. In the long run, humanitarian aid should be organised within the co-ordinated Swedish interaction with WHO.

There are other bodies in Sweden with relationships with WHO. The Medical Products Agency, the Institute for Control of Infectious Diseases, National Institute of Public Health, the Chemicals Inspectorate, the Labour Market Institute and others have a good deal of international activity, and act with respect to WHO as parts of the Swedish health care system. In some cases, the same body has a role in aid-funded co-operation with WHO, often under contract to Sida. There are also a number of institutions in Sweden that function as WHO Collaborating Centers. There are a number of contacts in the research community, mainly in the special research programmes.

The Nordic Countries

The Nordic countries consult prior to meetings of the Executive Board and the World Health Assembly (WHA). Joint Nordic proposals and resolutions are often raised in the WHA. There is, however, no formal consultation on voluntary contributions.

There has also been collaboration between the Nordic countries with respect to the need for reforms and evaluations.

The EU

There is some co-ordination within the EU during Executive Board meetings as well as during WHA meetings. It largely concerns issues of community competence, i.e. where there is an EU Directive. It is, however, not unusual for develop-

ment issues to be raised, such as synthetic baby milk, TRIPs etc. There are also plans to ascribe an important role to relevant health research in the EU's 6th Framework Programme of Research, particularly research into TBC, HIV and malaria.

Within the UN System

Within the framework of the UN reform, Sweden is pushing for efficient co-ordination within the UN system, not least at country level. The objective is to ensure that the UN agencies working within a country are to participate in a joint analysis of development problems and co-ordinate the planning of their aid programmes under the direction of UNDP. It is important that specialist agencies are also involved in this process. WHO has shown interest in the issue through its participation, as the only specialist agency, in the United Nations Development Group, which has the task of furthering the co-ordination process. Sweden raises the issue in its follow-up of multilateral aid including WHO's co-operation with UNICEF and UNFPA.

The Swedish Position

1. Co-ordination within Sweden is good, and should continue in its present form.
2. Co-ordination within the Nordic group has a long history and great value. This co-operation should be developed further, particularly in overall policy and reform issues, and with respect to voluntary contributions.
3. The existing EU co-ordination which takes place during the WHA should continue, but no increased co-ordination of EU action with respect to WHO is currently under consideration. The EU is an important WHO partner in the aid field, and in this context, Sweden should be actively involved as a member state of the EU.
4. In its dialogue with WHO as with other UN agencies, Sweden should emphasise the importance of an effective allocation of work and co-ordination with other UN bodies.

7. Experiences of co-operation and aid

Since the 1977 Alma-Ata declaration on primary health care, WHO has actively involved itself in health policy work and has supported the work of developing countries on national health strategies. WHO has also developed a number of programmes for the control of diarrhoea and respiratory tract infections in children, programmes for basic pharmaceuticals, tuberculosis programmes, maternity welfare programmes, programmes to promote breast feeding etc. Sida and SAREC supported these programmes from 1979 until the early 1990s.

WHO Global Programme on Aids (GPA) was adopted in the late 1980s and received broad support from Sweden through special funding from the Ministry of Foreign Affairs, administered by Sida. Apart from this programme support, Sida has given some project support to WHO disaster work and for water and environmental issues.

Support from Sida has primarily been based on the comparative advantages of WHO in development work and research. This support has involved active participation by both Sida staff and representatives of Swedish institutions in the annual meetings of the various programmes, something which has been of great importance in shaping the programmes.

In the past year, Sida has directed humanitarian funds via WHO disaster unit EHA (Emergencies and Humanitarian Actions). Experiences of this co-operation are mixed. WHO has a comparative advantage in the co-ordination of health work and normative policy work, and in some cases this has worked in practice. Often, however, the role of WHO has come to be excessively directed towards operative activity. The role of WHO in disaster situations and in humanitarian work is not yet sufficiently developed, but attempts have been made over the past two years to re-define the organisation's role and function.

Aid collaboration with WHO has given Sida and Sweden valuable contacts and information. Links have been established between WHO's programmes and bilateral operations. Sida's support has been based on the general Swedish policy towards WHO, and has expressed Sweden's willingness to contribute to strengthening WHO as a specialist agency in the health field, something which lies in Sweden's national interest as a member state.

The overall assessment is that WHO, with the help of Swedish support and collaboration, has clearly acted to create the prerequisites for the progress made in improving global health. Examples of areas where the work of WHO has been of particular importance are the development of primary health care, research into and eradication of tropical diseases, research into and development of contraception, child health care (above all vaccinations, respiratory tract infections and diarrhoea), and improved quality and use of pharmaceuticals.

WHO has been less successful in bringing about reduced maternal mortality, in integrating HIV/AIDS issues into the organisation after the formation of UN-

AIDS, in supporting the development of efficient health systems, in clarifying the links between health and development and the importance of health in the fight against poverty, and in its work in complex disasters and natural disasters.

Expectations that WHO would become a focal point for international health research have not been met. A number of international initiatives were taken in the late 1990s to address this problem. Through Sida, Sweden supports the "Global Forum for Health Research" which promotes international research into health problems related to the developing countries, and COHRED (Council on Health Research for Development) which has the task of promoting national health research. Sida's position however is that WHO should be able to shoulder the bulk of these tasks, but that the prerequisites for this are currently lacking.

In collaboration with Sweden and other nations, WHO has begun to introduce a gender perspective into its work. However, much remains to be done before mainstreaming has been achieved in the organisation.

The human rights perspective has been applied above all in the work of following up the UN Convention on the Rights of the Child.

8. Swedish priorities in 2002–2005

A number of central issues have been identified in Sweden's development co-operation with WHO. These are based on WHO's own priorities and those of Sweden (Swedish aid priorities and its priorities in its member state capacity). One ambition is to identify issues where a more in-depth dialogue between WHO and Sweden is important both for WHO and for Swedish development co-operation.

A. Institutional Issues

WHO as an institution and organisation has been analysed above. Sweden will emphasise two issues.

- Better control and clearer priorities

  The role of the Executive Board should be improved, the budget developed as an instrument of control, and follow-up of the activities improved.

- Improvements in WHO's work at country level

  The work of developing country operational strategies deserves support. These strategies should always be based on poverty reduction strategies of the individual country as expressed in a PRSP., If such a national strategy is not yet produced a process with broad participation should be supported. The role of Regional Offices and Headquarters as support for the country offices should be improved. Sweden should possibly focus on the situation in the African region.

B. Health Priorities

The basis of Sweden's collaboration with WHO, as in all Swedish development work in the health field, is to combat poverty, with the focus on the most vulnerable groups, above all impoverished women and children. All areas of co-operation are to be characterised by a clear gender and human rights perspective.

- Health as a development issue

  WHO has long had a disease-oriented modus operandi despite the fact that both WHO's definition of health and its mandate define its role as working for improved health in a broader context. The work initiated within WHO regarding links between health and poverty and the importance of health in development (economic, social and democratic) should be actively supported.

- A clearer public health perspective

  Despite WHO currently working with a number of issues of great importance for public health, there is no coherent public health perspective. WHO should work to further clarify the various determining factors for health (water, food, transport, education etc.) The role of WHO as an advocate/broker/ in areas outside the health sector must be clarified and strengthened.

Smoking-related diseases and mortality are one of the greatest health problems confronting the world over the next 30 years. WHO's work in attempting to achieve an international framework convention for tobacco control deserves strong Swedish support. Over and above this, Sweden should work for active WHO support for countries to reduce smoking through various measures.

– Development of health systems

Effective health care systems based on national needs giving fair access to services are an important factor in improving health. Issues of organisational development, policy, funding, staff planning and information systems have long had low priority within WHO. Both skills and capacity have been lacking. Today, there has been some reinforcement at Headquarters but the situation in most country offices is still poor.

Sweden should work to ensure that WHO produces a programme for the work of developing health systems (what issues and in what way: policy and strategy) with the aim of improving the work of WHO in the individual countries.

– Sexual and reproductive health and rights

Continued normative work to reduce maternal mortality should be a prioritised issue in WHO. The organisation may be of particular importance in the abortion field, and Sweden should actively participate in co-operation in this respect. The role of the midwife, the right of both mother and child to breastfeed and the right of young people to health care and sex education are other important Swedish priorities.

WHO carried out a good deal of active HIV/AIDS work through its Global Program on AIDS (GPA). When UNAIDS was formed, the work of WHO was noticeably reduced, not to say stopped entirely. There have been various new initiatives in recent years, but Sweden should actively work to ensure that WHO clarifies its role with respect to HIV/AIDS issues, increases its involvement as co-sponsor of UNAIDS, and increases its work at country level.

– Global initiatives

Today, health issues are increasingly important on the development policy agenda. One expression of this is that recent years have seen a number of global initiatives oriented towards eradication of, above all, the most infectious diseases. WHO is an important actor in several of these initiatives, such as GAVI (Global Alliance for Vaccine and Immunization), Roll Back Malaria and Stop TB. In addition, there are a number of special initiatives related to the global HIV/AIDS situation, and special initiatives in the field of pharmaceuticals.

These global initiatives present both opportunities and potential problems. The positive aspect is that health issues are given a more prominent position on the development agenda, which can lead to additional funding, both in the form of an increased flow of aid to the health sector and in larger proportions of national budgets being devoted to health. The global initiatives have proved able to attract private financiers to an extent not seen previously. Efforts to eradicate infectious diseases also have a clear poverty profile.

Problems can arise in implementation at country level, where disease-oriented measures risk obstructing the work of improving national health systems and processes whose aim is increased co-ordination, e.g. sector programmes.

Sweden should actively participate in the discussion of these global initiatives and should particularly monitor implementation at country level and the role of WHO.

C. Research

Access to up-to-date information and research results is necessary for the normative function of WHO to work from a fact-based analysis. WHO should therefore have access to, and contact with, health-related research and knowledge development in various fields. The creation of the "Evidence for Policy" Cluster, which includes a small department working with research policy and co-operation for the whole organisation, is of importance in the continued work of WHO.

WHO has a role in pointing out the need to promote national research as an integral part of countries' health systems, and in identifying areas requiring research that can have great relevance for the health problems of poor countries. Today, the poor research capacity of the developing countries limits their access to new results of research.

Sweden's view is that WHO's role in research should be strengthened. Less than 10% of international health research is devoted to problems of primary importance in developing countries. Poor research capacity limits the opportunities for these countries to receive, and utilise, research results. Research and analysis should therefore be an integral part of the work of WHO. At the same time, WHO should be able to deal with research issues in an overall interdisciplinary perspective. The present system of special research programmes outside but closely related to WHO has developed into platforms for international research networks and enjoys a good reputation among both practitioners and researchers. This system should be able to be developed and related to a coherent research function within WHO.

Through its support to WHO, Sweden has the opportunity to actively influence the shaping of research programmes and their orientation towards developing countries. Co-operation with WHO has given Sweden the opportunity to establish valuable contacts and gather information, and the opportunity to influence international health policy development work. Swedish researchers have actively participated in scientific committees and follow-ups of the current research programmes.

Most Swedish research support to WHO has been for the special programmes for tropical diseases and reproductive health. The main focus of these programmes is on the diseases of poverty, and they have achieved good results that have led to changed priorities. Smaller and variable amounts of support have been given to research within important areas of child health and to vaccine research. In the new organisation, the research programmes have been brought closer to the implementation programmes. This should

have positive effects on the possibility of making use of and distributing new products and new knowledge even more efficiently in the future.

WHO will also play an increasingly important role in research into health problems that have until now mainly affected the western world, but which are increasingly affecting the developing countries.

WHO's contacts with international health research should be developed further, as should its role in emphasising the importance of national research as an integral part of a country's health system.

Sweden should continue to actively support research in WHO, and should focus on correcting the unfair distribution of resources for research into the diseases of poor countries. It is necessary to improve operational research, including research into health policies/health systems, and this should be carried out where possible.

D. Humanitarian Work

The past ten years have seen an increasing complexity of global crises and disasters. In the health sector, WHO has an important role to play as a co-ordinating organisation with a clear normative orientation. WHO also has an important role in the build-up phase after a conflict.

Sweden would like to see a clarification and development of the role of WHO in humanitarian aid. Sweden will contribute to that development work where possible.

9. Swedish development co-operation with WHO in 2002–2005

Sweden's membership contribution to WHO during this period is expected to amount to just under 40 million SEK per year, which is 2.5% of the regular budget.

There is an agreed voluntary contribution of 80 million SEK per year for the period 2000–2001. This contribution is channelled via programmes/Clusters at Headquarters, but may be used for both regional and national activities. The preparatory process involved consultations with WHO and subsequent proposals submitted by all Clusters. The assessment of the applications has involved consideration of Sida's priorities in health issues as well as the quality of research where relevant.

The current agreement includes support for 17 measures. The primary focus of about half of the contribution is research. Other measures are motivated by their being priority health issues in Sweden's development co-operation. 5% of the agreed sum has been earmarked for enabling WHO to utilise Swedish institutions and Swedish expertise.

Apart from the global voluntary contribution, there are wide-ranging "multi-bi-contributions" ,where WHO is the implementing agency at the country level, regarding co-operation in Central America with PAHO (155 million SEK for the period 1999–2001), measures in Eastern Europe, and humanitarian work (about 20 million SEK/year).

The distribution between a more open contribution to whole development themes and Clusters, and a more clearly earmarked contribution to sub-departments and programmes, is also a matter for consideration in the work of preparing future WHO contributions. Previous experience demonstrates the value of an active role for Sida, including close contacts with the programmes receiving Swedish support.

Guidelines

1. Swedish goals for development co-operation, the Development Goals of the UN Millenium Decleration, WHO's two-year budget and Sida's policy for development co-operation and research co-operation in the health field are to constitute the framework and basis of negotiations concerning the Swedish voluntary contribution.
2. Negotiations concerning the Swedish contribution should be better utilised to conduct an overall policy dialogue with WHO. The Ministry of Foreign Affairs has the main responsibility for this, in close consultation with the Ministry of Health and Social Affairs and Sida.
3. The contribution should be made with as little earmarking as possible. Even at a low level of earmarking, dialogue and co-operation can be concentrated to certain selected programmes, and the contribution can thus be used to support issues that have priority in Swedish aid work.

4. Efforts should be made to increase the focus of areas of dialogue and co-operation with WHO.
5. Support for WHO's research-related activities should continue to constitute a considerable part of the Swedish contribution, helping to promote the normative role of WHO in international health research.
6. Some increase in co-operation on humanitarian aid considering WHO's comparative advantage is also predicted.
7. WHO should not be used for the implementation of measures unless the organisation has a clear comparative advantage. Examples of this are parts of PAHO's Central American activities, the construction of a health system in the Balkans, or humanitarian aid in disasters.
8. It is proposed that the voluntary contribution should increase somewhat for the period 2002–2005, to about 90 million SEK per year. The contribution is expected to be funded from both the multilateral budget as well as the global research budget.
9. Sweden should work actively for the employment of more Swedes, both in long-term posts in WHO (preferably permanent posts) and shorter assignments (individuals or institutions).
10. An assessment of the support earmarked for co-operation with Swedish institutions and experts should be carried out in late 2002.

10. The division of responsibility in Sweden

The Ministry of Health and Social Affairs and the National Board of Health and Welfare are responsible for co-ordination of Sweden's actions as a member state of WHO (Executive Board, WHA and European region).

The Ministry of Foreign Affairs has overall responsibility for Sweden's aid-funded support to WHO, as well as co-ordination of overall UN issues.

Sida is responsible for the preparation and follow-up of aid-funded measures and for producing material as a basis for these and future strategies, in consultation with other actors. DESO/Health unit is the focal point for WHO issues at Sida. SAREC is responsible for research issues, SEKA for humanitarian issues and ÖST for WHO measures in Central and Eastern Europe. Consultation should take place with NATUR regarding environment-related measures.

List of Health Division Documents

Strategies/Policies

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