Portfolio Overview

Sida's support to the World Health Organization (WHO) 2013

WHO is highly relevant to Swedish development policy as a result of its significance in the challenge of improving health and reducing poverty in the world. In 2013, Sida contributed to WHO programmes with a total amount of 171 MSEK.

Financial Overview

Sida has, during the last years, moved from programme support to core voluntary contributions (CVC) as a way of strengthening WHO's financing efficiency. This step was taken in order to limit the degree to which Sida uses WHO as a channel for bilateral and regional programmes. In 2013, 65 MSEK was provided as core voluntary contribution and 77.5 MSEK as earmarked voluntary contrubutions (VC) for specific programmes.

In addition, the Swedish assessed contribution (or member fee) to WHO's regular budget amounted to 31.7 MSEK in 2013, of which 76 percent counts as official development assistance (ODA). The total Swedish support for 2013 thus added up to 194.2 MSEK. Sweden is ranked as the 5th largest Member State provider of CVC and the 10th largest Member State provider of VC.

Geographical and Thematic Distribution

Sida's support to WHO is predominantly of global character. The thematic distribution is illustrated in Chart 2. In 2013, Sida contributed 72.5 MSEK to three of WHO's research programmes; Alliance for Health Policy and Systems Research (AHPSR), The Special Programme of Research, Development and Research Training in Human Reproduction (HRP), and the Special Programme for Research and Training in Tropical Diseases (TDR).

Through these programmes, Sida supports the strengthening of the knowledge base for the global development of WHO's normative functions and for coordinating, supporting and influencing global efforts to combat a portfolio of major diseases and insanitary conditions in developing countries. The focus lies primarily on preventing and controlling communicable diseases and improving sexual and reproductive health.

Sida also provided earmarked support for the International Health Partnership programme (IHP+). The objective of IHP+ is to strengthen the links between development effectiveness, universal health coverage and better health results. It emphasizes country leadership and alignment with national health strategies and plans.

Definition of Multilateral and Multi-Bi Support (Core and non-Core contributions)

Contributions from Sida to WHO are often entitled "multi-bi" (multilateral bilateral) support. Support to specific programmes or projects, so called earmarked, or non-core contributions, are labelled voluntary contributions (VC) in the case of WHO, while non-earmarked contributions to the organization's activities are labelled as core voluntary contributions (CVC). These should be distinguished from contributions to the organization's regular budget, in terms of Sweden's "member fee" (or so called "assessed contribution), which usually is called core support and labelled as "multilateral aid". The latter type of support is processed and decided upon by the Ministry for Foreign Affairs or other Government offices. The Swedish assessed contribution to WHO's regular budget is provided by the Ministry of Health and Social Affairs.

TABLE 1: SIDA'S ANNUAL DISBURSEMENTS TO WHO 2008–2013

	2008	2009	2010	2011	2012	2013
No. of contributions	13	9	11	5	3	6
Total Amount (MSEK)	219	224	144	114	145	171

CHART 1: SIDA'S SUPPORT TO WHO BY SECTOR 2009–2013 (MSEK)

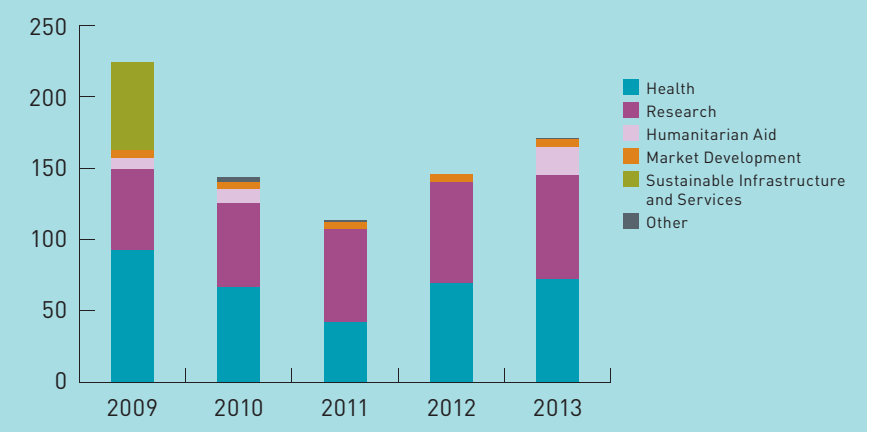
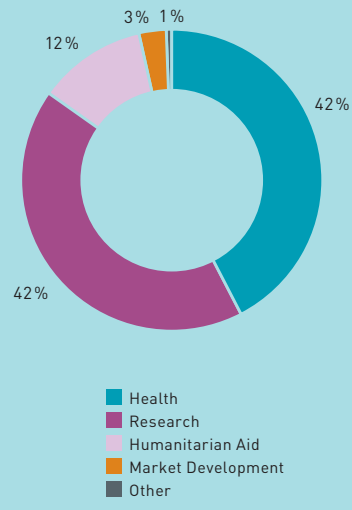


CHART 2: SIDA'S SUPPORT TO WHO BY SECTOR 2013



MANDATE AND STRATEGIC PRIORITIES

WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. As a specialized agency of the United Nations, WHO is a normative, knowledge-based organization. In the agreement for 2012–2013, Sida's main focus was to contribute with global, un-earmarked funding to WHO's activities and support its research programmes. The support will be followed up through a subset of WHO's own performance indicators, with a focus on sexual and reproductive health and rights and governance.

During 2013, Sida also initiated a two-year support to the reform of WHO's work in humanitarian interventions, with a total of 20 MSEK per year. The objective of the support is to improve the predictability, consistency and quality of WHO's work in emergency risk management and humanitarian response.

Sida financed three Junior Professional Officers (JPO's) during 2013, working for WHO in Burkina Faso, Uganda and Ethiopia.

During 2014 and 2015, Sida's voluntary contribution will increase to 170 MSEK per year and the research support to 87 MSEK and 88 MSEK respectively. Recognizing the problems that earmarking causes for the organization, Sida has made conscious efforts to move towards only CVC. Hence, Sida's support to WHO is constituted mainly by un-earmarked contributions and support to global health research (Chart 1; see also the box on Mandate and Strategic Priorities).

Results

Global Trends

WHO provides a global high-level leadership in the area of health and contributes to improved health in the world, both directly and indirectly. Indirectly, through the development of global norms and strategies, and directly through technical support provided to countries for implementing health strategies. WHO is also tasked with the responsibility to gather worldwide information and alert about serious health threats. WHO is not an implementing organisation but supports countries to implement evidence based and needs-driven plans for various health areas. It is therefore difficult to attribute results to WHO solely. However, WHO statistics show that the proportion of deliveries attended by skilled health professionals has increased globally, rising from 61 percent in the 1990s to 70 percent between 2005 and 2012. During the same period the global mortality rate and the under-five mortality rate fell by 47 percent.

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