NORWEGIAN MINISTRY
OF HEALTH AND CARE SERVICES
NORWEGIAN MINISTRY OF FOREIGN AFFAIRS

Strategy

Norwegian WHO Strategy

Norway as a member of WHO's Executive Board 2010–2013

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Anne-Grete Strøm-Erichsen Photo: ©Torgeir Haugaard/Office of the Prime Minister
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Norway's efforts in WHO are to be based on important principles such as respect for human rights, democracy and gender equality. The fight against poverty is a key factor in this respect.

Foreword

A strong World Health Organization (WHO) with a clear mandate and the necessary authority and legitimacy to fulfil its various roles is in the interests of all the member states.

We must enable WHO to meet the challenges of the 21st century, which will involve developing good national health systems, strengthening preventive capacity, and making a concerted effort to combat the major poverty-related diseases. Our health systems are under strain due to the shortage of health personnel. This applies to virtually all countries. The global burden of disease is changing. The current social inequalities in health can only be reduced through broad cooperation. Moreover, issues relating to vulnerability and health security are closely interwoven with traditional security challenges and thus with foreign policy.

Norway's efforts in WHO are to be based on important principles such as respect for human rights, democracy and gender equality. The fight against poverty is a key factor in this respect.

In this WHO strategy, Norway sets out its overall objectives and priorities for its work on the WHO Executive Board for the term of office 2010–2013. Our membership of the Executive Board gives us opportunities to exert an influence and to take our share of responsibility for strengthening WHO and helping it to achieve its objectives. We intend to use our board membership to promote WHO's role as the leading normative organisation for global health.

Our objective is also to help to ensure access to basic health services and better health for all. Through our work on the Executive Board, we will seek to promote universal access to health services based on the fundamental right to health services for all by promoting healthy living conditions and strengthening health systems.

Extensive, transparent international health cooperation – both in our region and at the global level – is also important for public health in Norway. We know that poor health is just as much a cause of poverty as a consequence of poverty, and we are aware of the links between access to health services, good health and prosperity.

This underlines the importance of developing health systems, including primary health care services, in order to ensure equity and good health for all. We have learned this from our own experience in Norway, and we must now help others to make use of this knowledge.

Oslo, 1 September 2010

Jonas Gahr Støre
Minister of Foreign Affairs

Anne-Grete Strøm-Erichsen
Minister of Health and Care Services

Erik Solheim
Minister of the Environment and International Development

WHO Geneva Photo: © WHO

1 Introduction

Norway has a seat on the Executive Board of the World Health Organization (WHO) from May 2010 to May 2013. The Norwegian board member is Director General of Health Bjørn Inge Larsen. In connection with this, the Public Health Administration and the Foreign Service have joined forces on a Norwegian strategy that will apply for the duration of the Norwegian term of office and to the end of 2013.[1]

Norway's WHO strategy is based on an interest and value-oriented approach.[2] WHO is an important arena for Norway's involvement in international health matters and thereby for safeguarding national interests. The links between health and an interest-oriented Norwegian foreign policy concern both Norwegian national interests and the interests we share with other countries. Our membership of the board will also play a role in the formulation and follow-up of Norwegian foreign policy and international development policy.

Both as a professional field and as a policy area, health is characterised by increasing globalisation. An aspect of this is the growing number of interfaces and closer links between matters of health and foreign policy. The features of globalisation are particularly discernible in areas such as the migration of health personnel, health security and the spread of communicable diseases. Health preparedness is increasingly becoming an international concern as communicable diseases rapidly spread across national borders.

Non-communicable diseases, such as those ascribed to the four greatest risk factors, tobacco, physical inactivity, unhealthy diet and alcohol, constitute an increasingly greater share of the various countries' burden of disease, not only in developed countries, but also increasingly in developing countries. However, in sub-Saharan Africa communicable diseases constitute the major share of the total burden of disease.

Three of the eight UN Millennium Development Goals are directly related to health: reducing child mortality, reducing maternal mortality, which includes reproductive health, and reducing the incidence of communicable diseases. Several of the other MDGs are also related to health, such as those concerning education, women's rights and gender equality, drinking water and sanitation/environmental sustainability and nutrition.

Norway's WHO efforts will be continually coordinated with other Norwegian UN policy and Norwegian policy in relevant multilateral organisations. They will also be based on and used to promote important principles espoused by Norway, such as respect for human rights, democracy, gender equality and the fight against poverty.

1 Norway will occupy a position on the board during the period from May 2010 to May 2013. The Strategy will apply until the end of 2013. For the sake of simplicity, the period for which the strategy applies is hereinafter referred to as the «term of office».

2 This is in keeping with the policy guidelines set out in the white paper *Interests, Responsibilities and Opportunities: The main features of Norwegian foreign policy (Report No. 15 (2008–2009) to the Storting) and in the white paper Climate, Conflict and Capital. Norwegian development policy adapting to change* (Report No. 13 (2008–2009) to the Storting).

World Health Assembly, WHO Photo: © Oliver O'Hanlon/WHO

2 Vision and purpose

Overall vision

Norway will seek to strengthen WHO as a leading, normative organisation for promoting global health. WHO will seek to highlight health considerations with a view to integrating health into all policy areas.

Through WHO, Norway will seek to promote universal access to health services based on the fundamental right to health services for all by promoting healthy living conditions and strengthening health systems.

Well developed and transparent international health cooperation is important for safeguarding Norwegian public health in relation both to our neighbouring areas and in the face of global challenges. This is an important security priority and thus an integral part of Norway's foreign policy and international development policy.

Purpose

The purpose of the strategy is twofold: firstly, to define the overall objectives and priorities of Norwegian WHO efforts, and secondly, to provide the basis for a clear, coherent Norwegian WHO policy, thus enhancing the consistency of Norway's approach in WHO forums as well as in the UN.

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3 Overall objectives for Norway's engagement

The overall objectives for Norway's efforts will be to:

3.1 Fight poverty by helping to achieve the UN Millennium Development Goals

The fight against poverty depends on the strengthening of certain public goods, including health. Today there is a clearly recognised connection between population health and prospects for development. Improved health helps to reduce poverty and at the same time reduces the security threats caused by poverty. Increased focus on and investment in health in the poorer parts of the world may also benefit rich countries. Over the years Norway has taken a leading position in efforts to strengthen global health cooperation, and in particular to increase the focus on Millennium Development Goals 4 and 5, which aim to reduce child and maternal mortality. This has been achieved through the use of development assistance funds and through political initiatives within the framework of the UN and a number of the new alliances designed to promote better global health cooperation.

3.2 Support and promote the right to health services

Everyone is entitled to the highest attainable standard of health. Good health is also one of the most important conditions for enjoying a meaningful and active life. Ensuring that the whole population has access to health services is primarily a national responsibility. The public authorities must, through their own policies, take the main responsibility for funding and regulating health services. They must facilitate broad cooperation that mobilises forces in local communities and allows different actors to offer services within a common binding framework.[3]

3.3 Help to reduce the great social inequalities in the world

There are great social inequalities in the world, both within and between countries. In many countries they are growing, and there are dramatic inequalities in access to and quality of health services. The circumstances in which we are born, raised, work, live and age are decisive for our health. These circumstances are determined by the distribution of money, power and resources at the global, national and local level. Changes in social circumstances can result in major health improvements. Better health cannot be achieved solely by building up the health sector; it is also dependent on access to clean water, healthy food, an unpolluted environment, gender equality, education and good governance.

3 The white paper *Climate, Conflict and Capital. Norwegian development policy adapting to change* (Report No. 13 (2008–2009) to the Storting).

3.4 Help to reduce the burden of disease[4]

All governments should give high priority to setting targets for reducing the burden of disease in the population. The health service itself must ensure that the measures taken reach all sectors of the population and detect changes in the disease status of the population. The global burden of disease is changing. Non-communicable diseases now cause approximately 60% of all deaths worldwide. WHO estimates that mortality from non-communicable diseases will increase during the next ten years, most in low and middle-income countries. An ageing population, tobacco consumption, obesity, unhealthy diet, physical inactivity and alcohol are all contributing factors to the increase in non-communicable diseases. In sub-Saharan Africa, communicable diseases still constitute a greater share of the burden of disease than non-communicable diseases. Common communicable diseases and malnutrition are still the main causes of high child mortality in this area. The cause of high maternal mortality is directly related to complications in connection with pregnancy and childbirth, which in turn are often directly related to poorly developed prenatal and obstetric care.

3.5 Promote women's rights and gender equality

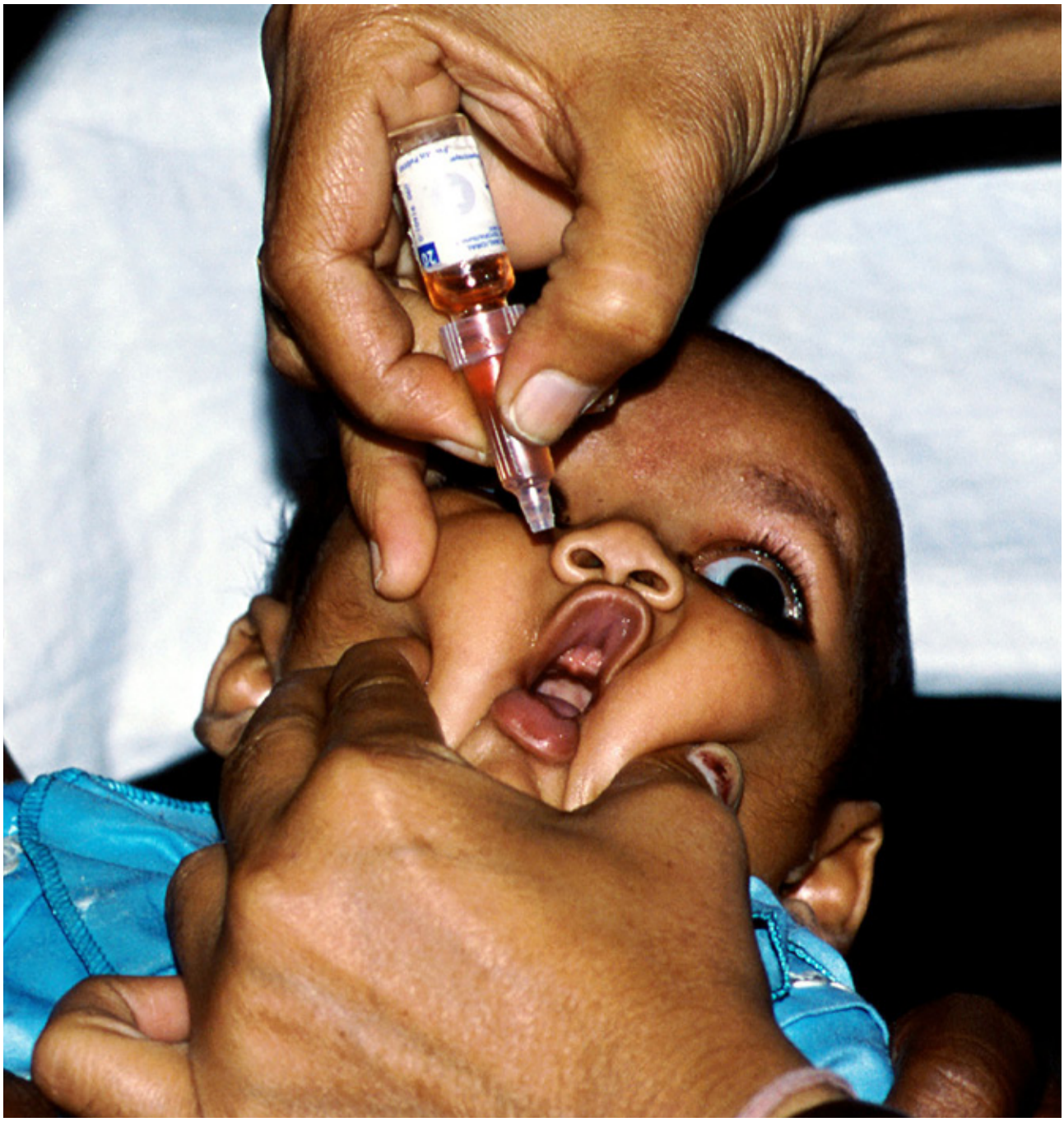
Women's participation and women's rights are crucial for achieving the UN Millennium Development Goals. The MDGs will not be achieved unless women are put centre stage and their resources and expertise are utilised. This means ensuring that women have economic opportunities, an opportunity to influence social development and control over their own lives. Sexual and reproductive rights and women's health play a central role in this, and are closely linked to gender equality. This involves focusing on good primary health care services and universal access to family planning and qualified midwifery services.[5]

Because of powerful counterforces at local and international level, Norway must have a clear policy and act wisely in cooperation with like-minded countries in this area. The Norwegian Government's Plan of Action for women's rights and gender equality in development cooperation will be incorporated into Norway's work in WHO, and establishes that Norway will advocate:

- the decriminalisation of abortion and of women who have had illegal abortions, so that they can safely seek treatment if complications arise;
- the decriminalisation of homosexuality and the fight to prevent all forms of discrimination and stigmatisation due to sexual orientation;
- international acceptance for the concept of «sexual rights», including the right to safe and legal abortion on demand, and equal treatment regardless of sexual orientation.

4 The WHO divides the disease burden into three main groups: communicable diseases, non-communicable diseases and accidents.

5 The white paper *On Equal Terms: Women's Rights and Gender Equality in International Development Policy* (Report No. 11 (2008–2009) to the Storting).



Polio immunisation Photo: © WHO

WHO Headquarters Geneva Photo: © WHO

4 Overview of WHO's structure, governance and funding

4.1 WHO's mandate and structure

The World Health Organization (WHO) is the UN specialised agency for health. WHO's mandate is to seek to ensure better health for all,[6] and to be the leading coordinating body for international health cooperation. As a normative actor, WHO has a unique position as regards making health policy statements on the basis of ethical and evidence-based assessments.

As the UN specialised agency for health, WHO has an obligation to help to achieve the MDGs.

WHO'S CORE FUNCTIONS

- providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- setting norms and standards and promoting and monitoring their implementation;
- articulating ethical and evidence-based policy options;
- providing technical support, catalysing change, and building sustainable institutional capacity; and
- monitoring the health situation and assessing health trends.

6 Article 1 of the WHO Constitution reads: «*The objective of the World Health Organization shall be the attainment by all peoples of the highest possible level of health.*»

The work of WHO can be described in terms of two axes:

- A normative axis, whereby the organisation in the capacity of its role in the field of health defines global norms and standards, and supports the member states in the formulation of national health policy. WHO attaches great importance to articulating evidence-based recommendations, and the collection and application of data are thus important.

- A development-oriented axis, which primarily consists of providing technical support to developing countries to enable them to implement recommendations and standards, strengthen their health systems and develop and implement comprehensive national health plans and programmes.

WHO is organised on three levels: global, regional and country. The organisation is headed by a Director-General, who is elected by the WHO member states. The organisation's headquarters are in Geneva. At the regional level, WHO is divided into six regions. WHO also has offices at country level.

WHO is governed through annual meetings of the World Health Assembly (WHA), whose main function is to approve WHO's strategic plans and two-year programme budgets and adopt resolutions outlining WHO's task and providing political and health-related guidelines for its work. The WHA is held in May each year, and is the supreme decision-making body for WHO's 193 member states.

The WHO Executive Board is composed of members from 34 member states, and its main function is to facilitate the work of the WHA and ensure implementation of its decisions. As a general rule, the board meets twice a year, in January and following the WHA in May. During the meeting in January each year, the board reviews the agenda of the WHA to be held in spring the same year, and sets out important guidelines for the WHA's consideration of the various matters, for example by means of draft resolutions.

At the regional level, WHO is divided into six regional offices, each headed by a Regional Director nominated by the region's member states and elected by WHO's Executive Board. The member states in each region come together at regional committee meetings once a year, where they discuss budgetary matters within the framework of the Medium-Term Strategic Plan (MTSP) and the two-year programme budgets as well as subjects of relevance to the region concerned. Norway is a member of WHO's European region (WHO EURO). Most of WHO EURO's activities take place at the regional office in Copenhagen, but there are also technical units in other member states.

At country level, WHO has 145 country offices, which serve 159 member states, divided between the six regions. WHO EURO is present in 29 member states through country offices and assists national health authorities in their work. WHO's country offices serve as a platform for cooperation between member states on promoting the global health agenda and support domestic strategies and priorities.

4.2 Governance

Governance instruments

The overall framework for WHO's activities is laid down in *Engaging for Health: Eleventh General Programme of Work* 2006–2015, according to which WHO is to assist in:

- investing in health to reduce poverty
- building individual and global health security
- promoting universal coverage, gender equality, and health-related human rights
- tackling the determinants of health
- strengthening health systems and equitable access
- harnessing knowledge, science and technology
- strengthening governance, leadership and accountability

The Medium-Term Strategy Plan (MTSP) for 2008–2013 sets out the main health-related challenges that the WHO is to work on, and defines the strategic direction for the period. The MTSP also establishes the results-based management system for all levels of the organisation. The two-year programme budgets are one of the main elements of this management system. In the current MTSP period the programme budgets are divided into 13 strategic objectives with subsidiary objectives, performance indicators and the distribution of resources for the various subsidiary objectives.

WHO prepares a status report on the achievement of objectives and use of funds, both halfway through the two-year budget periods and at the end of each period. This forms the basis for the management dialogue with the member states. The programme budget is

WHO'S 13 STRATEGIC OBJECTIVES

1 To reduce the health, social and economic burden of communicable diseases

2 To combat HIV/AIDS, tuberculosis and malaria

3 To prevent and reduce disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence and injuries and visual impairment

4 To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals

5 To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimise their social and economic impact

6 To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex

7 To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches

8 To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health

9 To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development

10 To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research

11 To ensure improved access, quality and use of medical products and technologies

12 To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work

13 To develop and sustain WHO as a flexible, learning organisation, enabling it to carry out its mandate more efficiently and effectively

subject to adjustments for each new two-year period, for example, on the basis of the need to target the indicators better or change the distribution of resources in order to ensure better goal achievement in specific areas.

A central feature of the results-based management system is the implementation of a global system for handling management information, the Global Management System (GSM). This provides continually updated information on the organisation's budgetary status at all levels, viewed in relation to achievement of the various subsidiary objectives set out in the programme budget. The GSM is currently being implemented in the organisation.

4.3 Funding

Regular and voluntary contributions

The total budget adopted for the programme period 2010–2011 is over USD 4.5 billion. WHO is funded by means of fixed regular contributions and voluntary contributions. Voluntary contributions for the period 2010–2011 are expected to amount to approximately 80% of the total budget, which is a larger share than ever before.

Voluntary contributions to WHO may be made in any of four ways:

i) Totally flexible

ii) Highly flexible, associated with WHO's strategic objectives

iii) Flexible, associated with organisation-wide expected results (OWERs)

iv) Earmarked funds

In recent years, there has been a shift in the direction of earmarking voluntary contributions. This means that donors specify which focus areas funds are to be used for. Earmarked contributions constituted 80% of the total voluntary contributions during the period 2008–2009, as against 70% during the period 2006–2007. Compared with other UN organisations, the number of voluntary and earmarked contributions is high.

In order to encourage an increase in non-earmarked funds, and ensure greater use of voluntary contributions to support priorities made by WHO's governing bodies, WHO has established a separate fund, the Core Voluntary Contribution Account (CVCA). Norway and a number of other like-minded countries have provided support to this fund, which currently constitutes two per cent of WHO's total budget.

Norwegian support to WHO

As a member of WHO, Norway is obliged to pay a regular contribution as a share of the adopted budget. Norway also contributes additional funds to WHO's development-oriented and humanitarian work. Norway is one of the largest donors of voluntary contributions to WHO.

Norway's regular contribution to WHO for 2009–2010 constitutes 0.782% of the total regular contributions paid by the member states to WHO. For 2010–2011, the membership fee has been set at 0.8711%, which is the equivalent of USD 4 045 570. Of this share, 70% is regarded as official development assistance. The regular contribution is covered over the budget of the Ministry of Foreign Affairs, with 30% over chapter 116, item 70, and 70% over chapter 170, item 78.

During the two-year period 2008–2009, Norway contributed NOK 431 million in voluntary contributions to WHO's development-related activities, including assistance to global health research. This is in addition to the funds provided by Norway to WHO for its humanitarian relief work in crisis situations.

Photo: © WHO

Social determinants of health Photo: © Marko Kokic/WHO

5 Challenges

5.1 WHO as a specialised agency of the UN

The UN is uniquely placed as a forum for developing global norms and conventions, as an arena for international negotiations and, through the UN Security Council, as a body for legitimising the use of force. The UN also provides an important, broader legitimising function for international policy development, based on a decision-making structure where each country has one vote. UN bodies have important tasks to fulfil, both in terms of the coordination of joint efforts in crisis-affected countries and in terms of its operational role at country level in developing countries.

WHO is one of the UN's most important specialised agencies. Thus it not only has a strictly technical role associated with health issues; it is also part of the UN system. This means that WHO must be prepared to take on tasks that enable the UN system to function as a whole, and that the organisation's priorities and work must be coherent and coordinated with the work carried out by other organisations.

Norway's strategy vis-à-vis WHO must be viewed as part of its general UN policy. The importance ascribed to WHO in the normative area is in keeping with general Norwegian UN policy. WHO's normative role derives from its capacity to function as an authoritative knowledge organisation with regard to global health.

To enable WHO to function better in cooperation with the other UN organisations, WHO must take an active part in ongoing efforts in the UN system to harmonise business practices. This includes performance management, transparency and accountability.

5.2 The role of WHO in the global health architecture

According to the WHO Constitution, Article 2 (a), the organisation shall «act as the directing and co-ordinating authority on international health work». As in other areas of vital interest to Norway, such as energy and social and economic development, we see that, in certain areas, other health organisations play a more important role than that of WHO. In many contexts the World Bank plays a more prominent operational role vis-à-vis recipient countries than any of the UN organisations by virtue of its financial weight. At the same time, through its ability to adapt and its cooperation with new actors, WHO demonstrates the fundamental value of the UN's normative role.

WHO's normative role is challenged by a large and growing range of global health actors. The health-related MDGs have spurred new partnerships between multilateral, bilateral, voluntary and private actors. Development assistance for health purposes increased from USD 5.6 billion in 1990 to almost USD 22 billion in 2007. There has been an increase in disease-specific funding in particular, with an emphasis on HIV/AIDS, malaria and tuberculosis. When allocating funds for specific purposes, it is often assumed that the fundamental aspects of a health system are in place, but that they are inadequate in some respects. New funding mechanisms are being employed to fund health programmes in low and middle-income countries, particularly as regards access to medicines.

At the same time, the increase in the number of health actors leads to an increased need for coordination in the global health arena, and this is also relevant for

ensuring results at country level. Over time, WHO has, with the blessing of its member states, developed a number of partnerships with other actors in the health area. This has resulted in increased use of both financial and administrative resources by the organisation. Increasing funds are being allocated to partnerships. However, in spite of the fact that the organisation plays an administrative and normative role in most of the partnerships, there is no corresponding increase in funds allocated to WHO's core activities.

WHO thus faces a major challenge in maintaining and further developing its capacity to set the agenda and be a common arena for global health, while also being a technically relevant partner for new investments that have a political focus and funding.

Given the range of actors involved, it is important that WHO's mandate is clear, and that the organisation has the necessary authority and legitimacy to fulfil its roles and function as a leading and coordinating actor. At the same time, the organisation must strengthen its capacity to deliver in its core areas.

5.3 Challenges connected with WHO's organisational structure

WHO's complex organisational structure, which involves three levels, poses a number of management challenges. The decentralised structure and the electoral processes at the regional level complicate efforts to get the organisation to work towards common goals. Although the independent regional structure poses particular challenges with regard to focus on results and performance, it lends political legitimacy to international health cooperation at the national level and helps to set priorities. Whereas the WHO Director-General is elected by the member states on the basis of a recommendation by the Executive Board, WHO's Regional Directors are nominated by the respective regional committees.

In order to ensure that WHO is as effective and efficient as possible, it is important that the division of responsibility between country, regional and global levels is clear and rational. Moreover, the mandate and management structures between the headquater and regional offices should be assessed. The autonomous status of the regional offices is a challenge for WHO as a global normative health actor. This is important not least with regard to WHO's capacity to play a role at country level within the framework of One UN and UN reform.

5.4 Funding challenges

In recent years, the organisation's financial basis has grown considerably. The budget has doubled since 2004, and voluntary contributions constitute approximately 80% of the total budget. Of these, 20% are non-earmarked contributions.

There is an imbalance between available funds and expectations as to what the organisation is to achieve, as decided by the member states through WHO's governing bodies. The member states adopt work plans for which there is insufficient budgetary allowance. There are also varying expectations as to what WHO should give priority to. Moreover, as a result of the financial crisis, WHO's budgets are not expected to

continue to grow in the next few years. If WHO is to be able to fulfil the objectives set by its member states through the World Health Assembly, the organisation must improve its ability to set priorities. Its ability and willingness to make priorities is largely dependent on financial predictability and flexibility. The member states and the organisation itself have a joint responsibility in this respect.

The large share of earmarked funds reduces the flexibility of the financial management system, thus reducing the organisation's ability to implement the programme budget adopted by the member states. Moreover, earmarking requires considerable administrative resources on the part of both WHO and the member states. The degree of earmarking affects the implementation capacity, and is assumed to be a contributory factor to the considerable increase in unused funds transferred from one year to another. This could call into question WHO's legitimacy. Since the member states' contributions are largely allocated over the development assistance budget, there may be a lack of correspondence between what member states say in WHO's governing bodies and how contributions to the organisation are allocated.

Better effectiveness and results are closely connected with how WHO is funded, and there is a need for a much closer correspondence between the prioritisation and funding of core responsibilities. This also requires changes in the way the WHO Secretariat works.

5.5 WHO as a political versus a technical arena

WHO is a specialised agency that deals with health matters. At the same time, it operates in a political landscape. Decision-making in WHO is more heavily politicised than it used to be.

In recent years a number of intergovernmental rounds of negotiation have taken place within the framework of WHO. Negotiation of the Framework Convention on Tobacco Control (FCTC), the International Health Regulations (IHR)[7], the Global strategy and plan of action on public health, innovation and intellectual property, and the negotiations on a global framework for pandemic influenza preparedness are examples of this. This is in keeping with WHO's mandate to propose conventions, agreements and regulations regarding international health matters.[8] WHO is increasingly being used as an arena for negotiations

7 The International Health Regulations (IHR) were adopted by WHA resolution 58.3. The Regulations relate to an international system for epidemic intelligence, a procedure for the WHO's recommendations on response to serious events of importance to international public health care and a set of international rules concerning routine measures for combating the international spread of communicable diseases. The purpose of the IHR is to prevent and counteract the international spread of communicable diseases, and to ensure internationally coordinated follow-up. This is to be conducted in ways that avoid unnecessary interference with international traffic and trade.

8 Article 2 (k) of the WHO Constitution reads: «to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organisation and are consistent with its objective».

that have political implications. This trend also illustrates the increasing importance ascribed by member states to WHO as the UN organisation for negotiating agreements and frameworks for global governance.

The growing recognition of the fact that the health sector has interfaces to most other sectors has resulted in closer cooperation between WHO and a number of other organisations and actors in efforts to safeguard health aspects. One example of this is the area of trade, where WHO has no mandate, but where the agreements negotiated may have major implications for health.

It is important to ensure that WHO maintains and strengthens its technical expertise. The organisation's political added value lies in the weight ascribed to its expert opinions. Its legitimacy as a normative body for global health requires that the organisation has sound expertise in both the administrative and the health field. The organisation's relevance and authority within the UN system also requires that its expertise in the health field is supplemented with expertise in and experience of international politics.

5.6 WHO as an international development actor – the organisation's ability to deliver at country level

Determining WHO's role at country level and the distribution of roles between countries and regions is one of the organisation's major challenges. Norway attaches importance to better UN coordination at country level in order to improve efficiency and ease the administrative burden for the host country. Since the High-level Panel on UN Reform, where Prime Minister Stoltenberg was one of three co-chairs, presented its report, this work has focused on the concept «delivering as one». WHO's representation and performance at country level varies, particularly in the African region, and is only partly capable of fulfilling its technical advisory functions vis-à-vis the rest of the system.

Several evaluations have been made of WHO's representation at country level, partly on Norway's initiative. Successive WHO Directors-General have sought to make improvements, for example by establishing better selection processes for new country representatives as well as better training. The selection of country representatives is to be based on applicants' qualifications and ability to deliver results. Country offices will be expected to show results.

In certain priority areas of Norwegian policy for global health, Norway finds it challenging that the WHO has not found an optimal role among the many international actors, and that the organisation's performance varies. Here, there is a need to strengthen the organisation's technical basis and its ability to facilitate consultation and coordination processes. This applies, for example, to the health-related MDGs and the ongoing efforts to strengthen health systems in developing countries in order to enable more targeted and effective measures related to child mortality, maternal mortality, reproductive health and communicable diseases. WHO's work in other fields, such as pharmaceuticals, vaccines and crisis response, generally functions well.

Photo: © Oliver O'Hanlon/WHO

Director General of WHO, Dr. Margaret Chan Photo: © Oliver O'Hanlon/WHO

6 Priorities

During its term of office, Norway will seek to achieve the overall objectives defined in Chapter 3. Norway will also seek to ensure that the objectives set out in WHO's Medium-Term Strategic Plan are achieved, and to safeguard and promote Norwegian interests in the matters on the agenda in WHO's governing bodies at any given time. During its term of office Norway will seek in particular to:

- improve WHO's budget and management mechanisms
- promote global health research as the basis for knowledge-based policy
- strengthen health systems, including access to health personnel
- intensify efforts to combat non-communicable diseases
- intensify efforts to combat communicable diseases and promote health security

In all of these areas, Norway will follow up WHO's efforts related to rights, gender and gender equality.

6.1 Improving WHO's budget and management

The Executive Board must give priority to addressing the organisational challenges posed by strong regional offices and the lack of accountability of the World Health Assembly with regard to funding.

Results at country level must determine priorities and allocation of resources, both financial and technical. WHO's contribution, either directly or via other actors, must be based on countries' own plans and priorities.

Countries' plans and priorities must also be reflected in the formulation of, debate on and adoption of work plans and budgets. The large share of earmarked contributions undermines the potential of the WHA and the Executive Board to establish a realistic and feasible programme and budget. Greater use should therefore be made of mid-term reviews to adjust work plans and budgets in order to call attention to the management challenges created by the donors themselves.

WHO's normative mandate and role as the UN specialised agency for health is being challenged by an increasingly complex and diverse architecture involving new actors. This requires a broader discussion within the UN system and in the UN reform process on the question of which UN organisation, if any, WHO should form a partnership with. This is particularly relevant in the light of developments in efforts to combat climate change, where developments in the field of health are increasingly viewed as a possible model for organising and mobilising efforts to combat climate change.

During its term of office, Norway will:

- seek to highlight and strengthen WHO's organisational efficiency, as part of its contribution to UN reform.
- participate actively in the follow-up to the discussions initiated by the Director-General concerning WHO's future role and funding.
- seek to ensure that work plans are formulated within the framework of funds that are actually available, and that donors who tie or earmark voluntary contributions are made accountable by disclosing this in work plans. Un-earmarking is effective when carried out jointly by several donors.

- raise the debate on WHO's role and place in the global health architecture, including the question of WHO's role at country level. Raise the issue of and mobilise resources for WHO's role as a normative, specialised body with a view to clarifying the organisation's role and responsibility regarding the many partnerships and arrangements in the field of global health.
- continue the greatest possible un-earmarking of Norwegian contributions contingent on sound performance reporting based on clear indicators to show progress in relation to priorities. Earmarked contributions may still be given to WHO special programmes that are characterised by independent governance and certain time-limited targeted programmes (such as support for eradication of polio).
- actively follow up the implementation of WHO's policy for women's rights and gender equality, both as a targeted and integral part of the technical work and within management of the organisation. Reporting involving gender-sensitive data in both areas will be required by Norway.
- impose strict requirements on the management of the Norwegian contributions in order to achieve objectives and avoid irregularities. Norway will seek to strengthen internal control systems, control routines, attitudes and practices in the WHO system in order to prevent, detect and deal with financial irregularities.
- In the Executive Board, Norway will actively advocate strengthening WHO's capacity to exercise international leadership in priority areas, and increase the focus on WHO's performance and operations directed towards the poorest countries with a high burden of disease.

6.2 Promoting global health research as the basis for knowledge-based policy

One of WHO's core functions is «shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge».[9] Owing to the large number of actors in global health research (both external and internal), strong interests and fragmentation within the organisation, it is difficult for WHO to exercise global leadership. In recent years, the organisation has shown initiative in coordinating intergovernmental processes associated with intellectual property rights and international coordination of global health research, and in putting the need for improved internal coordination on the agenda. Given the organisation's normative role, there is a particular need for it to improve the application of research-based evidence when drawing up recommendations, guidelines and standards.

Global health research is a condition for:

- meeting current and future health challenges in poor countries, supporting efforts to achieve the UN Millennium Development Goals, particularly the goals related to improving the health of the poor.
- acquiring the knowledge needed to address the health challenges and ensure that the measures implemented are based on the best available knowledge and that resource use is proportionate to the benefits of the measures.
- reduce inequalities in health, particularly in relation to women's health and gender equality.

9 WHO's general programme of work 2006–2015.

Norwegian research resources are limited compared with the resources available to the major international actors in the field. However, Norway can play an important role as a member of the Executive Board, by supporting WHO's special research programmes (TDR, HRP, AHSPR)[10] where Norway is a major donor, through technical cooperation and by promoting WHO's role in international processes.

A new research strategy for WHO was adopted in May 2010. The strategy is broad and ambitious, and covers WHO's own research activity, its use of research, and its leadership role in global health research. The recommendations are addressed to the WHO Secretariat, member states and partners, including international partners, NGOs and the private sector.

During its term of office, Norway will:

- give special priority to sexual and reproductive health and gender equality in the special programme HRP, where Norway is taking over the chair.
- support WHO's stewardship within global health research, including in the follow-up to the Global strategy and plan of action on public health, innovation and intellectual property.
- participate in efforts to improve WHOs efficiency in global health research, for example by clarifying the division of responsibility and labour internally in the organisation, and the role of the WHO Expert Committees and its interface to special programmes and to external actors, such as public-private partnerships for product development. WHO's pre-qualification for approval of pharmaceuticals and products must not become a bottleneck, and more flexible procedures for this must be considered.
- promote systematisation and dissemination of research results for policy development, both national and international, in order to ensure that polices and measures are founded on knowledge and are performance-based. Particular focus should be given to evaluating the results of measures connected with health policy and health systems (cf. the research programme AHSPR) and monitoring the health status of the population by means of efficient information systems. It is important to link this to internationally recognised Norwegian centres of expertise and to employ other instruments.
- improve management processes and systems for monitoring and reporting on implementation of WHO's research strategy.

6.3 Strengthening health systems, including access to health personnel

Developing sound health systems, including preventive capacity, is one of the most important challenges facing rich and poor countries alike. The proven link between a satisfactory health service and the health and prosperity of a population demonstrates the need to invest in health systems with well developed primary health care services in order to achieve good health and equal access to health services in a population.

Norway's goal is to intensify WHO efforts to develop health systems, with particular focus on primary

10 UNDP/UNICEF/WHO/World Bank Special Programme for Research and Training in Tropical Diseases (TDR); UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP); Alliance for Health Policy and Systems Research (AHPSR).

health care services/public health care and health personnel. It is important that the efforts to develop health systems are in accordance with all of the strategic objectives of the MTSP, and that they are based on national ownership and the authorities' priorities.

In many low-income countries the obstacles to the availability of services to the whole population, particularly in rural areas, are known but the problem has not been resolved. Funding, health insurance/social security systems, the right socio-cultural conditions, infrastructure (logistics, medicines, transport) and not, least health personnel, are factors that must be dealt with.

WHO's role is to propose solutions for countries and establish standards, approaches and tools to enable the population to gain access to satisfactory health services and contribute to their own health.

During its term of office, Norway will:

- give priority to WHO efforts to ensure universal access to health services with an emphasis on primary health care services. Social health insurance systems, funding of health services and access to pharmaceuticals for poor countries at affordable prices are core areas for ensuring general access to health services.
- support WHO's efforts to address the health personnel crisis, both as regards specifying norms and standards for training/licensing of various categories of health personnel, and measures to prevent attrition.
- follow up work on a voluntary Code of Practice on the international recruitment of health personnel across national borders. This must safeguard countries' potential for retaining personnel so that they can fulfil their obligation to provide services to the population, while at the same time ensuring that health personnel's right to relocate/migrate is not restricted. The Code of Practice must be monitored, and data concerning trends in the area of health personnel migration must be systematised.
- give priority to ensuring that WHO is encouraged and enabled to interact with other sectors and actors in the area of Human Resources for Health (HRH), through global alliances (Global Health Workforce Allianse, the MDG 4 and 5 initiatives, etc.). The link to other health system components such as health information systems and the knowledge basis for health service data will be emphasised.
- ensure that efforts to promote women's and girls' health and safeguard their rights are taken into account in WHO's work in the above areas, so that national health systems are better enabled to provide available, non-discriminatory, safe and patient-oriented services. The decriminalisation of abortion, safe abortion on demand and «sexual rights» are controversial and sensitive issues of major importance for women's health and living conditions, and are issues where WHO must continue to develop and disseminate an ethical and scientific basis that can be used by the authorities in their policy-making at country level.

6.4 Intensifying efforts to combat non-communicable diseases

Tobacco kills half of the people who use it. In 2004, at least 2.8 million people died of causes linked to obesity, which in turn is associated with physical inac-

tivity and unhealthy diet. Harmful use of alcohol is ranked as the third greatest risk factor for premature death and function impairment (DALY),[11] and is estimated to cause approximately 2.3 million deaths a year worldwide. The incidence of non-communicable diseases is growing at a greater rate than the decline in communicable diseases in all parts of the world. In those parts of the world where communicable diseases continue to dominate, the growth in chronic disorders poses a challenge in that it adds to the existing burden of disease.

Injuries associated with accidents and violence constitute a serious health problem resulting in lost years of life and human suffering. WHO estimates that by 2030, 3.6% of global mortality will be associated with road and traffic accidents. WHO also anticipates an increase in mortality associated with violence towards 2030, when it will account for 1.2% of global mortality.

During the last decade, WHO has established strategies to address the above challenges. The most important of these is the Framework Convention on Tobacco Control (FCTC), which entered into force in 2005. In 2000, the World Health Assembly adopted the strategy for the prevention and control of non-communicable diseases (NCD).[12] In 2004, the global strategy for diet, physical activity and health and a strategy for health promotion and healthy lifestyle were adopted. In 2005 the WHA adopted a resolution on harmful use of alcohol. In 2007, an Action Plan for the prevention and control of non-communicable diseases (NCD) was adopted. This includes measures to combat obesity, including measures to restrict the marketing of unhealthy food and beverages to children. A draft global strategy to reduce the harmful use of alcohol was adopted by the WHA in 2010.

A central element in these strategies is reducing risk factors, such as tobacco, obesity, alcohol and physical inactivity. The effectiveness of the strategies for combating tobacco, alcohol, unhealthy diet and physical inactivity is contingent on the development of good health systems with a particular emphasis on primary health care and a sound basis in the most recent research on non-communicable diseases.

In Norway's view, there should be greater focus on non-communicable diseases, mental health, accidents and violence. It is important that the health authorities implement effective measures to limit the risk factors associated with chronic disorders, while at the same time ensuring that health systems are better enabled to serve a population with complex problems.

11 In collaboration with the IBRD (the World Bank) the WHO has developed an analysis tool for measuring the global disease burden, including the effect of various risk factors. The purpose is to provide a better basis for setting priorities in efforts to reduce the disease burden than is provided by mortality statistics alone. Disability adjusted life years (DALY) is a measure of the sum of premature death as a result of disease and years of function impairment as a result of disease.

12 WHA Resolution 53.17.

During its term of office, Norway will:

- promote a greater focus in WHO on non-communicable diseases, including efforts to achieve the objectives of the Action Plan for non-communicable diseases;
- support the further development of efforts to combat tobacco consumption;
- actively advocate that WHO gives priority to global and regional efforts to implement the alcohol strategy;
- continue to give high priority to efforts to restrict the marketing of unhealthy food and beverages to children; and
- seek to strengthen research on the prevention of non-communicable diseases.

6.5 Intensifying WHO's efforts to combat communicable diseases and improve health security

In a globalised society, the need to manage health risks opens up opportunities for establishing new arenas and alliances that cut across established professional and political dividing lines. Although international cooperation on the management of health risk may be controversial, «good health» is generally accepted as a basic value, and is thus uncontroversial and serves a bridge-building function. WHO is the most important arena for working on global health security as a framework that can be used by states to address and manage health risk.

The International Health Regulations (IHR 2005) were adopted during WHA 58 in 2005 and entered into force in June 2007. The full implementation of IHR 2005 is of major importance for international health security. WHO's efforts to promote a common understanding and implementation of the IHR in the member states are important, particularly with regard to routine controls and adequate public health care measures. WHO also plays an important role in providing policy and technical support to enable all member states to monitor communicable diseases of importance to public health.[13] IHR 2005 is a good basis for intensifying international cooperation within the health sector in areas such as pandemics, virus sharing and patent rights.

Tuberculosis as a common communicable disease that is hazardous to public health is a major health problem in Europe and, not least, in poor countries outside Europe. In Europe, this applies particularly to the former Soviet republics. However, owing to migration, it is also beginning to apply to Western Europe. The problem is particularly associated with the growing incidence of the disease in several countries and the development of resistant and multi-resistant tuberculosis. Highly endemic areas, which are generally low-income countries, are dependent on the transfer of knowledge and outside help in the competence building required to establish a national control programme and for the funding of specific control measures.

Besides vaccines, *antibiotics* are important tools in the fight against communicable diseases. Resistance to antibiotics is a serious and growing health problem that affects both rich and poor countries. The use of antibiotics is increasingly viewed as the most important

13 This is a consequence of MTSP, Strategic Objective 1.

cause of increased antibiotic resistance. The prudent use of antibiotics is crucial in ensuring that antibiotics continue to be an effective treatment in the years ahead. The lack of good hospital hygiene is a related problem that is common to both poor and rich countries. Good hand hygiene is a simple and effective measure.

Contaminated water poses a major health problem. Over half the world's hospital beds are occupied by people suffering from diseases associated with contaminated water. Diarrhoea kills 4 100 children every day, more than die from AIDS, malaria and measles together. Almost all deaths from diarrhoea are caused by contaminated water, insufficient sanitation and poor hygiene.

During its term of office, Norway will:

- seek to facilitate health-promoting international policies that view foreign and international development policy in context and that help to reduce security threats resulting from disease, poverty, social inequalities and inadequate health systems.
- seek to ensure continued capacity building in the member states and promote closer international cooperation on the implementation of IHR 2005.
- seek to improve the quality of international efforts to deal with tuberculosis through better laboratory services, measures to control communicable diseases, high-quality medicines, patient-oriented support measures and monitoring systems.
- give priority to efforts to promote the prudent use of antibiotics in the member states and encourage better hospital hygiene through international campaigns for hand hygiene.
- continue to give priority to efforts to combat communicable diseases, including WHO efforts to eradicate polio, HIV/AIDS, tuberculosis and malaria (MDG 6).
- seek to ensure that WHO assumes a catalytic role in global and national forums in order to inform policy-makers and decision-makers of the importance of clean drinking water, good sanitation and good hygiene for achieving the health-related MDGs. Importance will be attached to preventive measures, the need to mainstream these efforts in other sectors, national prioritisation of these issues and incorporation of the right to water into national legislation.

World Health Assembly Photo: © Oliver O'Hanlon/WHO

7 Working methods

During its term of office, Norway's focus will be on targeted efforts to achieve political priorities, characterised by transparency, dialogue and expertise. One of the overall goals will be to involve the general public more closely in these efforts by establishing routines and systems for contact with affected parties and interest organisations. Importance will be attached to the dissemination of information on consultations under the auspices of WHO. Ahead of the January meeting of the Executive Board, dialogue meetings will be held with affected parties and interest groups.

7.1 National working methods

Close cooperation within and between the various administrative levels is important for ensuring that the secretariat for the political staff is prepared and has the relevant expertise to assist the Norwegian board member so that he can:

a. function effectively on the Executive Board on behalf of Norway,
b. actively promote Norwegian health policy, foreign policy and international development policy matters, and
c. help to ensure consistency in health policy, foreign policy and international development policy.

Division of labour in connection with the preparation of instructions for the board meeting

a) Approval of instructions:

Instructions for Executive Board meetings, the WHA and the Regional Committee meetings are to be approved by the Ministry of Health and Care Services and the Ministry of Foreign Affairs.

b) Preparation of instructions:

The Directorate of Health is the secretariat for the WHO forum, and prepares draft instructions for the meetings of the WHO Executive Board, the WHA and the regional committee meetings. The WHO forum consists of representatives from relevant ministries and subordinate agencies, including the Ministry of Health and Care Services, the Ministry of Foreign Affairs, the Directorate of Health, the Norwegian Medicines Agency, the Norwegian Institute of Public Health, the Norwegian Board of Health Supervision, the Norwegian Food Safety Authority, Norad, the Norwegian Knowledge Centre for the Health Services and the Permanent Mission of Norway to the United Nations in Geneva. The WHO forum was established for the purpose of preparing and coordinating draft instructions prior to the board meeting in January, the WHA in May and the Regional Committee in September.

During the meetings

The Head of Delegation is responsible for approving positions beyond what is stated in the instructions. If it is necessary to go beyond the instructions, the Head of Delegation or the person so authorised by him or her is to consult the competent ministry in Oslo before putting forward a position. The Ministry has responsibility for consultations with other affected ministries.

Between board meetings

A core group chaired by the Secretary General of the Ministry of Health and Care Services is established for discussions/clarifications/briefings between board meetings. This group consists of representatives from the Ministry of Health and Care Services, the Ministry of Foreign Affairs and the Directorate of Health. The Mission in Geneva takes part as needed.

7.2 Partner countries and forms of cooperation

Norway is dependent on extensive cooperation with other countries in order to gain acceptance for priority matters. This involves ongoing cooperation throughout the year and cooperation on specific matters with selected countries prior to consideration by WHO's governing bodies. Decisions made in board meetings form the basis of the outcome og induvidual matters. Immediately prior to and during board meetings, it is important to be particularly aware of which of the other countries represented on the board might be willing to collaborate on reaching a consensus.

Decisions made in the Executive Board meetings do not put any formal constraints on the conduct of member states during the WHA. Many small countries are either not present at board meetings or are present only to a limited extent, and may request changes at a later date. Developments within a specific area may also prompt one or more member states to re-open the debate concerning documents that have already been adopted by the board. It is therefore important to be constantly attentive to issues of major importance until decisions are made by the WHA. This requires efforts at various levels and in different arenas, where regard must be paid to both technical and political considerations.

Main forms of cooperation:

- *Forming alliances across WHO's six regions:* Alliance building increases knowledge of the way in which a matter is relevant for countries in other regions, and provides a basis for making a decision. While being attentive to countries in the other five regions represented on the board, it is also important to be informed about/engage with the most influential countries in the respective regions, and be aware of how they in turn could influence others. The main rule in the other regions is a rotating arrangement for nominating countries to have responsibility for regional coordination. Regional coordinators are thus both important sources of information and can influence the outcome of processes.
- F*orming alliances with developing countries:* A large number of the matters on WHO's agenda involve international development policy as well as health dimensions. It is important to be aware of this, and to be familiar with the main features of the arguments in both dimensions. Norway's main partner countries in development policy are relevant here as cooperation partners, as are countries with which Norway has bilateral cooperation projects.
- *Exploiting the potential for bilateral cooperation with key Western countries when political conditions are conducive to it:* Key Western member states of WHO that, by virtue of their technical and economic importance are major supporters of and contributors to WHO, are important alliance partners. Several of these countries have a long-term engagement,

characterised by predictability, in areas of importance to Norway, and we have already established cooperation with these countries. As regards other countries, this may to a greater extent depend on the political leadership at any given time. This group of countries is important in terms of influencing WHO's political and economic framework conditions.

- *Exploiting the potential that lies in contact at the technical and political level in the missions in Brussels, Geneva and New York, and in the bilateral network of embassies:* WHO's room for manoeuvre is also affected by factors in the interfaces to the agendas of other UN organisations and the actions of the various member states in these contexts. The mission and embassies have or will be able to establish contact with representatives of relevant countries and communicate impressions and input to the Norwegian processes.
- *Maintaining close and ongoing contact with the WHO Secretariat:* A good understanding of the procedural rules that apply to board meetings and the WHA is important for achieving the desired results. In many cases, the rules establish decisive guidelines concerning the solutions on which it is possible to reach decisions. In addition, the Secretariat has valuable knowledge of the field of health and insight into the current position of key countries on various solutions. If solutions promoted by Norway in governing bodies have a basis in WHO, this will increase the likelihood of the matter being followed up in a constructive manner. However, if in specific connections the Secretariat holds a different view of the need for or desirability of following up a matter, this must not have a decisive influence on the position held by Norway.
- *Maintaining an awareness of the guidelines set out in the Norwegian WHO strategy, including when WHO is part of a larger partnership:* Norwegian representatives often encounter WHO as an actor in larger partnership processes, both in international contexts (e.g. expert committees and working groups associated with global funds and initiatives or international negotiations) and at country level (as part of One UN, or in dialogue with national authorities). This type of interaction facilitates valuable dialogue, collaboration and policy learning. In such contexts, it is important to promote relevant elements of the Norwegian strategy, but also to draw on the experience gained here in domestic processes.

Partner countries and groups

Relevant partner countries and groups vary from case to case. However, there are a number of countries that Norway has developed close cooperation with over the years.

- The other Nordic countries are important partners, and close and systematic cooperation with these countries has been established both in WHO and in other UN forums. The Nordic countries that are members of the EU constitute a valuable link to the EU in the WHO context.
- Their global health agendas make the UK, the Netherlands and France important partner countries in health policy areas in which Norway is heavily involved. It is also important to take advantage of the opportunities for strategic cooperation with the USA and other key countries in areas where we have interests in common.
- The Foreign Policy and Global Health Initiative (FPGH) is a cross-regional group of non-like-minded countries, which makes it particularly appropriate for cooperation. Owing to the regular and close contact created through this platform, the countries

are important individually as consultation partners for Norway, both in relation to their own positions and as a window into other regions. Brazil, Indonesia, South Africa and Thailand are, by virtue of their positions, countries of regional and global importance in this connection.

- A large number of political processes and decisions are being transferred to new actors, such as the G8 and the G20. It may also be appropriate to establish good relations in the health context with countries in both the G8 and the G20, where key countries such as Russia and Canada take part.
- Established expert meeting places and networks must be used where appropriate.

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14 The countries involved in the Foreign Policy and Global Health Initiative are France, Norway, Brazil, Indonesia, Senegal, South Africa and Thailand.

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