Sweden’s development cooperation for health 2018
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Introduction

The global health situation has improved considerably since 1990, but the successes have been uneven in their distribution. The poorest countries, those suffering conflict and the countries categorised as fragile states are lagging behind. In addition, there is considerable health inequality within many countries, both geographically and between different population groups. The positive news is that the traditional infectious diseases such as HIV and tuberculosis have declined, and the mortality rate for children and mothers has reduced. However, multidrug-resistant tuberculosis poses a major threat and the number of people dying from malaria remains undiminished, largely due to the lack of long-term and stable funding for measures aimed at controlling malaria.

With rising incomes and changing lifestyle habits in middle and low-income countries comes an increase in what are referred to as the non-communicable diseases. This means that health systems have to handle the double burden from both the traditional infectious diseases and the rising proportion of non-communicable diseases such as diabetes, cardiovascular disease and cancer. While many of these countries have had sections of the population suffering undernutrition, they now increasingly also need to address the overweight and obesity caused by lifestyle and dietary changes.

Although non-communicable diseases are on the rise, child and maternal mortality and infectious diseases continue to account for the majority of the illness and death in low-income countries. Global maternal mortality stands at a little over 300 000 deaths per year, and these are deaths that are avoidable. 15 000 children under the age of five die every day, the vast majority during their first month of life. In 2017, 22 per cent of the world’s children under five suffered stunted growth, which has strong links to other diseases and negatively affects cognitive ability. Three quarters of these children lived in Africa and Southeast Asia.

Sexual and reproductive health and rights (SRHR), child and maternal health and initiatives to strengthen health systems are clear priorities within development cooperation for health. Safe water and sanitation are crucial for survival and for reducing disease in poor countries, as well as being an essential condition for Sweden to obtain results from its development cooperation for health. Much of Sweden’s health assistance focuses on broad programmes that cover several of these areas and promote equitable health, which is the ultimate goal of Swedish development cooperation for health.

Sweden’s development cooperation for health comprises bilateral, regional and global support through a broad spectrum of actors, primarily multilateral and civil society organisations. This support generally includes a combination of health service support, initiatives to enhance capacity and advocacy work. Important research and development results are generated through the health-related research funding, while the humanitarian assistance saves lives. Swedish development cooperation and support contributed to important results in 2018, not only through financial support, but also through dialogue and advocacy work.

In 2018, Sweden has had to respond to the positive and the negative trends within global health. On the positive side, WHO’s work on Universal Health Coverage, including a stronger focus on primary care, has generated a great deal of interest and commitment around the world. At the same time, the international climate for gender equality and SRHR has hardened further, largely as a consequence of the USA’s policies and actions within the context of the UN. Although advances have been made in some countries as regards access to abortion, in part through policy changes, the climate for SRHR issues has become tougher. Generally speaking, the shrinking democratic space and the regression on SRHR are serious impediments to work on strengthening the sexual and reproductive health and rights of women, girls, young people and vulnerable groups.

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Sida

Anders Nordström  
Ambassador for Global Health  
Ministry for Foreign Affairs
Sweden’s development cooperation for health 2018

Swedish development cooperation for health amounted to almost SEK 5.3 billion in 2018, and made up 12.4 per cent of total Swedish development cooperation, excluding deductions for asylum costs. Just over SEK 3 billion, or 58 per cent, of this amount is multilateral core support provided via the Ministry for Foreign Affairs (UD). The remaining 42 per cent, a little over SEK 2.2 billion, was channelled via Sida’s country cooperation, global programmes, regional cooperation and research support. Table 1 gives an overview of Swedish development cooperation for health in 2014–2018.

The proportion of Swedish development cooperation that is invested in health initiatives varies slightly from one year to the next. An increase of around SEK 206 million can be noted for 2018, compared with the previous year. However, as a proportion of total development cooperation, health is down on the previous year, from 13.8 per cent to 12.4 per cent. The principles and methodology for calculating the size of Swedish development cooperation for health are set out in annex 1.

Table 1. Sweden’s development cooperation for health 2014–2018

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
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<th>2018</th>
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<tr>
<td></td>
<td>MSEK</td>
<td>%</td>
<td>MSEK</td>
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<td>MSEK</td>
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<tr>
<td>Ministry for Foreign Affairs (UD)</td>
<td>2 777</td>
<td>62%</td>
<td>2 561</td>
<td>61%</td>
<td>2 841</td>
</tr>
<tr>
<td>Multilateral core support</td>
<td>2 772</td>
<td>62%</td>
<td>2 561</td>
<td>61%</td>
<td>2 841</td>
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<tr>
<td>Other</td>
<td>5</td>
<td>0.1%</td>
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<td></td>
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<tr>
<td>Sida</td>
<td>1 710</td>
<td>38%</td>
<td>1 658</td>
<td>39%</td>
<td>1 825</td>
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<tr>
<td>Country cooperation</td>
<td>662</td>
<td>15%</td>
<td>649</td>
<td>15%</td>
<td>775</td>
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<tr>
<td>Global programmes</td>
<td>673</td>
<td>15%</td>
<td>751</td>
<td>18%</td>
<td>719</td>
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<tr>
<td>Regional cooperation</td>
<td>375</td>
<td>8%</td>
<td>258</td>
<td>6%</td>
<td>331</td>
</tr>
<tr>
<td>Total development cooperation for health</td>
<td>4 487</td>
<td>100%</td>
<td>4 219</td>
<td>100%</td>
<td>4 666</td>
</tr>
<tr>
<td>Total development cooperation (all categories)</td>
<td>31 027</td>
<td></td>
<td>32 213</td>
<td></td>
<td>31 971</td>
</tr>
<tr>
<td>Health as proportion of total development cooperation</td>
<td>14.5%</td>
<td></td>
<td>13.1%</td>
<td></td>
<td>14.6%</td>
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Figure 1. Sweden’s development cooperation for health 2014–2018: split between Ministry for Foreign Affairs and Sida
It is important in work to improve global health not to focus solely on the considerable financial support that Sweden contributes. Sweden is also a strong voice in the international development community and achieves much through dialogue and advocacy on governing boards and in international forums. Sweden participated actively on the governing boards of multilateral organisations in 2018, pursuing issues that included continuing to focus on low-income countries for the allocation of funding, having a rights perspective that runs through activities and requiring multilateral organisations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and Gavi, the Vaccine Alliance to show that they contribute to the strengthening of health systems, which are an essential basis for other interventions. A particular initiative that Sweden worked on during 2018 was to promote SRHR issues within the framework of the broader Universal Health Coverage agenda. Sida continued to prioritise safe abortion as a specific issue in its dialogue with partner organisations and other donors. As an example, a regional meeting was organised with a view to increasing access to safe and legal abortion in a couple of selected countries in Sub-Saharan Africa. At country and regional level, Sweden conducted a constructive dialogue with recipient countries, civil society and other donors concerning priority issues for Swedish development cooperation for health.

Work for better global health is a long-term undertaking and the results must be viewed over time. Swedish development cooperation is based on supporting the efforts made by partner countries and the results are achieved jointly with several other actors, and also in a context where many factors interact. Many of the effects reported in 2018 usually originate from activities in previous years and similarly the effects of support provided in 2018 will only be seen in coming years. This applies both to financial support and to advocacy work.

**Sweden’s priorities**

Sweden’s priorities are based on the policy framework for Swedish development cooperation in which the overall objective for health is to make a contribution to more *Equitable Health* by Sweden:

- contributing to effective **national health systems and institutions** that deliver injury and disease prevention interventions and good-quality, integrated and equal health care for all.
- taking particular account of the **gender equality perspective** in the light of existing gender differences regarding health and access to health care. The human rights of women, girls and young people are of central importance. **Child and maternal health care** is given priority.
- continuing to defend the universal right to health, with a particular focus on **sexual and reproductive health and rights**. The needs and circumstances of young people will be highlighted, as will respect for LGBTQ rights.
- having a long-term, rights-based and broad approach in its efforts to combat the spread of **HIV**.
- highlighting the importance to health of access to clean **water, sanitation and hygiene**, as well as sufficient, safe and nutritious food, along with sustainable energy.
- working to ensure that more attention is paid to **non-communicable diseases** on the international agenda and in national health programmes.
- continuing to show leadership in action against **antimicrobial resistance** (AMR) and working to develop capacity in accordance with the global action plan on AMR.
- working to strengthen the global capability to detect and manage **threats to health** by implementing the International Health Regulations (IHR 2005).
- raising awareness of the **link between health and environmental and climate challenges** and between health and security in development cooperation, in humanitarian operations and in the interface between them.

Development cooperation is then governed through decisions on special cooperation strategies for both core support to multilateral organisations and programmes through Sida (at global, regional and country level).

**For 2018 we have chosen to summarise what Sweden’s development cooperation for health has contributed to in three areas:**

1. awareness of and access to sexual and reproductive health and rights (SRHR);
2. strengthening national health systems and basic health services;
3. prevention and management of threats to health.
1. **Awareness of and access to sexual and reproductive health and rights (SRHR)**

<table>
<thead>
<tr>
<th>Table 2. Sweden’s development cooperation for SRHR 2014–2018</th>
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<tr>
<td>%: Share of Sweden’s total development cooperation</td>
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<table>
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<tr>
<th>Year</th>
<th>MSEK</th>
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<th>MSEK</th>
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<th>MSEK</th>
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<th>MSEK</th>
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<th>MSEK</th>
<th>%</th>
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<tbody>
<tr>
<td>2014</td>
<td>2,275</td>
<td>7.5%</td>
<td>2,263</td>
<td>7.2%</td>
<td>2,538</td>
<td>8.2%</td>
<td>2,583</td>
<td>7.0%</td>
<td>2,963</td>
<td>6.9%</td>
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<tr>
<td>2015</td>
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<td>2018</td>
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</table>

There are significant challenges when it comes to people’s sexual and reproductive health and rights in the world’s poorest countries. Political opposition, lack of financial resources, discrimination against women and girls and societies that are reluctant to openly deal with questions of sexuality are just some of the factors that prevent women, girls, young people and vulnerable groups from being able to make their own decisions about their body, sexuality and fertility. It is still the case that over 200 million women in low and middle-income countries who want to protect themselves against unwanted pregnancy do not have access to modern contraception. At the same time, the majority of the world’s 25 million unsafe abortions take place in low and middle-income countries, where laws and regulations relating to abortion are often highly restrictive.

**Sweden’s SRHR support** covers a broad spectrum of initiatives relating to areas such as relationships and sexuality education, greater access to contraceptives and safe abortion, youth-friendly services, prevention of sexual and gender-based violence, prevention and treatment of HIV, the health and rights of LGBTQ people and work against child marriage and female genital mutilation. In recent years, Sweden has substantially increased its support for reproductive health, including contraception and safe abortion.

Young people’s access to information and knowledge about SRHR, plus access to contraception and youth-friendly advice, are central to all of Sweden’s SRHR support. In Uganda, Mozambique and the Democratic Republic of the Congo, health centres and clinics have been helped to achieve a stronger youth focus. In Uganda, over 300,000 young people have visited youth clinics to obtain contraception, to be tested for sexually transmitted infections, or for other advice.

Through two major regional actors in Africa, Sweden has helped to increase both access to and demand for contraception in 11 African countries. Through ‘social marketing campaigns’, these actors are able to market and sell more expensive products to customers who can afford them, with the profits subsidising simpler products for people with less disposable income. In 2017, one of these actors sold 61 million condoms, 5.1 million contraceptive pills, 4.3 million emergency contraceptive pills, almost 2 million doses of misoprostol (tablet for abortion) and 565,000 combi-packs for medical abortion. Calculations indicate that, overall, the sales prevented 940,000 unwanted pregnancies, 745,000 unsafe abortions and 5,100 cases of maternal mortality.

As HIV issues are increasingly integrated into broader SRHR programmes, there is a range of support available through civil society organisations that focus on HIV prevention, including for ‘risk groups’. In 2017, the International HIV/AIDS Alliance (now FrontAIDS), which receives support from Sweden, distributed antiviral medication to almost 1.6 million adults, young people and children, while over 800,000 people in the risk groups gained access to HIV prevention initiatives.

Sweden provides significant support for sexuality education at three levels: global, regional and national. Since 2013, Sweden’s regional support in Africa, through UNESCO, has resulted in 13 million students at over 40,000 schools receiving education on sexuality and personal relationships. UNESCO has worked with governments to introduce or strengthen policies and frameworks that make sexuality education part of the national curriculum and syllabus. 2018 saw the expansion of support for UNESCO’s comprehensive sexuality education programme to include a further five countries, which means that the programme now covers 30 countries in total.
The sexuality education programme in Zambia has reached almost two million students aged 11 and above. It is important to also reach those children and young people who, for various reasons, do not receive sexuality education through their school. In a partnership that covers eight countries in Sub-Saharan Africa, a method has been developed that builds up the knowledge and capabilities of adults who have direct contact with young people on a daily basis, such as parents, teachers, religious leaders, health professionals and the police.

In its drive to change legislation, policies and conservative norms, Sweden supports civil society organisations and other actors who, in various ways, conduct information and advocacy work aimed at improving sexual and reproductive health and rights for women, girls and young people. In Afghanistan, a collaboration between civil society organisations and religious leaders has resulted in the adoption of a health policy that bans ‘virginity testing’ at the country’s clinics and hospitals.

The Inter-Religious Council of Liberia issued a joint communiqué expressing support for sexuality education and calling for the inclusion of sexuality education in national curriculums. In a country such as Liberia, where many of the schools are run by religious organisations, this is expected to mean a great deal for young people’s SRHR.

In Mali and Ethiopia, Sida’s support has been a contributory factor in encouraging numerous villages to prohibit female genital mutilation. Through Sida’s International Training Programme on SRHR, participants from Kenya, Uganda, Ethiopia, Zambia and Zimbabwe have been trained in leadership and communication so that they can push for change on SRHR in their respective countries.

Increasing access to safe abortion is a crucial factor in saving lives and reducing maternal mortality around the world. Sweden has long supported organisations that work in various ways on abortion care and on information and advocacy work to change restrictive abortion laws and medical guidelines. While opposition to abortion has grown in certain parts of the world, positive policy changes on abortion have occurred in at least 13 countries where partners have been actively lobbying with support from Sweden. In Sub-Saharan Africa, support is given in order to expand access to medical abortion products in new markets.

As a donor country Sweden has long been, and continues to be, one of the strongest advocates of universal access to SRHR, including abortion rights. The position and guidance paper on the Mexico City Policy/Protecting Life in Global Health Assistance, which Sida adopted in 2017, has continued to generate major interest among civil society organisations, other donors and the media. None of Sida’s SRHR partners have signed up to the US policy, but a few of the leading SRHR organisations have lost US aid as a result of not wishing to follow the US policy. In January 2018, Sida and WHO hosted a meeting on medical abortion in Geneva, which resulted in an action plan showing how different actors can help to increase access to and demand for medical abortion products in low-income countries.

Swedish expert knowledge, coupled with support for and coordination of partners, has been instrumental in the adoption of SADC’s SRHR policy and the associated ‘scorecard’. Sida was also a member of the Advisory Group attached to the Guttmacher-Lancet Commission on SRHR, which in May 2018 launched a groundbreaking report containing a new definition of SRHR, plus recommendations on a package of basic SRHR services that countries ought to provide.

UNAIDS works with the Global Fund towards the objective of eradicating AIDS by 2030. The target for 2020 is for at least 90 per cent of people living with HIV to be aware of their status, for at least 90 per cent of those diagnosed with HIV to receive effective medical treatment and for at least 90 per cent of those receiving treatment to have radically lower levels of the virus. Sweden was the second largest donor of core support to UNAIDS in 2018, helping UNAIDS to continue playing its central role as a catalyst, policy developer and coordinator in the field of HIV. These central functions, as well as the work of UNAIDS on statistics, legislation and policy at country level, combined with technical support for countries’ analysis and planning work, mean that countries are able to achieve success and demonstrate results in their cooperation with other partners, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the United States President’s Emergency Plan for AIDS Relief (PEPFAR).

Swedish priorities on the UNAIDS Board have been HIV prevention, gender equality and human rights, especially SRHR. Sweden has also underlined the importance of engaging young people and men and
boys in HIV prevention work. Within the framework of reforms to the UN’s development system, Sweden has lobbied for the work of UNAIDS to be adapted to the reform agenda.

Sweden was the largest donor of core support to the United Nations Population Fund (UNFPA) in 2018, and the second largest donor overall. The Swedish portion of UNFPA’s core support between 2014 and 2017 has, amongst other things:

- prevented almost 3.1 million unwanted pregnancies and over a million unsafe abortions;
- enabled UNFPA to assist with 760,000 pregnancies and births;
- given almost 5 million people access to contraception;
- given 12.3 million young people access to integrated sexual and reproductive health services;
- made it possible for UNFPA to provide almost 1.5 million women and girls in humanitarian situations with sexual and reproductive health services, plus initiatives to prevent gender-based violence.

In 2018, as a member of UNFPA’s board, Sweden continued to push the organisation to strengthen its normative and operational rights work, with a focus on gender equality and SRHR. Issues that have been raised include the need to change the attitude of men and boys with regard to SRHR for women and girls. Sweden has urged the organisation to reinforce its capacity and presence in humanitarian situations, which should comprise both preventive and emergency measures, and to increase the dissemination of information among humanitarian actors on the importance of gender equality and SRHR. Sweden has also lobbied for sexual and reproductive health services to include access to contraception, safe abortion, maternal health care, menstrual health and STI testing, including for HIV.

The work of the United Nations Development Programme (UNDP) on institution building includes support for health ministries and other institutions that promote health. The work of UNDP on health issues is rooted in its close relations with governments and government agencies and its extensive presence in low and middle-income countries. In 2018, Swedish contributions to UNDP helped in part to promote environmental and socially responsible procurement and waste management in the health sector. UNDP conducts its health-related operations in partnership with other actors in the UN system, the business world and civil society. UNDP is one of the ‘co-sponsors’ of UNAIDS and implements programmes for the Global Fund to Fight AIDS, Tuberculosis and Malaria, primarily in contexts that are difficult to work in.

UN Women works to promote gender equality and empowerment of women and girls. Sweden has been the organisation’s largest donor since 2017. UN Women’s work in the field of health is run primarily as part of the Global Health Partnership H6. Within H6, UN Women stresses that women and children’s right to health depends on removing barriers such as gender inequality and lack of financial self-determination. At country level, the focus is on engaging men and boys in the advancement of women and girls’ rights and SRHR, and on supporting the development of national policies and strategic documents that affect SRHR, including maternal health care. Initiatives to spread knowledge and information about SRHR and the rights of women and girls, including access to contraception, are now reaching 1.2 million people. In partnership with UN Women, Sweden has advocated for the organisation to take a rights-based approach, with a clear focus on human rights, including access to SRHR for all women and girls.
2. **Strengthening national health systems and basic health services**

Good health outcomes rely on access to functioning and well-financed health systems that are able to deliver health services of high quality on the basis of people’s needs. Sweden gives support to numerous organisations working on strengthening national health systems, including the World Health Organisation (WHO), UNICEF, UNFPA and the World Bank. Strong health services are necessary for work on sexual and reproductive health, functioning child and maternal health care, global health security and limiting antibiotic resistance. The Ebola outbreak in West Africa in 2014–2016 provided a greater insight into the importance of strong, robust health systems that are capable of handling health threats and disease outbreaks. The majority of Sweden’s support for health and SRHR helps to strengthen the health systems of cooperating countries.

Low-income countries face a major challenge in achieving **sustainable funding for their health system** so they can deliver good-quality health services. With Swedish support channelled through regional partners, African countries have received technical assistance with the widespread reform of health financing, evidence-based planning and the expansion of health insurance provision. Patient advocacy groups and citizens demanding accountability is one way to improve the availability and quality of health care. A number of civil society partners have worked on mobilisation and capacity enhancement in order to increase the participation of specific priority groups in health care.

**Health care professionals** are a cornerstone of every country’s health system. Through bilateral support, Sweden has contributed towards the training and/or employment of midwives and maternity staff in countries such as Somalia, South Sudan, Uganda, Zambia, Zimbabwe, Afghanistan, Bangladesh, Myanmar and Guatemala. Sida has worked on maternal health over many years in partnership with UNFPA, helping to ensure that over 32 000 midwives in low-income countries have received further training.

The collaboration with the **Zambian** Ministry of Health aims to improve the health system, with a particular focus on the health of children, mothers and young people. Initiatives are largely aimed at primary care, and at increasing people’s demand for health care at local level.

In the **Democratic Republic of the Congo (DRC)**, the authorities have established 26 Provincial Health Divisions (DPS) and drawn up agreements to ensure that all aid is channelled through these.

In **Bangladesh**, support via UNFPA, in partnership with the Ministry of Health, has helped to boost the capacity of the health system to deliver good quality health care for mothers and children. Through this collaboration, Bangladesh has adopted national regulations for the new profession of midwifery, midwifery training has been introduced in line with international standards and the Bangladesh Midwifery Society has been strengthened. 5 000 midwives have now graduated since the programme was launched in 2013.

Much of the child and maternal mortality in low-income countries is caused by poor **access to safe water, sanitation and hygiene (WASH)**. The majority of the planet’s population, 4.5 billion people, still lack access to safely managed sanitation, while 2.1 billion people have no access to safe drinking water in the home. In terms of access to and quality of water and sanitation, there are considerable inequalities, both between and within countries and regions, and between different groups. Lack of water and sanitation impacts on women and children to a greater extent.

Practically all the WASH organisations with which Sida works have begun to switch their focus towards **urban problems**, where access to water and sanitation is a major challenge, particularly in the growing slum areas. Thematic support for UNICEF’s WASH programme gave a total of 10.5 million people access to safer water and 10.2 million people access to sanitation in 2016. Sweden’s support in **Somalia, the DRC** and **Mali** has resulted in improved access to clean water and sanitation. The challenge often lies in getting responsible ministries within the countries to work together and collaborate effectively. Sweden has been a driving force on this issue, in dialogue with bodies such as UNICEF, WaterAid, the Water Supply and Sanitation Collaborative Council (WSSCC) and the World Bank. Participation in the annual World Water Week is another example of Sida’s commitment to this vital issue.
In Bangladesh high arsenic levels in the groundwater are reducing access to safe drinking water. In the urban areas that have received Sida’s support, the use of safe drinking water has increased from 90 per cent to almost 100 per cent over the past six years, while use of hygienic latrines has risen from 8 per cent to 81 per cent.

In 2017–2018, the need for water, sanitation and hygiene at health centres/clinics, particularly in low-income countries, rose high up the international agenda. Without water and sanitation, it is impossible to maintain hand hygiene, which leads to an increased risk of infection in conjunction with treatments and surgical interventions. The most important of all infection control procedures is good hand hygiene. In Sierra Leone, Liberia and Nepal measures to enhance capacity have helped to improve procedures for hand washing and hygiene at health clinics and in a domestic context.

Menstruation issues, and the limitations and suffering that menstruation brings for many of the world’s girls and women, entered the media spotlight internationally and in Sweden during 2018. A couple of Sida’s WASH programmes include support aimed at improving knowledge of menstruation and increasing access to menstrual hygiene products. In Bolivia, over 10 000 girls and boys in 100 schools have had menstrual health on their timetable, with a view to improving knowledge of and attitudes towards menstruation issues.

Despite major progress, maternal and child mortality and infectious diseases account for over half of all early deaths in low-income countries. Sweden’s support for basic health services, including child and maternal health, covers areas such as vaccinations, treatment of childhood diseases, improved access to contraception, midwifery, fistula treatment and better nutrition.

In Somalia, 5.2 million women and children have gained access to medicines and vaccinations through mother and child clinics and almost 19 000 mothers had access to a safe delivery as a result of Swedish support. In Bangladesh, the use of maternal health services and the number of births that take place at health care institutions has risen as a result of the nation’s Third Health Sector Programme. Also in Bangladesh, Sida’s research support has led to the development of the Q-mat, which helps to reduce maternal mortality due to haemorrhaging after birth (one of the main causes of death in childbirth). The mat is placed under the new mother and shows whether medication is needed to stem heavy blood loss. The recipient of a prize from the Bill and Melinda Gates Foundation, the mat is used by many NGOs in Bangladesh.

In some countries, Sweden supports various types of insurance and/or social security programmes aimed at increasing citizens’ access to health care services. In Kenya cash benefits for mothers, tied to maternal and child health care, led to a rise in births attended by trained staff from 33 per cent in 2013 to 69 per cent in 2017, while the proportion of pregnant women with access to professional maternal health care rose from 35 per cent to 54 per cent over the same period. In Uganda 72 000 have been for maternal health checks and 20,000 newborn babies have received postnatal care thanks to a voucher programme. In addition, Sweden has helped to improve the health and rights of older people in 77 low and middle-income countries.

Through bodies such as UNICEF, Sweden has also contributed to higher childhood immunisation levels. 2.5 million children were vaccinated in just one year in the DRC and in Myanmar the vaccination level is almost 100 per cent in the areas where the Three Millennium Development Goal (3MDG) Fund operates, with Swedish support. Child and maternal health care has reached a total of 6.4 million people through the 3MDG Fund. Sida’s research support for a cholera vaccine in Bangladesh has resulted in over 700 000 doses of cholera vaccine being distributed in refugee camps in Bangladesh where Rohingya sought shelter after fleeing from Myanmar.

Undernutrition stops children from growing properly and stunts their cognitive abilities. Through Sweden’s humanitarian support, emergency nutritional initiatives were mobilised for people in need in the DRC, Zimbabwe and Mali. In Zambia over 300 000 children and mothers received food via a nutrition programme.

Over the funding period 2016–2020, Sweden is the 12th largest donor to Gavi, the Vaccination Alliance. In addition to core support, smaller-scale support is also given annually to the International Finance Facility for Immunisation (IFFIm), which is one of the instruments for Gavi’s funding. In 2017 Gavi reported that it was on track to meet all the mission targets set out in the strategic plan. Thanks
to Gavi’s support, more than 10 million deaths have been avoided since 2000 and over 1.5 million girls have been vaccinated against HPV since 2013. In 2017, 65 million children were immunised with the support of Gavi. December 2018 saw a Mid Term Review, where successes and remaining challenges were presented. Difficulties in achieving equitable coverage are seen primarily in failing states with inadequate health systems. There is also a link between low coverage and low education among women, not to mention poverty. Lack of gender equality is an obstacle to goal fulfilment on which Gavi is actively working, based on its gender policy. Increasing demand and adapting implementation methods in order to achieve better and more equitable coverage have been declared priority issues for the remainder of the strategy period. Over the year, Gavi also encountered challenges in securing vaccines from suppliers and in implementing the transition to a sustainable national immunisation programme. In 2018, Sweden lobbied for Gavi to maintain its focus on achieving equitable coverage in the poorest countries, strengthening health systems for routine immunisation at national level and improving its coordination with other global health actors in a joint drive towards SDG3. The board decided on a new vaccine investment strategy and future funding of inactivated polio vaccine (IPV), as well as clarifying the process for drawing up the next strategic plan 5.0 in 2019.

Each year, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) invests around USD 4 billion in programmes implemented by organisations in countries and communities with the greatest burden of disease and need for support. Sweden was the eighth largest donor at the end of 2018. For the year 2017, GFATM reported that it had contributed to 17.5 million people receiving antiretroviral treatment against HIV, preventive initiatives had reached 4.9 million people in key groups, 5 million people with tuberculosis had received treatment, and 108 million people had been treated for malaria. The Global Fund estimates that its support has helped to save 27 million lives. Despite this progress, the Global Fund reports a worrying reversal in the trend, with growing numbers of people contracting these three diseases. More new cases of HIV are occurring in key groups and among young women and girls in southern Africa, tuberculosis is the infection that causes most deaths globally, and countries with high incidences of malaria are falling behind in the battle to eradicate the disease. According to the Global Fund, the response needs to be multidimensional, with a focus on factors such as respect for human rights, SRHR, combating poverty and strengthening national health systems. In 2018, Sweden promoted these issues on the board, along with increased funding for preventive measures, improved coordination with other actors and better integration between the Global Fund’s operations and national health systems. Sweden also lobbied for greater efficiency and a better working culture on the board and working committees. The process of recruiting a new chair and vice-chair for the board began at the end of the year.

The support that Sweden gives to the UN’s body for health issues, the World Health Organisation (WHO), has made a general contribution towards Sweden’s goal of equitable health. As the world’s leading normative actor on health issues, WHO provides technical assistance regarding national policies and guidelines on health and medical issues.

In 2018, reform of the WHO, strengthening of national health systems and implementation of the International Health Regulations were important Swedish priorities. In dialogue with WHO, Sweden has promoted rights issues, gender equality and social equality. In its role as a member of the WHO board in 2015–2018, Sweden played an active part in the organisation’s board meetings. Swedish priorities included issues concerning the prevention and control of non-communicable diseases, serious health threats with a focus on antibiotic resistance, Universal Health Coverage (UHC), SRHR and the health of LGBTQ people.

In 2017, Sweden was the second largest provider of core support for UNICEF and the fourth largest donor overall. The support that UNICEF received from Sweden helped to ensure that 141 million children in Africa were vaccinated against polio, over 25 million births took place in health facilities with trained staff present, and 15.2 million children and women in humanitarian situations had access to health care.

UNICEF works on the early development of children and young people, child and maternal health care, and effective health systems, including for the treatment and prevention of HIV/AIDS. One of the priorities for Sweden is that UNICEF meets young people’s need for and entitlement to SRHR.
3. **Prevention and management of threats to health and humanitarian disasters**

In 2018, Sweden’s work on **health and safety in development cooperation and in humanitarian operations** continued to contribute humanitarian support to people in need in areas including South Sudan, Somalia, Myanmar and the Middle East. The health interventions included health care of undernourished people, the provision of mobile clinic services, child and maternal health care and surgery for survivors of sexual and gender-related violence. By supporting WHO, Sweden also contributed to national capacity building for the implementation of the International Health Regulations (IHR).

In 2018, Sweden’s Ministry for Foreign Affairs and Ministry of Health and Social Affairs donated to WHO’s Contingency Fund for Emergencies, which provides a rapid response to disease outbreaks. Examples of the fund’s work include helping to stop the Ebola outbreak in the DRC.

Through WHO and the global ReAct network, Sida has contributed to international advocacy on **antimicrobial resistance**. In 2018, Sweden contributed to the work of the Interagency Coordinating Group (IACG) on Antimicrobial Resistance. IACG has gathered together a panel of international experts and organisations to draw up a report for the UN Secretary-General. Sweden has specifically contributed to work on analysing the need for a stronger global response and potential structures.

WHO has also supported countries in drafting action plans for their work to address antimicrobial resistance and ReAct has provided similar support for national AMR plans in Africa.
Development cooperation for health via the Ministry for Foreign Affairs

Development cooperation for health via the Ministry for Foreign Affairs mainly consists of the support channelled as core support to multilateral organisations. Core support refers to non-earmarked support direct to the organisations’ central budgets.

Through its core support and well-developed positions on issues that it considers important, Sweden has worked proactively to influence the priorities of the organisations, instead of earmarking its support for particular programme areas or projects. Core support gives multilateral organisations predictable and flexible financing. In recent years the proportion of support given to multilateral organisations as core support has decreased and many donors have preferred to earmark their support instead.

The Ministry for Foreign Affairs’ multilateral development cooperation for health 2014–2018 is shown in table 3 below. Figure 3 (page 16) shows multilateral development cooperation for health via the Ministry for Foreign Affairs and Sida in 2018.

Table 3. Development cooperation for health via the Ministry for Foreign Affairs 2014–20181

<table>
<thead>
<tr>
<th>Ministry of Health’s total development cooperation for health</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multilateral support</td>
<td>2 777</td>
<td>2 561</td>
<td>2 841</td>
<td>2 907</td>
<td>3 078</td>
</tr>
<tr>
<td>Global Fund</td>
<td>800</td>
<td>850</td>
<td>850</td>
<td>800</td>
<td>850</td>
</tr>
<tr>
<td>UNFPA</td>
<td>485</td>
<td>485</td>
<td>504</td>
<td>575</td>
<td>739</td>
</tr>
<tr>
<td>Gavi</td>
<td>450</td>
<td>350</td>
<td>300</td>
<td>300</td>
<td>350</td>
</tr>
<tr>
<td>World Bank</td>
<td>402</td>
<td>241</td>
<td>287</td>
<td>386</td>
<td>209</td>
</tr>
<tr>
<td>UNICEF</td>
<td>292</td>
<td>221</td>
<td>430</td>
<td>312</td>
<td>328</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>230</td>
<td>200</td>
<td>250</td>
<td>260</td>
<td>314</td>
</tr>
<tr>
<td>EU COM</td>
<td>77</td>
<td>114</td>
<td>111</td>
<td>127</td>
<td>136</td>
</tr>
<tr>
<td>EDF</td>
<td>48</td>
<td>51</td>
<td>57</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>WHO</td>
<td>36</td>
<td>29</td>
<td>26</td>
<td>38</td>
<td>80</td>
</tr>
<tr>
<td>IFFIm</td>
<td>18</td>
<td>18</td>
<td>18</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>UNDP</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>UN Women</td>
<td>8</td>
<td>13</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

1 Multilateral core support: Various methods and samples have been used in collecting data, so the figures are not directly comparable between years.
World Bank: 2014 also includes other development banks.
WHO: States the support to WHO that goes via the whole of the Government Offices.
European Union (EU)

As a member of the European Union, Sweden has undertaken to contribute financially to the European Development Fund (EDF). The European Commission (EU COM) also plays an important role in shaping the global health policy agenda, as part of broader development cooperation and on the basis of established principles for the effectiveness of development cooperation. In 2017 the EU adopted a new development policy (The New European Consensus on Development) to take account of the 2030 Agenda. According to the thematic priorities in the EU’s GAP II (Gender Action Plan), all women and girls should have equal access to effective and rehabilitating health care of high quality. Every individual should have full control over their own sexuality and sexual and reproductive health, free from discrimination, coercion or violence. In view of the scope of the EU’s development cooperation, as well as its role in the normative area, Sweden attaches great importance to negotiations on particularly critical issues such as SRHR. Sweden has been and remains a strong advocate of SRHR being prioritised and respected in the EU’s development work.

Development cooperation for health via Sida

In 2018, development cooperation for health via Sida amounted to a little over SEK 2.2 billion, an increase of around SEK 35 million on the preceding year. This corresponded to around 9 per cent of Sida’s total development cooperation budget, down from 10 per cent in 2017. It should be noted that the figure for Sida’s payments for health includes health-related research support, but not humanitarian assistance. If Sida’s health-related humanitarian work had been included, the figure would have been considerably higher. This is because Sida estimates that around 17 per cent of its humanitarian assistance goes towards health-related initiatives (equating to around SEK 704 million in 2018).

Country cooperation (also called bilateral cooperation) makes up around 48 per cent, while global programmes account for approximately 31 per cent of Sida’s development cooperation for health. Regional support accounts for the remaining 21 per cent. Figure 3 shows the distribution of Sida’s development cooperation for health at global, regional and country level.

In 2018, Sweden provided ongoing country support via Sida for health and/or SRHR in over 20 countries. The 10 countries that received the most support for health and/or SRHR were Myanmar/Burma, Zambia, Zimbabwe, Bangladesh, the Democratic Republic of the Congo, South Sudan, Ethiopia, Mozambique, Uganda and Bolivia.
Table 4. Development cooperation for health via Sida 2018
The 10 largest recipients of bilateral support are listed.

| Country cooperation                  | 1066 | Myanmar/Burma   | 192 | Zambia       | 191 | Zimbabwe     | 128 | Bangladesh   | 84  | Democratic Republic of the Congo | 80  | South Sudan   | 64  | Ethiopia     | 61  | Mozambique   | 46  | Uganda      | 46  | Bolivia     | 36  | Other       | 138 |

The actors involved in the implementation of bilateral (country level), regional and global support include multilateral organisations, civil society organisations and states/government agencies (see table 5).

Table 5. Development cooperation for health via Sida 2014–2018, by implementing channel/organisation

<table>
<thead>
<tr>
<th>Channel</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MSEK</td>
<td>%</td>
<td>MSEK</td>
<td>%</td>
<td>MSEK</td>
</tr>
<tr>
<td>Multilateral organisations</td>
<td>887</td>
<td>52%</td>
<td>855</td>
<td>52%</td>
<td>932</td>
</tr>
<tr>
<td>NGOs and civil society</td>
<td>695</td>
<td>41%</td>
<td>664</td>
<td>40%</td>
<td>725</td>
</tr>
<tr>
<td>Public institutions</td>
<td>55</td>
<td>3%</td>
<td>63</td>
<td>4%</td>
<td>116</td>
</tr>
<tr>
<td>Private sector</td>
<td>17</td>
<td>1%</td>
<td>7</td>
<td>0%</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>56</td>
<td>3%</td>
<td>70</td>
<td>4%</td>
<td>49</td>
</tr>
<tr>
<td>Total</td>
<td>1 710</td>
<td>100%</td>
<td>1 659</td>
<td>100%</td>
<td>1 825</td>
</tr>
</tbody>
</table>

Sida’s total development cooperation for health (MSEK)

Sida’s choice of implementing actor depends on the context in which Sweden’s development cooperation is operating and the expected results determined through Sweden’s cooperation strategies. A great deal of Sida’s development cooperation for health has been allocated to fragile states, including conflict and post-conflict countries. This means that the proportion channelled via multi-bi support is relatively large, while support to the state/public sector is limited. Multi-bi support means support to UN organisations and the operations of the World Bank at country level. In many countries marked by conflict and post-conflict situations there is great political uncertainty and the national systems are so weak that the risk of channelling development cooperation through the national health budget is judged to be too high. In 2018 just over 51 per cent of Sida’s development cooperation for health was channelled through multilateral organisations such as UNFPA, UNICEF, WHO and the World Bank. This figure covers multi-bi health support at all levels: global, regional and bilateral/national. Figure 3 (page 16) shows multilateral development cooperation for health via the Ministry for Foreign Affairs and Sida in 2018.
There is a growing trend for donors to provide earmarked support for projects and programmes instead of core support. Through Sida, Sweden is one of the few donors still giving extensive core support to multilateral and civil society organisations. This creates a strong need for dialogue and close cooperation with these organisations, in order to monitor and ensure that issues given priority by Sweden are not neglected.

As set out above (section 3), strengthening health systems, SRHR and child and maternal health are specific priorities for Sweden in its development cooperation for health. Around 58 per cent of Sida’s development budget for health is estimated to be spent on SRHR (for the calculation model, see method). Promoting the sexual and reproductive health and rights of women, girls and young people helps to strengthen the health system and to improve child and maternal health in a country. Table 6 shows the proportion of development cooperation for SRHR via Sida. It has to be said that deciding how to classify certain support given is not always a simple matter, since interventions often contribute to several areas at the same time. For example, much of Sida’s support for human rights and gender equality has a strong focus on SRHR, but because it is classified under a different sector code, it does not appear in the health statistics.

Table 6. Development cooperation for SRHR via Sida 2014–2018

<table>
<thead>
<tr>
<th>Sida’s development cooperation for SRHR</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRHR as proportion of health cooperation</td>
<td>61.0%</td>
<td>64.0%</td>
<td>67.0%</td>
<td>58.0%</td>
<td>57.9%</td>
</tr>
<tr>
<td>SRHR as proportion of total funding</td>
<td>5.5%</td>
<td>6.0%</td>
<td>6.5%</td>
<td>6.0%</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

Figure 3. Multilateral development cooperation for health via the Ministry for Foreign Affairs and Sida 2018

UNOPS (United Nations Office for Project Services) channels Sida’s country support to Myanmar/Burma.
WFP: World Food Programme.
WHO: The figure for the Ministry for Foreign Affairs is the support to WHO that goes via the whole of the Government Offices.
Research cooperation

Swedish research support contributes to the building of research capacity, to the production and publication of research relevant to development and to the development and strengthening of the links between research and innovation. Support for health research amounted to SEK 254 million in 2018.

For the first time in 20 years, the US Food and Drug Administration (FDA) approved a new medicine for river blindness, moxidectin, in 2018. River blindness is a disease that affects the very poorest people and a new medicine is of vital importance for the 200 million people who live in areas where the disease is prevalent. The WHO-based research programme Tropical Diseases Research (TDR), which Sida supports, has been involved in the development work for almost 20 years, in partnership with corporations, academics, experts and government agencies.

The research of the Human Reproduction Programme (HRP) has generated a wealth of results that form the basis for WHO’s recommendations on SRHR. In 2018, for example, the programme produced evidence that carbetocin, a heat-tolerant drug that is used to control bleeding after giving birth, is just as effective as the more commonly used oxytocin. Oxytocin requires a cold chain, which makes its use more difficult in regions that are short of resources. Each year, 14 million women around the world suffer severe bleeding during birth, and it is the most common cause of maternal mortality: 99% in low and middle-income countries.

Almost 200 000 people were vaccinated against cholera in northern Mozambique, and in the same area a cholera surveillance system was put in place with the help of the International Vaccine Institute (IVI), one of Sida’s research partners. IVI also launched a five-year study to investigate whether one dose of the HPV vaccine is sufficient (instead of two), which would enable more countries to afford an HPV vaccination programme.