

# Global partnerships for health

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## Traditional partners

Relations with the United Nations and other intergovernmental bodies are the result of formal agreements which call for ratification by a two-thirds majority of the World Health Assembly. From the outset, these agreements made provision for reciprocal representation at meetings, the establishment of joint committees for special purposes, the exchange of information and the coordination of statistical services. In 1965, 1971 and 1994, the general programmes of work of WHO highlighted the importance of the health element in national socioeconomic development and of coordination with other organizations' work in health, to make optimum use of all resources available. In order to coordinate the activities of the specialized agencies, the **Administrative Committee on Coordination** (ACC) was set up in 1949, composed of the Secretary General of the United Nations and the executive heads of the specialized agencies. In response to the concerns of Member States for the follow-up of the major United Nations conferences in the 1990s, the ACC established three time-limited interagency task forces, a prominent theme of which is the alleviation of poverty, with health being a central issue. WHO has been particularly active in that forum, bringing health issues to the centre of the debate and seeking cooperation for the renewed health-for-all policy and updated strategies.

WHO has closely coordinated its activities with the **United Nations** since 1948, including for example in the area of personnel management, in order to establish a single, unified international civil service, or in relation to the major international conferences and their follow-up. Since 1949, WHO has played an important role within the international drug control system of the United Nations based on the advice of the Expert Committee on Drug Dependence, which evaluates individual psychoactive substances and recommends appropriate control measures. The modalities for collaboration are now being reviewed as a result of the new reform package launched in 1997 by the Secretary General of the United Nations. Several aspects of the proposed package have implications for WHO's work since it addresses the whole spectrum of development issues, including emergency response programmes. The danger of overlapping and duplication continues to exist, at both global and country levels, with respect to WHO's mandate to direct and coordinate international health work, in the light of the growing involvement of organizations of the United Nations system in health.

The United Nations system-wide **Special Initiative on Africa**, within which health and education are priority components, provides an opportunity to reinforce collaborative activities with the Organization for African Unity, the Economic Commission for Africa, the African Development Bank and African regional economic communities. A WHO working group

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on continental Africa was established in 1994 to facilitate WHO's contribution to the implementation of the United Nations New Agenda for the Development of Africa.

From the outset WHO's closest collaboration has been with **UNICEF**. The First World Health Assembly recommended that the health projects financed by UNICEF should be established by mutual agreement between the two bodies and their implementation regulated by a Joint Committee on Health Policy, which consists of representatives of the Executive Boards of the two organizations. In 1949, the principles that should govern the cooperative relationship between WHO and UNICEF were defined. UNICEF's role in health programmes was to furnish the required supplies and services, while WHO would study and approve plans for all health programmes for which countries may require supplies from UNICEF. At the end of the 1950s, WHO provided the international health personnel and UNICEF the supplies. Projects ranged over practically every field of interest to child health – e.g. the campaigns for BCG vaccination, the programme for the supply of streptomycin and malaria projects, to which were later added projects on maternal and child health, nutrition (in association with FAO), environmental sanitation, aid to hospitals, and milk hygiene.

One example of a current activity exploiting modern technology is the WHO/UNICEF joint programme on data management and mapping for public health (Health Map), originally established to provide support to national programmes for monitoring dracunculiasis eradication activities. The scope of its activities has now been extended to support other disease control activities. This service, through the use of mapping and geo-

graphical information systems, has improved monitoring and management of public health programmes established for dracunculiasis, onchocerciasis, African trypanosomiasis, trachoma elimination, and tetanus immunization. National public health atlases have been developed which allow for a comprehensive and dynamic review and assessment of multisectoral issues in individual countries. They will soon be available on CD-ROM and on Internet.

The Joint Committee on Health Policy is currently being expanded to include **UNFPA** and has been accordingly renamed the WHO/UNICEF/UNFPA Coordinating Committee on Health.

WHO was closely associated with the **International Labour Organization** (ILO) during the 1950s, for example in the establishment of the International Anti-Venereal-Disease Commission of the Rhine, other aspects of the hygiene of seafarers and occupational health, and the medical examination of migrants.

**UNESCO's** programme of fundamental education (combined with community development) included the study of subjects of direct interest to WHO, e.g. school health, health training for teachers, and teaching of social sciences. Other traditional subjects of collaboration were the medical aspects of research conducted at high-altitude research stations and the use of radioisotopes. The Council of International Organizations of Medical Sciences (CIOMS) is a special body set up under the joint sponsorship of UNESCO and WHO, mainly for the coordination of medical science congresses.

Cooperation with the **Food and Agriculture Organization** (FAO) concentrated on work in nutrition and the zoonoses. Joint expert committees have examined these and related subjects such as the use of food additives,

milk and meat hygiene, and their recommendations have been the basis for joint FAO/WHO activities – nutritional surveys, training courses, seminars and coordination of research programmes. Since 1962, WHO has implemented the FAO/WHO Food Standard Programme, through the Codex Alimentarius Commission, whose objective is to protect the health of consumers while facilitating trade in food. Since 1995, and the formation of the World Trade Organization, the Codex standards are the global benchmarks or international reference values for food safety (see Box 5).

Other traditional cooperative activities were, for example, with **ICAO** concerning the disinsecting and disinfection of aircraft, international quarantine, and hygiene and sanitation of airports; and with **ITU**, on matters of notification such as epidemiological radio bulletins, as well as on certain aspects of the hygiene of seafarers. WHO was in touch with the Universal Postal Union (**UPU**) at different times with regard to the transport of dangerous goods, including therapeutic substances and insecticides, and delays in the shipment of perishable biological and pathological materials due to variations in national postal regulations.

Examples of activities conducted in 1997 with WHO's traditional partners include: community-based rehabilitation programmes (with ILO, UNESCO and UNICEF); programming for adolescent health (with UNFPA and UNICEF); and caring for the nutritionally vulnerable during emergencies (with UNHCR).

Since 1945, a large number of institutional mechanisms have been evolved to reconcile the desire for an international economic order with the domestic concerns and priorities of States. The most general channels of cooperation were the so-called

Bretton Woods institutions, the IMF and the **World Bank**. Although they played only a subordinate role in the first postwar decade, they represented a depoliticized way of dealing with economic issues. Since the WHO/World Bank review meeting held in 1994, systematic collaboration activities have been developed at the country level and are reflected in the Bank's 1997 publications. The Bank adopted the idea of WHO partnership in health development. Two key forms of collaboration are required: country-level collaboration in which WHO technical expertise is mobilized to improve the design, supervision and evaluation of Bank-supported projects; and global collaboration in which WHO and the Bank join forces to advance international understanding of health, nutrition and population issues.

In 1996, a new joint United Nations Programme on HIV/AIDS (**UNAIDS**) was launched, cosponsored by UNDP, UNESCO, UNFPA, UNICEF, WHO and the World Bank. Its objectives are to foster an expanded national response to the epidemic, to promote strong commitment by governments to an expanded response, to strengthen and coordinate UN action against HIV/AIDS at the global and national levels, and to identify, develop and advocate international best practice.

WHO works with the five major **regional development banks**, concentrating on regional health sector policy formulation and on country-specific support. Closer links have also been formed with regional inter-governmental organizations and regional political groupings such as the Organization of African Unity, the African Economic Community, the Southern African Development Community, the Organization of American States, the Association of South-East Asian Nations, the African,

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**Box 29. Diabetes – longstanding cooperation between WHO and IDF**

The International Diabetes Federation (IDF) has been in official relations with WHO since 1957. In 1962 WHO's Executive Board adopted a resolution drawing attention to the public health importance of diabetes mellitus and calling for action to combat it.

In response, the first WHO Technical Report on the subject of diabetes was published in 1965. The second WHO Expert Committee on Diabetes met in 1979, following which ties between WHO and IDF were strengthened, and a network of collaborating centres was established, now numbering 30.

WHO and IDF have collaborated on many issues relating to diabetes, including standardization, national action plans, patient education, insulin provision, and improving diabetes care at the primary level. A WHO study group on diabetes which met in 1985 recommended such collaboration at regional level, and this has been the trend since. One important example was the joint IDF and WHO Regional Office for Europe meeting in 1989 which issued the Saint Vincent Declaration, aimed at stimulating activity in Europe to improve the life and health of people with diabetes. Recently, a similar declaration has been adopted for the Americas.

World Diabetes Day (held on 14 November each year since 1991) is cosponsored by IDF and WHO and has a special theme each year. The theme in 1996, the 75th anniversary of the discovery of insulin by Frederick Banting (whose birth date was 14 November) and Charles Best in Toronto in 1921, was "Insulin for life: 75 years of insulin".

In 1997 the theme was "Global awareness: our key to a better life". About half the people worldwide who have diabetes are unaware of their condition although they are prone to develop serious complications. The complications of type 2 (non-insulin-dependent) diabetes are potentially life-threatening and as serious as those of type 1 (insulin-dependent) diabetes, a fact that is often overlooked. The emphasis in 1997 was on creating increased awareness among the general public of the causes, symptoms, treatment and complications of diabetes, so as to encourage prevention, earlier diagnosis and improved health care.

Approximately 140 million people in the world today have diabetes, and many of them need insulin, which is designated as an essential drug by WHO. However, for various reasons, insulin is not always available to or affordable by those who need it for survival or for adequate metabolic control. To overcome this problem will require the combined efforts of governments, WHO, IDF, diabetic associations and industry.

Caribbean and Pacific Group of States and the League of Arab States.

Since the 1950s, cooperation between European nations has extended to a number of areas, and progress towards unification has led to the emergence of the **European**

**Union.** There is much that WHO and the Union can do together. Exchange of information, cooperation on particular issues and eventually in joint programmes are only a start. The mandates given to both organizations by their shared Membership call for the establishment of a close partnership in Europe (where WHO can be proactive in conceptual developments and linkages with the international scientific community) and in developing countries, where WHO provides a framework and often a channel for health programmes initiated through bilateral and regional agreements. An example of a joint activity in 1997 was the convening of a working group on cross-border advertising, promotion and sale of medical products through the Internet, which among other specific technical recommendations aimed to encourage the international community to formulate self-regulatory guidelines for good informational practice, consistent with the principles of the WHO ethical criteria for medicinal drug promotion.

To be eligible for admission to official relationship with WHO, a **nongovernmental organization** (NGO) must be concerned with matters within WHO's competence and pursue aims and purposes in conformity with the spirit, purposes and principles of the WHO Constitution. The NGO must be of recognized standing and represent a substantial proportion of the persons organized for the purpose of participation in the particular field of interest in which it operates. It must have a directing body and authority to speak for its members through its authorized representatives. An NGO admitted to official relationship is entitled to appoint a representative to participate, without right of vote, in WHO meetings and, on the invitation of the Chairman, to address the meeting on

an item in which it has a particular interest. They fall into two main categories: those engaged in some particular branch of medical science or research (*Box 29*) and those representing a more general interest.

In 1997, the decision of the Executive Board to admit an additional five NGOs into official relations with WHO brought their number to 188. These help to illustrate the scope and variety of this longstanding type of collaboration. The International Association for Dental Research has helped WHO to assess future oral health research needs, while the World Federation of Chiropractic has participated in the development of guidelines on the prevention and management of neuromusculoskeletal disorders in occupational health. ORBIS International, which works to fight blindness through education and practical training for ophthalmologists, nurses, biomedical technicians and health care workers, supports WHO efforts to assess global trends in blindness, and at the national level contributes to improving skills. The International Association for the Scientific Study of Intellectual Disabilities is contributing to the revision of the ICD, and Inclusion International, composed of the intellectually disabled and their families, friends and advocates, will be contributing to the evaluation of the new International Classification of Impairments, Activities and Participation (*see Box 21*).

### Partners today

The multifaceted nature of health and the multisectoral interactions that influence it have induced an increasing number of organizations, within and outside the United Nations system, to become active in the health field. These new partners on the health scene have brought new challenges

to WHO and given added impetus to its mandate and its constitutional role as directing and coordinating authority in international health work.

New avenues for collaborative work have opened up, making it essential for WHO to strengthen its leadership role and provide a dynamic orientation of cooperation towards global partnership and burden-sharing. As governments and donor countries are increasingly concerned to get good value for money on their investments in health, balanced health funding by bilateral and multilateral institutions has become a vital issue.

In 1984, a collaborative agreement was established between WHO and the International Olympic Committee (IOC) to promote sport and physical activity through the programme *Winners for health*, linking sport with health-for-all goals. Since 1988, WHO has endorsed the organization of smoke-free Olympic games. Another example of linking physical activity, sport and health is the global initiative on active living launched in cooperation with a group of partners such as the IOC, UNESCO, the International Federation of Sports Medicine, and Rotary International among many others. WHO collaborating centres on health promotion in Finland, Japan, the United Kingdom and the United States have also been involved. Less traditional partners are also being sought, such as for example the initiative launched in 1997 with the organizers of EXPO 2000, concerning *Health futures* (*Box 30*).

Broad-ranging partnerships are increasingly being set up to target specific health problems. For example, to achieve polio eradication, a global partnership was formed with, among others, ministries of health in polio-endemic countries, Rotary International, UNICEF, the Governments of Australia, Canada, Denmark, Japan, the United Kingdom

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and the United States, as well as NGOs. An estimated \$1 billion of external funding is needed until final eradication. The very success of the venture, which has resulted in diminishing threats from vaccine-preventable diseases, is in danger of being its downfall, as the public and donors tend to lose interest when the diseases come under control. But experience shows that the diseases return as soon as vaccine coverage drops.

### Partners in response to emergencies

The traditional forms of action in response to emergency situations, due to natural or other disasters, originally consisted mainly of immediate aid in the form of urgently needed drugs, vaccines, medical equipment and other medical supplies. In the 1970s, however, WHO and the international community emphasized and developed primary health care approaches and, more recently, relief programmes focusing on preventive programmes. Technical cooperation with disaster-prone countries increasingly aimed at improving national capacity to take preventive measures and to remain more effectively in control of emergency situations. This involved Member States in activities relating to the public health management of emergencies, research on the epidemiology of disasters, studies of populations at risk, assessment of needs, priorities in the event of mass casualties, and disease control following disasters. Under WHO's impetus, several universities have established undergraduate and postgraduate programmes on health management of disasters. In collaboration with **UNHCR** and other international agencies, WHO has increasingly become involved in the health problems of refugees and has participated fully

in the provision of emergency assistance by the United Nations system.

Emergency relief, disaster preparedness and management of disasters are the three main lines of action for WHO's involvement. Emergency humanitarian action is made possible through funding from donors as extrabudgetary contributions (\$25 million in 1996). The Panafrican Emergency Training Centre and the Emergency Health Management Training project based in Addis Ababa provide support to countries of the African continent. In the Americas, the Regional Emergency Programme has strengthened the capacity of emergency managers to coordinate with the national health sector, and to this end developed a computerized relief supply management system. In South-East Asia, the national capacities of Member States and their coordinating mechanisms were reinforced, especially in Bangladesh, India and Myanmar. At the global level, several sets of guidelines were issued and training programmes were implemented.

The new WHO policy for emergency and humanitarian activities is based on three concepts:

- the Organization's position as a "health facilitator";
- its complementary role, in view of its specialized health knowledge, within the UN framework of emergency management coordination (such as monitoring the distribution of drugs in certain situations, e.g. Iraq); and
- its insistence on linking emergency management policy to development in order to help affected countries to achieve long-term improvements in public health status – a prerequisite for sustainable development.

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### Box 30. Health Futures at EXPO 2000

WHO is planning to take millions of people on a fascinating journey to discover Health Futures, an exhibition presenting its vision for healthy living in the 21st century. The exhibition is being developed in cooperation with the organizers of EXPO 2000, the World Exhibition set to celebrate the third millennium in Hanover, Germany, from 1 June to 31 October 2000.

In 2000, the theme will be the future itself under the banner "Humankind – Nature – Technology". EXPO 2000 aims to stimulate people's imagination, and encourage them into actively meeting the challenges facing humankind on the eve of the 21st century. The United Nations programme of action for sustainable development which resulted from the 1992 Earth Summit in Rio de Janeiro, Brazil, will provide the framework for the many events at EXPO 2000. In the Thematic Area, Agenda 21 will be brought to life in several subexhibitions: health, humankind, environment; landscape and climate, nutrition, knowledge; information and communication, the future of work, energy, mobility, basic needs, the future of the past and the 21st century.

WHO will develop Health Futures as part of the Thematic Area, highlighting the health chapter of Agenda 21, which underlines that health and sustainable development are inextricably linked. Health Futures will make clear that the promotion and protection of health are crucial to sustainable development. Reaching millions of Expo visitors, the health exhibition is a unique opportunity to promote public awareness of the factors that influence health, posi-

tively or adversely, and to encourage people to protect and promote their health more actively in various ways.

Visitors will learn that health and well-being are the product of many factors, and that good health needs supportive environments; that given supportive environments, people have the power to improve their health; and that new knowledge and technologies are revolutionizing approaches to health, health care and health systems. Areas to be highlighted are youth and active ageing, infectious and chronic diseases, healthy cities and technology for health. The exhibition will illustrate realistic, practical, cost-effective and sustainable approaches that are available now or will be in the near future.

Based on WHO's new policy for health for all in the 21st century, the exhibition will underline the major determinants of health ranging from nutrition to the empowerment of women and will remind visitors of the equity gap in health care, and of the gap in life expectancy at birth between developing and developed countries, stressing the need for international cooperation to eliminate or eradicate infectious diseases.

Health Futures will explore the effectiveness of modern media to communicate complex health messages to a mass lay audience, combining theatre stage productions, science centre approaches and multimedia messages to form an innovative learning experience. Educational media envisaged include CD-ROMs, electronic games, health on-line systems, and an Internet site including "a virtual walk through Health Futures".

### Partners for research

The *International Agency for Research on Cancer* was established in 1965. Subject to the general authority of WHO, it concentrates on environmental biology and cancer epidemiology.

In 1972, WHO launched a special programme of research, development and research training in *human reproduction* with particular reference to the needs of developing countries. In 1988 UNDP, UNFPA, and the World Bank joined as cosponsors. In the 25 years of its existence, the pro-

gramme has made major contributions to the improvement of reproductive health in the world. Key achievements in the area of development and improvement of methods of fertility regulation include the development of two once-a-month injectable contraceptives, extension of the duration of effectiveness of the copper IUD to 11 years and establishment of its safety in women at low risk of sexually transmitted diseases; demonstration of the feasibility of developing steroid-based contraceptives for men; clinical studies on the various uses of antiprogesterins in

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fertility regulation; and generation of a wealth of new data related to the development of immuno-contraceptives. In the area of evaluation of the safety and efficacy of methods of fertility regulation, it has published findings of global importance on the relationship between hormonal contraceptives and cancer, and oral contraceptives and cardiovascular disease. Studies conducted by the Programme have assessed, among others, the behavioural determinants of choice of family planning methods and issues surrounding gender, sexuality and reproduction.

The programme currently relies on a global network of over 100 centres for the conduct of much of the research it sponsors. These centres help to guide and evaluate the programme's work, conduct nationally relevant reproductive health research and participate in the global research effort. Some 1700 scientists in developing countries have been trained in various disciplines associated with human reproduction research, and a collaborative relationship has been fostered with a large number of scientists in the reproductive health community.

A special programme for research and training in **tropical diseases** was established in 1975 by WHO together with UNDP and the World Bank. It was concerned with eight diseases for which the situation was worsening: malaria, schistosomiasis, lymphatic filariasis, onchocerciasis, Chagas disease, leishmaniasis, African trypanosomiasis and leprosy. In the 22 years since its creation the special programme has put more than 30 products into use (including drugs, diagnostics and vector-control tools), and has approximately 30 more (including vaccines) in the pipeline. The training of more than 900 scientists from developing countries has been supported. These trainees have as-

sumed influential positions in ministries of health and elsewhere, and have introduced significant managerial, technical and political changes in the research and control of tropical diseases.

Since 1994, research on each of the eight diseases has been carried out in three broad cross-cutting areas: strategic research, product research and development, and applied field research. The emphasis in 1997 was on identifying and developing new drugs, improving the use of existing drugs, improving drug distribution, mass chemotherapy, community-directed treatment, vaccines, genome studies, rapid assessment methods, vector control, or in some instances, more efficient diagnosis. Challenges include: development of drug and pesticide resistance; high costs of drug development; social and economic constraints in disease endemic countries; problems in drug delivery; changing patterns of land use; lack of research capacity in developing countries; and negative gender attitudes towards women. In research, many leads ultimately come to nothing, despite their early promise. There have also been disappointments, particularly in the field of drug development. Some products, although useful, need further improving, e.g. eflornithine (for the treatment of advanced cases of African trypanosomiasis) is still prohibitively expensive and costs much more than patients in endemic countries could ever afford. Most needed are more funds; novel ways of collaborating with industry and strengthening product research and development in developing countries.

In 1990, the World Health Assembly called on Member States to undertake essential health research appropriate to national needs and strengthen national research capabilities. In 1994 the **Advisory Committee on Health Research** and

CIOMS organized a landmark meeting on the impact of scientific advances on future health. The ACHR has now prepared a research agenda to complement and support the WHO policy and strategy for health for all in the 21st century. It reviews evolving problems of critical significance to health, and suggests ways of harnessing the power of science, technology and medicine to contribute to problem solution. It is not limited to conventional biomedical research or the health sector, but rather addresses all disciplines and all fields of research that can contribute to human health. WHO's role is to facilitate the networking of the research community so as to bring the power of scientific knowledge, research and technology to bear on global health development.

The Second World Health Assembly (1949) laid down the policy that the Organization should not consider the establishment, under its own auspices, of international research institutions, and that research in the field of health is best advanced by assisting, coordinating and making use of the activities of existing institutions. All **WHO collaborating centres**, whether they deal with research or not, have been designated under that policy. Thanks to their permanent linkages with technical and scientific institutions in the countries, these centres contribute to the development of new areas and types of health research at country level, and to the application of the results of research and the transfer of new technology to the national network of institutions. The large increase in the number of centres in the course of the last three decades has been due mainly to the development of the research component of WHO's programme. The WHO collaborating centres are therefore the keystones of the collaborative research capacity and in-

stitutional strengthening efforts developed under WHO's leadership at all levels.

The **WHO Centre for Health Development**, established in 1996 in Kobe (Japan), is fully financed from extrabudgetary resources provided by a Japanese consortium. The Centre collects, analyses and disseminates information, and carries out interdisciplinary and multisectoral research to identify ways of integrating health in international and national policies. It will also provide training for health leaders in different areas of research methodology and international public health. The priority areas of research selected as an initial programme for the Centre are progressing urbanization and the ageing of societies.

### Partners for the future

In 1995 the World Health Assembly called for a global consultative process that would involve the widest range of partners, starting with Member States, in order to develop a new global health policy for the 21st century. The consultative process since then has involved extensive and detailed analyses of successes and future challenges in most countries of the world. During 1997, several global and regional meetings identified how countries could work better together to achieve health for all. Selected global meetings that brought together international experts and a diversity of inputs in 1997 included a consultation with CIOMS on ethics, equity and human rights in a meeting on intersectoral action for health, cosponsored by the Canadian, Swedish and Finnish governments; a formal consultation with 130 international nongovernmental organizations; and a critical assessment of impediments and challenges to the development of sustainable health systems. A draft policy was reviewed by WHO's gov-

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erning bodies in 1997. The consultation has extended beyond government and health ministries to consider the views of nongovernmental organizations, United Nations partners (including the World Bank and the World Trade Organization), the private sector, and academic and research institutions. Hundreds of individuals and organizations have been mobilized in the process. Their views have been systematically analysed and are reflected in the new health policy, *Health for all in the 21st century*, to be submitted to the 51st World Health Assembly in May 1998.

The Global Knowledge Partnership, which includes all the major United Nations agencies, is currently preparing an inventory of current "knowledge for development" activities conducted by their respective organizations. WHO is participating in the multilateral development of knowledge in the global health domain. Global knowledge builds on what began at the 1995 G7 meeting on the global information society, and continued at the more broadly-based 1996 conference on the information society and development. The Global Knowledge '97 Conference, of which WHO was a partner, was part of a much broader process of preparing

societies and individuals for the information age. Coming to terms with the knowledge revolution is a central part of rethinking development for the 21st century.

The global knowledge revolution has only just begun and we are still at the dawn of the information age, but we are already faced with a series of urgent riddles and challenges.

Many individuals and probably the world as a whole will benefit from new technology. However, if left on its present track, the revolution will probably bypass billions of people. No one actor alone has the combination of power, resources and vision necessary to guide the revolution so that it advances the general good, neither the governments, the private sector, civil society nor the voluntary community. The knowledge revolution comes at a time when traditional concepts of international development are being questioned. The developing world has fragmented into a kaleidoscope of countries and blocs, and old donor-recipient relationships have become archaic. Global problems, too big for national governments and international agencies, call for new partnerships, coalitions and networks capable of responding at an appropriate scale, speed and level.