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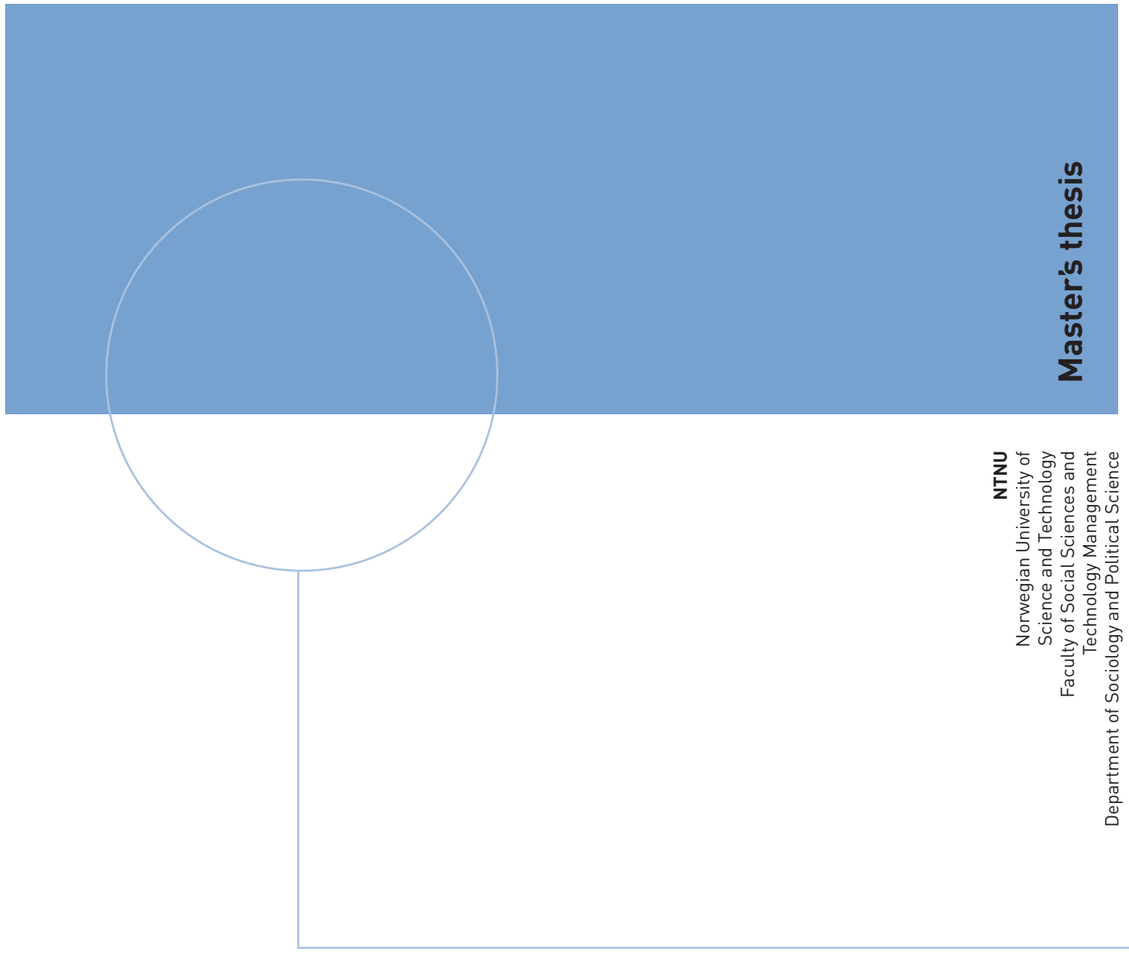
# A Norwegian effort towards Millennium Development Goal 5

A qualitative study concerning Norwegian health-aid strategies towards reducing maternal mortality in the world's least developed countries

Master's thesis in Political Science

Trondheim, spring 2015

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## Acknowledgements

Then many years of education is almost completed. It has been a very exiting and interesting journey in life. The field of Political Science was a somewhat inadvertently choice based on a teacher's statement after completing a course called *Politics and Human Rights* in high school, as she recommended me that Political Science might be the right choice. I decided to follow her advice.

The studies began at the University of Agder in 2010 where I started the bachelor in Political Science, and I soon realized that I had chosen the right study. However, already in high school, I had a desire to study abroad during the study period at the University. I decided eventually to move to the United States more specifically Montclair State University in New Jersey, where I spent the last year of my Bachelor's degree. The year as an exchange student is probably most exciting, knowledgeable and influential time so far.

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Margareth Sandvik Alfredsen
Trondheim, February 2015

## Abbreviations

| | |
|---|---|
| ANC | Antenatal care |
| CPI | Corruption Prevalence Index |
| DAC | Developing Assistance Committee |
| DHS | Demographic Health Survey |
| FLE | Female Life Expectancy |
| ODA | Official Development Assistance |
| OECD | Organization for Economic Co-operation and Development |
| GAVI | Global Alliance for Vaccines and Immunization |
| GDP | Gross Domestic Product |
| GG | Good Governance |
| GGGI | Global Gender Gap Index |
| HDI | Human Development index |
| IMF | International Monetary Fund |
| PBF | Performance-based Funding |
| RBF | Result-based Funding |
| LDC | Least Developed Countries |
| MDG | Millennium Development Goals |
| MM | Maternal mortality |
| MMR | Maternal Mortality Ratio |
| MSF | Medicines Sans Frontiers |
| NGO | Non-Governmental Organization |
| NTNU | Norwegian University of Science and Technology |
| SDG | Sustainable Development Goals |
| STD | Sexual Transmitted Diseases |
| TFR | Total Fertility Ratio |
| UN | United Nations |
| UNEG | United Nations Evaluation Group |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations International Children Emergency Fund |
| WHO | World Health Organization |
| WHS | World Health Survey |

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# 1. Introduction

This thesis concerns Norwegian bilateral health-aid strategies linked to improvement of maternal health in the world's least developed countries, due to the increased focus concerning global health emphasized in the Norwegian White Paper No. 11 (2011-2012), 2012). Today, maternal mortality remains one of the world's greatest health issues, for that reason it need to be addressed though a global initiative. This as measures illustrates that in 2013, a total number of 289 000 women died under the circumstance of what the United Nations has defined as maternal mortality, this corresponds to an overwhelming 800 lives per day. At the same time, approximately 10 million women suffer from injury, infection and (or) other diseases (WHO, 2014:a). About 99 percent of the total maternal deaths around the world occur in developing countries, indeed maternal mortality is considered one of the most important health outcomes for measuring health differences between developed and developing countries (Foster-Rosales 2010, p.279). This study is primarily based on aid-receiving countries within sub-Saharan Africa and Southern Asia, as they are the most affected by maternal deaths (WHO 2014:c).

This study focus particulary on the Norwegian efforts towards achievement of the United Nations Millennium Development Goal 5 that is improvement of maternal health, by a) reducing the maternal mortality ratio by 75 percent, and b) through achievement of universal access to reproductive health (United Nations, 2013 pp.22-33). In this Paper three important challenges and goals are outlined for achievement by 2020; (I) mobilizing for women and children's rights and health, (II) reducing diseases by focusing on prevention, and finally (III) promoting human security through health (White Paper No. 11 (2011-2012), 2012, p.6). These objectives are closely linked to the United Nations Millennium Development Goals (MDGs) established in 2000 while highlighting maternal and reproductive health (WHO 2014:c). In the writing moment, there remains one year for the targets to be accomplished. Meanwhile, the current progress only corresponds to a 45 percent decline compared to 75 percent, which was the determined target of the United Nations Millennium Development Goals (Ibid.) Nevertheless, recent studies have concluded that the global effort of reducing maternal mortality and morbidity have not been coinciding with other global health priorities. This while many donor countries fails to implement appropriate and adaptive measures in the beneficiary countries (Barot 2011, pp.25-26). Filippi et al. (Filippi, Ronsmans, Campbell, Graham, Mills, Borghi, Koblinsky & Osrin 2006, p.1537) also discovers that maternal health

has yet not been financially prioritized internationally, despite the international engagement expressed in accordance with the MDG 5. These findings identify the need of evaluations concerning bilateral donors priorities and effort towards achieving progress linked to MDG 5.

Meanwhile, the Norwegian government has adapted a strategy of result-based funding (RBF) in order to increase the impact of its health-aid disbursements, this strategy has been advocated by a number of international organizations such as the World Bank and the Global Fund with focus on maternal health improvements (World Bank, 2013). The main purpose of this strategy is in particular to increase aid to countries that manage to progress sustainable development upon predefined results such as the MDG 5 (Grittner 2013, p.5). However, this strategy has been criticized in recent research. According to Riddell (2007, p.3) has Norway (and other bilateral donors) been influenced by the consideration that aid predominantly should be distributed to those countries that are able to utilize it well, such an assumption has led to a debate that questions whether there is an equitable distribution of health-aid linked to health inequalities in LDCs. Riddell (Ibid, p.4) also argues that, insufficient aid disbursements refers to one of the greatest issues within Norwegian health related aid, this due to absence of aid provided the poorest countries where the need is greatest. Accordingly, the slow progress towards MDG 5 also provides further basis for donor-recipient evaluations, discovering whether the United Nations target of a three quarter decrease were too ambitious, or whether donor countries have been lacking clear objectives to reach the 75 percent decline.

In contradiction to these former studies, which chiefly have analyzed rather general perspectives of bilateral aid contributions, this thesis tends to evaluate the specific Norwegian health-related aid allocations targeted to improve maternal health in least developed countries. In such matter, both the United Nations MDG 5 and the Norwegian government's targets of improving global health are assessed against Norwegian health-aid contributions in the worlds LDCs. This to evaluate and discover what characterizes Norwegian strategies in aspect of provided health-related commitments within these countries. The Organization of Economic Cooperation and Development has emphasized the need of such donor country evaluations in order to improve their work by promoting knowledge, generate greater results, facilitating feedback as well as saving resources related to the Millennium Development Goals (Hildenwall, Sjöberg & Öbrand, 2008, p.1). All these measures tend to increase the impact of bilateral health aid.

In accordance with the OECD have also the United Nations recognized the lack, as well as the need for such donor-evaluations by demanding reports in order to attain knowledge and experience due to further work. Seemingly, while addressing the need of sustainable development due to the post MDG period 1990-2015 (UNEG, 2012, p.18). In such matter, this study aims to evaluate the Norwegian effort towards MDG 5, this based on the absence of donor evaluations and the insufficient distribution of health-aid. Furthermore, this study desire to answer whether Norway tends to be a loophole actor (i.e. a donor supporting those countries receiving least from other donors) compared to other donors, or if the amount of distributed aid has been distributed through comprehensive assessments.

However, this study is nevertheless not intended to attempt or determine the effect of the Norwegian development policies, but rather to discover, whether or not Norway could have prioritized its health-aid commitments differently, this in accordance with the advocated focus on maternal health put forward in the White Paper No. 11 (2011-2012), 2012, p.6). Development aid might incidentally consist of both bilateral and multilateral agreements, meanwhile this study is limited to include only bilateral allocations, i.e. direct disbursements from one country (donor) to another (recipient). This as bilateral aid usually amounts to the largest share of a country's aid disbursements. However, most of the literature and reports that has been performed in order to evaluate bilateral health-aid have been lacking country-specific analysis of achievement, in favor of rather general measurement considering multiple indicators.

Particulary two qualitative methods have been used in order to perform this study, respectively; *indicator prediction* and *document analysis*. First, an indicator prediction was implemented in order to reveal which countries that constituted the greatest need of health-aid in order to reduce maternal mortality improve maternal health. In such manner, predominately two indicators were considered as crucial predicators, respectively the Human Development Index and the Maternal Mortality Ratio. Furthermore, document analysis was initially adopted on the basis of governmental publications concerning maternal health in a global health perspective. These public records consist of a document related to implementation, funding, priorities and further supplementary descriptive information regarding Norwegian health assistance in 2013. Similarly, two of the most recent White Papers related to global health and development aid, respectively; White Paper No. 11 (2011-2012), 2012) and White Paper No.

40 (2008-2009), 2009) have been evaluated in order to discover whether or not Norway has given attention to maternal health in accordance with those priorities emphasized in the White Papers.

Furthermore, this particular thesis is a part of a current cooperation project between Bridge NTNU and Unicef Norway, whereas a group of students from different disciplines are writing their thesis on topics demanded by Unicef Norway.

### 1.1 Research question

The research question for this study is; *what characterizes Norwegian health aid strategies towards reducing maternal mortality in the world's least developed countries? Could Norway have prioritized differently in order to improve maternal health in 2013?* This research question examines the fundamental strategies and priorities implemented in accordance with the efforts towards achievement of United Nations MDG 5, this evaluated in accordance with the government's targets and priorities emphasized in White Paper No.11 (2011-2012), 2012). A secondary objective in answering these research questions aims to discover whether or not Norway can be considered a loophole donor compared to other health-aid donors, i.e. a donor supporting those countries receiving least health-aid from other countries.

### 1.2 Use of terms and concepts

Before getting further into the broader picture of the Norwegian effort towards MDG 5, there is a need for some conceptual clarifications. The literature concerning aid proves to be quite complex, indeed is the definition of the term. Consequently, it is essential to delineate the scope of aid being analyzed here. This study predominantly focuses on bilateral aid, meaning assistance allocated from one government (donor) to another government (recipient). This type of aid usually amounts to the largest share of a country's aid disbursements. These types of aid will also be interchangeably referred to as ODA (official development assistance), meaning all types of funding provided for archiving sustainable development (Norad, 2012).

*Humanitarian and development aid*

The type of health related bilateral aid consistently mentioned in this paper, can be defined as development aid, responding to systemic problems in the particular countries. These allocations are often results of long-term goals, such as the United Nations Millennium Development Goals, by focusing on political, social and economic development within a

determined date of achievement (Humanitarian Coalition, 2014). On the other hand, the literature on global aid tends to have a somehow unpredictable distinction between humanitarian and development aid, as the former often relates to short-term assistance related to unpredictable crisis. However, when referring to humanitarian aid in this paper it relates to rather long-term assistance, beyond the need of immediate relief (Rose, O'Keefe, Jayawickrama & O'Brien, 2013 p.74). The relatively new term *complex humanitarian aid* might be the far most explanatory definition, this referring to conditions characterized by inter alia political instability, armed conflicts, large population displacement, food shortage, social disruption, *and* collapse of public health infrastructure. Such situations are highly linked to the need of health assistance, as mortality rates as well as malnutrition tend to increase considerably (Gasseer, Dresden, Keeney, & Warren 2004). Both these terms development- and humanitarian aid will be implemented interchangeably within this paper.

### 1.3 Thesis outline

This paper is structured into five main chapters. Following this introduction, Chapter 2, will introduce the existing literature on maternal health and the strategies of Norwegian bilateral health-related aid. Chapter 3, will provide a theoretical framework, which explains the current situation of the Norwegian bilateral aid policy, this provides a more in-depth of the priorities and challenges of such strategies. Furthermore, Chapter 4 concentrates on the methodology explaining the performance and structure of this analysis. In the following Chapter 5 examines the analysis by taking a further look into data on the specific amount of Norwegian disbursements, while discussing and comparing the need of aid in developing countries. Eventually, these main findings will be further discussed in Chapter 6, this in accordance with the main theories and existing literature referred to in the previous chapters. In conclusion, I will sum up the most relevant findings in this study.

## 2. Existing Research

This chapter will present an overview of the literature surrounding development and global health related to maternal mortality. Moreover, the prevailing literature has been divided into two perspectives. First I will present the existing research concerning Norwegian bilateral aid based on a *donor country perspective*, this by giving an insight into Norway as a health aid donor, while addressing the main strategies of implementation, priorities and trends. Then I'll move on to discussing a *recipient country perspective*, this by looking at the scope of maternal mortality as a global issue, the main causes of death, and the need for further resources in order to attaining progress towards achievement of the Millennium Development Goal 5.

### 2.1 A donor country perspective

As already put forward, existing research regarding Norway's bilateral aid position remains quite scarce. This is a result of a relatively general directed research community with emphasis on aid recipients rather than donors, whereas evaluations have been somewhat absent. In this context, there is an increasing demand for such donor evaluations advanced by a number of the worlds foremost intergovernmental organizations (IGOs) such as the United Nations and the OECD (Hildenwall et al., 2008, p.1; UNEG, 2012, p.18). The main purpose of such evaluations is in particular to acquire lesson from earlier experiences, while addressing sustainable development in accordance to the post MDG period (1990-2015). However, Riddell (2007, p.2) has been highlighting this lack in a policy evaluation concerning Norwegian aid effectiveness, while addressing challenges and issues concerning the Norwegian bilateral aid architecture.

> *The quality of humanitarian aid evaluations continues to be assessed as "poor" while the assessments of NGO development projects and programmes have scarcely begun to focus on the relationship between aid inputs and broader development outcomes. Growing interests in accountability and transparency issues suggest growing pressure for more rigorous, evidence from those types of aid.*

This study desires to contribute in filling these gaps illuminated by Riddell, while seemingly contributing to the existing literature regarding the Norwegian health assistance. The current scope of literature will therefore be further presented in the following sections. However, first and foremost there is a need to illuminate a perception of the main pattern of Norwegian health aid allocated in 2013.

### *2.1.1 Norwegian health-aid disbursements in 2013*

A total of approximately 10 to 13 percent of Norwegian foreign aid were allocated to global health related objectives, in 2013. Thus, the Solberg I government recently proposed an increase of $24.7 million in 2015, which corresponds to a total of approximately $478 million (Norwegian Department of Foreign Ministry, 2014).[1] The fundamental aim of these funds is related to the achievement of the Millennium Goals, as well it is assumed to be a significant connection between health, education and poverty, this as neither one can be solved separately.

Nevertheless, recent numbers illustrates that Norway in 2013 donated in total more than $411 million to global health. According to estimations preformed by OECD and the Development Co-operation Directorate do Norway account for 2.8 percent of the worlds total global health aid. In the Norwegian White Paper No. 11 (2011-2012), 2012) Women and children's rights and health were highlighted as one out of three main priorities towards improving global health within 2020. However the Norwegian effort does not only include development aid in the traditional sense, but also technical cooperation through global bodies such as the World Health Organization, as well as significant efforts through global initiatives and funds such as the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund of fighting AIDS, Tuberculosis and Malaria (Ministry of Foreign Affairs, 2013).

The 36 countries included in this study received approximately $114.8 million of the total amount allocated to health-related sectors, although some of the countries did not receive assistance at all (Norad, 2013:b). However, it is important distinguishing between the total amounts of humanitarian aid, compared to the total amount of health related aid donated. By focusing on the 36 least developed countries in this analysis, Norway provided 32 out of 36 with humanitarian aid, whereas to 27 out of 36 countries were provided with health related aid. Among these 27 countries there were large differences between the smallest and largest payout per capita. In this regard, there is an important question that should be brought up: what exactly is the cause of this skewed distribution of aid? As well as whether such a complex question could be answered with the simplicity of *results-based funding*. The answer is probably as complex as the question. However, the next section will address this relatively

[1] This number refers to all countries receiving Norwegian health aid, not in particular the countries examined in particular the countries examined within this study.

[2] Result-based funding (RBF) is also often referred to as performance-based funding (PBF); both terms can be

new strategy of RBF in order to attain a further understanding of the priorities, and inversely the lack of priorities within Norwegian health-related aid in 2013.

### *2.1.2 Result-based funding*

The definition of results-based funding (RBF) can be understood as a structure of project implementation, where the leading actor usually a bi- or multilateral donor, who provides with aid funding, pays the agent, who further implements the project upon predefined results (Grittner 2013, p.5). These results can additionally be described as conditions that have to be accomplished either in advance or after receiving aid, however this will be further explained in the next chapter. The aim with results-based funding is simple: to create intensives for achieving results, this through outcomes and inputs from which can measured and quantified in order to identify the relevance of providing humanitarian aid and improving global health in particular recipient countries (Klingebiel & Janus, 2014). [2]

The health sector has expanded its efforts of improving effectiveness of aid allocations in developing countries, at the same time has also ODA (Official Development Assistance) funds to developing countries increased significantly. Yet, the health sector illustrates many disputes concerning aid effectiveness. Interventions such as the Millennium Development Goals are often related to as core examples of objectives in the health sector, were result-based funding could be an advantageous strategy for archiving results. In this case Norway (as a donor country) has conducted a number of such intensives in the White Paper No. 11. (2011-2012), 2012). The effort of the beneficiary countries under improvement and incentives determines whether a country will be 'rewarded' with more funding, or not. This method of achieving results has been much debated and criticized, mainly because there is a lack of experience and research on this method of global aid funding (Klingebiel & Janus, 2014). Though it's important to notice that results-based funding is not an implemented strategy in all contexts. The main feature is that donations are only provided once predetermined targets have been achieved, while in other situations the actual target is to provide advanced funding in order for achieving results. Examples of Norwegian introduced RBF within health related sector could for instance be a scheme where a clinic or hospital receives payments possibly due to the quality of treatment, or due to the number of therapies. Such funding can be allocated to health personnel, health institutions, municipal authorities, or organizations.

[2] Result-based funding (RBF) is also often referred to as performance-based funding (PBF); both terms can be implemented interchangeably.

Norway has also contributed in the development of such models concerning results-based funding in the health sector. One of these projects includes 27 developing countries through an initiative by the World Bank Fund (Norad, 2011).

In the publication of White Paper No. 35 (2003-2004) concerning poverty the Bondevik II government evaluates their efficiency and country selection based on the given criteria's in the following statement (translated from White Paper No. 35 (2003-2004), 2004 p.114):

> *Recent international research results combined with Norway's own experiences illustrates that aid have the greatest impact in countries where economic policy, governance, and other conditions contribute and promote development and poverty reduction. In this context, several multilateral financial institutions and some large bilateral donors have taken new initiatives to increase aid to countries where these conditions are present, while reducing aid to other countries where the general conditions are less favorable.*

The rhetoric representation in this White Paper can arguably be considered as somewhat contradicting in the sense that aid is mainly provided and prioritized for those countries being able to attain progress and development, while the poorest and least-developed countries (read the most vulnerable) remains status quo. However, as stated forward in the policy document this strategy has been adopted in accordance with global actors. Furthermore, the White Paper addresses that there is a broad consensus internationally about the necessity of common clear and realistic goals in developing countries, as well as on the donor side.

The intensives referred to, as *realistic goals* are further in the document pointed out as number of indicators for evaluation of recipient countries policy and institutions, often related to as CPIA (Country Policy and Institutional Assessments). These estimations include a total number of 20 indicators measuring corruption, macroeconomic policies, trade, social distributions, and official management in developing countries (White Paper (2003-2004), 2004, p.114). A possible issue with these indicators is however not that they are poor measurements, but arguably rather their irrelevance when determining the requirement of health-related aid. A relatively more time-consuming (and indeed advantageous) evaluation proposed to adopt several indicators for the different types of aid allocated (humanitarian, military, economical etc.) Although, it is important to address that the indicators used to determine the recipients of Norwegian bilateral aid has not been clarified in the policy document. However, none of these reports, respectively; White Paper No. 35 (2003-2004),

2004) and White Paper No. 11 (2011-2012, 2012) states clearly which indicators are adopted in order to determine and choose which of the developing countries that should be given priority, nor the factors that determine the significant proportion of aid being distributed. Although the Norwegian Parliament decided in 2008 that development aid should be based "on the international principles of humanity, neutrality, impartiality and independence" (White Paper No. 40 (2008-2009), 2009, p.13). In such manner, the evidence of result-based funding still remains somewhat imprecise and vague, despite that result-based funding has been considered as most functional and effective in the health sector (Klingebiel & Janus 2014, p.9). This is probably a decisive reason explaining the lack of evaluations on result-based funding in general, as for instance Norway.

*Experience with result-based funding in the health sector*

A recent contribution to the existing literature concerning results-based funding in relation to development aid has been performed by Amanda M. Grittner (2013), her study discovers that results-based aid potentially could improve and coverage health care needs, especially for the poor. However, Klingebiel (2012, p.35) argues that three requirements ought to be fulfilled by the particular recipient country in order to manage health improvements due to RBF, respectively good governance, economic freedom and investment in their citizens. The table below illustrates the principal components incorporated in results-based aid related within the health sector (Grittner, 2013).

**Table 1.** Result-based aid funding in the health sector

| | **Results-based aid** |
|---|---|
| **Principal** | Donor country |
| **Agent** | National government |
| **Funds** | Donor funds |
| **Relationship** | Aid partnership |
| **Examples** | The United Nations Millennium Development Goals Contracts, Cash on delivery, Millennium Challenge Account, GAVI, and the Immunization Services Support (ISS). |

Table illustrating the main components incorporated in RBA in the health sector (Grittner 2013, p. 53, Table 1).

Nevertheless, the documented effect of health related RBA in the literature has been scarce. Ingvar T. Olsen from the health department at Norad points out that relatively few studies provide good evidence. In a contribution to the existing literature, Olsen recently evaluated

five cases whereas Norway provided RBA.[3] He found inter alia that despite the lacking research on a number of different strategies, that such schemes have proved to be contributing with increased access and provision of services. Simultaneously as the number of births in hospitals and clinics increased. Secondly, Olsen emphasizes that it is not possible to discover whether RBA tends to detect more rapid or increased development according to the Millennium Development Goals, due to lacking information about the quality of certain services as well as the current health status in the respective populations. Thirdly, RBA has been compared with possible negative side effects, such as cheating, distortion effects, considerable demands and costs of verification. While a control body in order to avoid such side effects also would imply relative costs. Finally, there has not been documented any long-term effects nor the possibility of sustainable RBA systems (Olsen 2012, p.11).

### *2.1.3 Aid management and development effectiveness impact on LDCs*

Bilateral aid donors have experienced an increased pressure on improving the effectiveness of their contributions; the result has been more concentrated aid to countries that achieve development. Riddell, as mentioned above (2007) has been evaluating the Norwegian aid pattern based on a request of the Foreign Ministry to meet challenges and increase the effectiveness of Norwegian aid. According to Riddell (2007, p.3) has Norway as well as other bilateral donors been influenced by the consideration that aid predominantly should be distributed to those countries that are able to utilize it well. However, this trend has mainly advocated by the World Bank (2013) and the Global Fund being two of the major actors influencing bilateral donor countries (in this case Norway). In such matter, Riddell argues that the "influence inevitably led to some of those countries in the greatest need of aid, but [who are] unable to use it as effectively as others receiving proportionately less than they required" (Ibid, p.3). This refers to one of the greatest issues within Norwegian aid, as insufficient aid disbursements are being provided, this applies mainly to (or absence of) allocations provided the poorest countries where the need is greatest. Riddell further concludes that there is no necessary interaction between the amount of Norwegian bilateral aid distributions and the aid requirement of each recipient country. Accordingly, figures illustrate that LDCs received a third of the total ODA in 2013, whereas the poorest countries received approximately 33 percent of this aid (United Nations, 2014). However the United Nations reported diminishing

[3] These particular cases where: Rwanda, Mexico and Nicaragua, Afghanistan, and Tanzania (Olsen, 2012, p.12).

aid allocations to Sub-Saharan Africa in 2013, meanwhile representing a majority of the least developed countries (Ibid).

Another study discussing Nordic donor countries performed by Gates & Hoeffler (2004) support Riddell's conclusions, this as they discover and concludes that if aid is continuing to be allocated to those countries with good policies only, then it implies that Nordic donors should withdraw form least developed countries with poor institutions. However, Alesina and Dollar (2000) tends to favor these prioritizations in regard of more effective bilateral aid, while arguing that Norway tends to provide aid in harmonization with the right objective when providing more aid to poor recipients with good policies and open democratic regimes.

Based in accordance with the existing research concerning a donor country perspective, this study provides the following hypothesis:

*$H_1$: there is no evident relationship between least developed countries aid requirements and the amount of aid received*

*$H_2$: Norway's commitment to results-based aid causes that those countries with the greatest need of health-aid receives the least*

However, a number other studies have also examined the Norwegian bilateral aid pattern *inter alia*, Selbervik's (2003) dissertation on Norway as a donor in the conditionality epoch; Tvedt's (2007) study of the Norwegian Model on development aid, foreign policy and power; Tvedt's (2009); study concerning the impact of international on Norway as a donor country; and Olsen's (2012); evaluation report of Norwegian result-based funding within the health sector in low-and middle income countries. However, these studies will be further mentioned and referred to throughout this paper.

### 2.2 Maternal mortality as a global issue

The literature concerning maternal mortality is covered within a broad sphere of disciplines, and viewed from different perspectives. The global attempt towards improving women's health, and combating maternal mortality ratios are both results of the United Nations efforts in respect of MDG 5, and the underlying goals. Arguably, this has proved to be one of the world's greatest universal attainment concerning global issues. Nevertheless, despite that all regions have advanced their maternal mortality rates, there is still critically high MMR's in

some countries, especially in the Sub-Saharan Africa. However, it is important to point out that a number of countries have achieved the goal corresponding to a 75 percent decrease of their MMR (WHO 2014:a, p.37). A broad sphere of the literature addressing this issue has been preformed (mostly) though qualitative statistical analyzes, measuring the effect of global efforts or aspiring to discover future preventive and promotional measures.

*The Lancet Global Health Journal* is probably the most frequently updated and acknowledged journal consisting of advanced research pertaining to least developed countries. In contribution with supplementary research this journal has been consulted repeatedly throughout this study in order to illuminate important issues regarding reproductive as well as maternal health.

### *2.2.1 Main Causes*

Firstly, the definition of maternal mortality implemented in this analysis relates to women who die within 42 days of termination of pregnancy, this in regard of diseases either directly or indirectly related to pregnancy. The World Health Organization has identified ten direct and indirect causes of maternal deaths.[4] Firstly, *direct causes* of maternal deaths imply deaths resulting from obstetric complications during pregnancy (labour and the puerperium) coming from interventions, omissions, and incorrect treatment linkage-effects from one of the above. Secondly, *indirect causes* of maternal deaths imply deaths resulting from previous diseases or diseases developing throughout pregnancy i.e. not due to obstetric cause, but rather worsen by physiologic effects during pregnancy (WHO 2012, p.9). However this analysis is mainly focusing on the direct causes, as those are the most common in the two regions represented, accordingly Sub-Saharan Africa and Asia. A study discovering the most occurring causes of death in these two regions illustrates that heamorrhage is the leading cause of death, both in Africa and Asia representing more than 30 percent of all maternal deaths. Meanwhile, there are some regional differences whereas 6 percent of the deaths in Africa are caused by HIV/AIDS compared to a tenth of the deaths in Asia. Other frequent findings included differences between developing and developed countries, whereas hypertensive disorders and sepsis tended to vary significantly (Khan, Wojdyla, Gülmezoglu & Van Look 2006, p.1072).

[4] These include heamorrhage, hypertensive disorders, sepsis/infections, abortion, obstructed labour, ectopic pregnancy, embolism and other direct causes. Anemia, HIV/AIDS and other indirect causes (Khan et al. 2006, p.1068).

### *2.2.2 A journey of combating maternal mortality - to be continued*

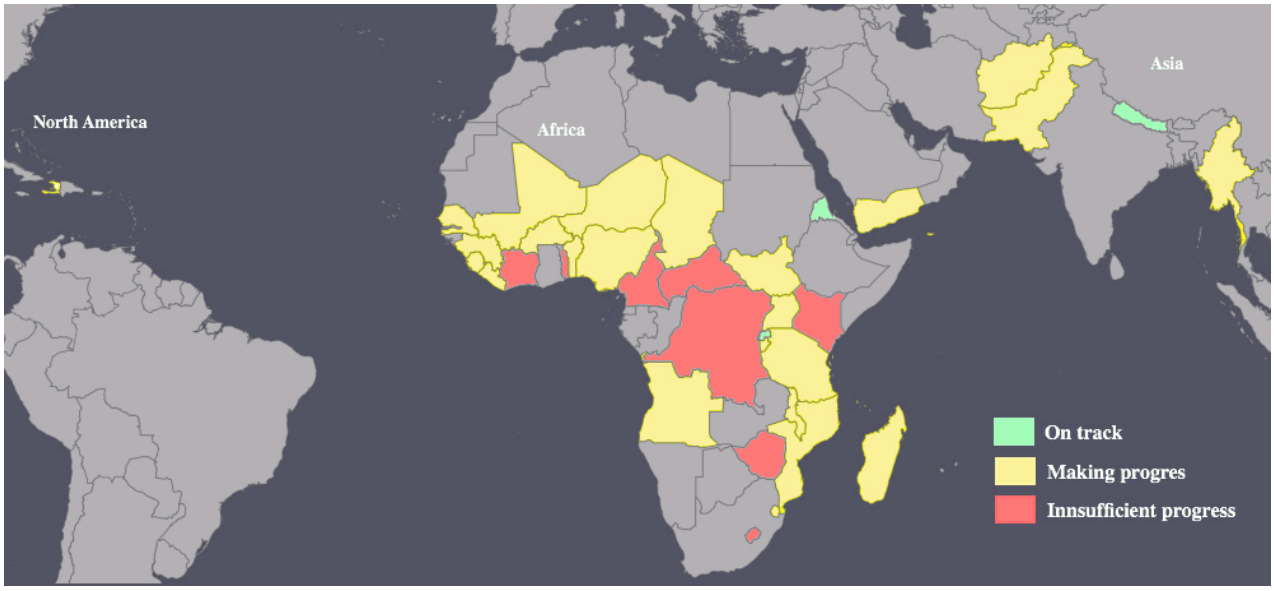


**Figure 1.** Map illustrating the countries progress towards MDG 5, in 2013. Own complication based on figures obtained from the World Health Organization (2014:b, pp.36-43).

Figure 1 illustrates the particular 36 countries (included in this study) progress towards achieving MDG 5. Countries referred to as 'on track' are those with an annual percentage decline of 5.5 percent or more, while 'making progress' indicates a decline between 2 and 5.5 percent and eventually 'insufficient progress' relates to those with less than 2 percent annually decline. This recent study by the World Health Organization (Ibid) has been studying the trends in maternal mortality in the period 1990 to 2013. In the study it was discovered that the total number of maternal deaths globally has decreased with 45 percent due to the 1990 estimates. This corresponds to an annual average decline of 2.6 percent world wide, although figures illustrated an increased decline between 2005 and 2013 (World Health Organization 2014:b, pp. 26-27). However, relatively few of the counties in Figure 1 have attained successful progress towards MDG 5, although it should be mentioned that these countries in particular relates to those countries having the highest MMR in 2013.

As the MDG deadline approaches researchers have been preparing post-2015 strategies in order to continue improvement of maternal health, while others have focused on the importance of looking back at how this could have been done differently using other methods. Filippi et al. (2006, p.1537) discovers in their study that maternal health has yet not been financially prioritized internationally, despite international engagement expressed in accordance with the MDG initiative. This is being justified by the fact that several of the

largest contributors donate about 1 percent of its total ODA flows related to health. Also Barot (2011, pp.25-26) concludes that the global effort of reducing maternal mortality and morbidity have not been coinciding with other global health priorities. However, both analyzes refers to a small increase of ODA funds related to health the last couple of years. Assumingly, as recent research has revealed the need of increased appropriations coincidently with expanding focus indicating that there is a reciprocal relationship between maternal health improvement and achievement of general development. Seemingly, Deleye & Lang's (2014) representing one of the most recent research contribution regarding maternal health concludes that maternal health policies tends to differ greatly among donor countries concerning their views regarding preventive and improving strategies focusing on causes, diseases, capacity building as well as their research contributions.

### *2.2.3 Mothers self-assessed poor health*

Can your country make you sick? As follows reads the title of a recent PhD dissertation by Margot Witvliet, a study exploring population's health and human rights in a global perspective (Witvliet et al. 2013, p.48). Her study also includes a study concerning mother's self-predicted poor health in a number of 32 countries in Europe, Latin America, Africa and Asia. This study gives attention to self-assessed poor health as an important and supplementary indicator related to the Maternal Mortality Ratio. This as these two indicators together provides a powerful predictor in order to assess the need of resources due to maternal health improvements such as the MDG 5. Meanwhile this research in particular focus on lone mothers self-assessed poor health condition compared to couple mothers, this study provides significant figures that has not been addressed though a similar study before. Perhaps, a relation linked to the countries in this thesis could help identify whether Norway has prioritized those countries reporting the highest prevalence of self-reported poor health.

Witvliet et al. (2013, pp.57-60) concludes that lone mothers reported poorer health compared to couple mothers, though there were somehow regional variation in the magnitude of effects concerning well-being, religion, and culture. However, in relation to this thesis that mainly concerns South African countries (representing the highest MMR) Witvliet et al. discovered that there is a relation between the odds of lone mother's reporting poorer health compared to couple mothers. An observation that should be interpreted with caution is adjacent to the majority of Muslim population in these countries (Ibid, p.58). However, another assumption relates to the different understanding of what poor or inversely good health actually means.

Nevertheless, Witvliet et al. further points out that a increasing “need exists for global multilevel studies of the joint influences of both the individual- and country-level exposures on individual health using data from divers countries” (Ibid. p.105). Something that is also essential related to achievement of the United Nations Millennium Development Goals.

## 3. A Theoretical perspective

The chapter begins with addressing the placement of women's health within the field of existing literature. In such manner two theories have been adopted in order to explain the slow progress towards MDG 5, respectively Tudor-Harts *Invers Care Law* and *the Life Course Theory*. Further, this chapter presents the main strategies towards improving maternal health based upon a sustainable development approach. Eventually, a conditionality approach explaining the relationship between donor and recipient countries, this in terms of explaining Norway's strategic actions and priorities related to the structure implementation of results-based funding.

### 3. 1 Development theory

When studying bilateral health-aid and its influence on women's health, we are in the field of public health global development research. Global public health is a relatively new era, which has been receiving increasingly international emphasis referring to the advancement of public health through a global perspective, mainly focusing on developing countries. Nevertheless, there is a need for some definitions before stepping into the broad theoretical perspective within this field. Firstly, *global public health* is defined by Beaglehole & Benita (2009, p.2) as "the art and science of preventing disease, promoting public health, and extending life through organized local and global efforts". The increased interest concerning global health is likely to be considered as an effect of the complexity of globalization. Secondly, the term *development* is frequently referred to within global health research, often associated with something latent. For instance, the term development related to in aspect of a theoretical framework in this study applies to the gap between the objectives of public policy, and what is being achieved in practice, i.e. response to perceived success, failure or surprise (Currie-Alder, Kanbur, Malone & Medhora 2014, pp.2-3).

*The Inverse Care Law*

Although, it can be argued that the academic paradox of global health lack a grand theory of development, yet there is a broad sphere of approaches acknowledged by the most renowned researchers within this field. An important generalization of public health in least developed countries is predicted by Julian Tudor Hart (1971, p.405) known as the *Inverse Care Law* "[the] availability of good medical care tends to vary inversely with the need for it in the population served (…) since the lower classes have higher death rates, then they must be both

sicker or less likely to secure treatment than other classes", i.e. that those who need it most, are least likely to receive the healthcare they need. Tudor-Hart also points out that *they*, who can here be understood as least developed countries, are more vulnerable to diseases, as they lack access to secure treatment. Perhaps, this is still the *status quo*, almost half a century after. Tudor-Harts theory is frequently adopted in research issuing an unequal distribution of health resources. This despite that those countries with higher number of maternal deaths are in greater need, these poor unfavorable populations tends to be the least prioritized in order to benefit from improved health policies and interventions (Thomsen, Phong Hoa, Målqvist, Sanneving, Saxena, Tana, Yuan & Byass 2011, p.177).

*The Life Course Theory*

Waage et al. (2010, p.991) and Anand & Sen (2000, p.2038) examines the *Life Course Theory* when explaining this unfavorable pattern by emphasizing the importance of intragenerational equity in health in sense of moving towards sustainable development. An intragenerational process of health explains the linkage-effect arising, e.g. that improved maternal health contributes to child health conditions, regained health later in life, and improved reproductive health. Arguably, equity in health should ensure and promote human development, as well as improved maternal health in poor and least developed countries. In that respect, implication of intragenerational health equity can be understood as a pro-poor approach benefiting the most marginalized countries in terms of the MDGs (Ibid. p.1017).

### *3.1.1 A new global health paradigm*

The new era of global public health evolving in the last decades has shaped a new development paradigm. Global aid actors such as donor countries, NGOs and IGOs have tended to implement different strategies in order to promote health. Barot (2011, p.25) argues that the most important global health inducing international contribution is "the UN Millennium Development Goals (…) [being] the overarching development paradigm that guides most global efforts to combat poverty and improve health." Hilson (2005, p.65) argues that NGOs have enunciated a progressive political discourse, while certain conservative governments have implemented inefficient strategies that rather have lead to impoverishment of least developed countries. Researchers have been addressing whether the Millennium Development Goals were over ambitious or if there has been lacking a common strategy in order to meet these goals. For instance, the United Nations Conference on Sustainable Development held in Rio de Janeirio conveyed upon a set of Sustainable Development Goals

(SDGs) interacting with the achievement of the post-MDGs, as the 2015 deadline is approaching. In order to achieve sustainable health development Waage et al. (2010, p.1016) applies the principle of holism i.e. that the health sector needs to be improved as a complex system, for that reason it is important to focus on the greater health disputes such as the sexually transmittable diseases, as well as immunization and vaccination that should be prioritized initially.

### 3.2 Strategies towards maternal survival

When focusing on maternal health in less developed countries there is a broad consensus on five strategies and measures acknowledged to improve poor maternal health and reduce maternal mortality, including both *ad hoc* and preventive care strategies these are: intrapartum care, family planning, antenatal care, reproductive health and postpartum care (Campbell & Graham 2006; Beaglehole & Benita 2009; Filippi, Campbell, Graham, Mills, Borghi, Koblinsky & Osrin 2006). For instance, these motives of improved health inducing factors needs to be examined more specifically.

Firstly, *intrapartum care* i.e. midwifery practice is acknowledged as the main strategy of reducing the maternal mortality ratio, in order to the meet the target of 75 percent decline. Filippi et al. (2006, p.1535) ascertain that "[the] Millennium Development Goal for maternal health (MDG-5) to reduce maternal mortality by two-thirds by 2015 will best be achieved by adoption of a core strategy of intrapartum care based in health centers." Skilled birth attendance has also been recognized by Campbell et al. (2006, p.1296) as they argue that all women should have the opportunity to chose to deliver in health centers, as empirical research illustrates that the maternal mortality ratio per 100 000 livebirths, in all countries where this approach has been adopted are less then 200, and some even lower. This corresponds to calculations proving that about 16 to 33 percent could be prevented through skilled birth attendance (Bullough et al. 2005, p.1184).

Secondly, *family planning* is also one of the main preventive strategies towards maternal survival, assuming that increased contraceptive prevalence improves women's reproductive autonomy by preventing unwanted pregnancy, illegal abortion, as well as reducing the number and risk of births (Bullough, Meda, Makowiecka, Ronsmans, Achadi & Hussein 2005, p.1183). Donnay (2000, p.93) concludes that family planning information and services could reduce pregnancies, maternal deaths and injuries by 20 percent, or even more in

developing countries. Sedgh, Singh & Hussain's (2014, p.301) have contributed with the most recent research on pregnancy trends, as they concluded that there is a great need of family planning strategies. When referring to 2012 estimations it illustrates that in total 85 million out of the total 213 million pregnancies occurring were unwanted, of these ended 50 percent in abortion, 13 percent in miscarriage and the remaining 38 percent in unplanned birth. Family planning is needed most in developing countries, where 89 percent of the annual pregnancies occur (Ibid, p.306).

Thirdly, *antenatal care* (ANC) the rationale purpose behind this strategy is to detect possible signs or risks of disease at an early stage of pregnancy, this by aiming to reduce maternal and perinatal mortality and morbidity (Campbell et al. 2006, p.1294). This has been one of the most improving initiatives in regard of decreasing maternal mortality, as an effect of the MDGs. This strategy recommends having four antenatal visits during the period, whereas most women in least developed countries receive only one visit. Antenatal care also increases the chance of receiving skilled healthcare as well as contribution to better health later in life.

Fourthly, *reproductive health* is a strategy focusing on preventive health services, such as treatment of sexual transmitted diseases (STD). These measurements have proved to reduce the total number of unplanned pregnancies in developing countries (Donnay 2000, p.93). Reproductive health does not only focus on medical treatment, but rather the physical, mental and social well being of mothers health condition throughout life.

Lastly, *postpartum care* (or postnatal) refers to care immediately or a few days after birth. Medical research has proved that two days postpartum is the most vulnerable period during pregnancy, with the highest risk of death, this as about 60 percent of maternal deaths occur in this period (Campbell et al. 2006, p.1295; Bullough et al. 2005, p.1185). However, compared to the other strategies there has been performed significantly less research on postpartum care.

Although some of these strategies have illustrated to be less effective than the other, it is important to account for equity in health as mentioned, as all the five strategies remains within the complex system (or paradigm) in order to reduce maternal mortality. A number of international organizations have been adopting these strategies in order to achieve maternal survival and improve maternal health in least developed countries, e.g. the World Health Organization initiative *Making Pregnancy Safer*, the US Secretary of State initiative *Saving*

*Mothers Giving Life* particular focusing on Sub-Saharan countries, and the United Nations initiative *Every Woman Every Child.*

### 3.3 A conditionality approach

Conditionality is an approach describing the bilateral pattern between a donor country and a recipient country. According to Collier, Guillaumont, Guillaumont & Gunning (1997) conditionality can be defined, as conditions implemented in order to induce reform, i.e. increasing effectiveness of aid, by yielding to *good governance* (GG). There are often two types of conditionality debated in the light of bilateral aid, for instance *ex post* and *ex ante* conditionality[5]. In case of *ex post* conditionality the recipient country is agreeing upon certain conditions determined by the donor country, achievement of these conditions will be carried out subsequently. Inversely in case of *ex ante* conditionality the recipient country needs to fulfill certain conditions in order to receive aid. Conditionality explains the strategy behind donor countries economical and political core interests due to sustainable aid. This involves explicit and implicit requirements for the recipient countries. However, conditionality can be referred to as both negative and positive. Stokke (1995, pp.164-165) claims that negative conditionality implies denial of aid to countries that is not meeting certain standards, while positive conditionality refers to countries that achieve good governance.

#### *3.3.1 Norwegian political conditionality*

The theory of *ex ante* conditionality can be adapted in order to provide further understanding regarding Norwegian bilateral aid policy, this in aspect of its criteria for selecting countries concentrated on prioritization of funds, strategies and implementation of aid policies. Stokke (1995, p.168) points out the core values of Norwegian bilateral aid policy by addressing that "[The] overall objectives set for Norway's development co-operation are the very norms which form the core objectives for politically conditionality: namely, the promotion of *social, economic and political human rights and democracy*". These values have been relatively stable throughout the Norwegian aid history. However, there has been an increasing focus on the right to development, improved governing processes, participation and democracy, i.e. those countries performing *good governance* (GG). This relates to countries fulfilling certain quality requirements such as accountability, transparency, absence of corruption and respect towards the human rights (Johannessen & Leraand 2014). For instance, it can be discussed to

[5] *Ex post* and *ex ante* can also be referred to as *ex post facto* and *ex status quo* (Selbervik 2003, p.74).

which extent donor countries should be involved in recipient countries (read sovereign states) development process, Singh (2002, p.302) illustrates this point as he argues "changes in governance must be left as far as possible to the internal process of these countries, unless there are compelling reasons for the international community to be involved as in the case of genocide or widespread violation of human rights."

The first criteria was decided in the beginning of the 1970s as affirmed in White Paper No. 29 (1971-1972), 1972) that Norwegian long-term development aid should be concentrated on least developed countries. In 1976 were a second criteria established based on the United Nations Human Rights Declaration, as recipient countries were expected to obey the human rights (Stokke 1995, p.169). Arguably, it is reasonable to assume that these two criteria were determined in order to increase the effectiveness and sustainability of Norwegian bilateral aid, in that respect it can be interpreted as political conditionality. Yet, a third criterion were adopted in the early 1980s based on a proposal from the Parliament concluding that countries ought to be included or excluded based on their past performance in regard of their maintenance of the human rights (Ibid. pp.171-172). Nevertheless, these criteria did not lead to aid being terminated or limited in the prioritized countries due to lack of achievement, though some recipient countries have been terminated rather due to insecure and extreme conditions (such as conflicts, terror etc.). Stokke (1995, p.193) further concludes that Norwegian political conditionality "includes both coercive and supportive measures aimed at obtaining policy reform on the recipient side using aid as the instrument (…) The result is what ultimately matters, deciding the extent of success or failure vis-à-vis the objectives set". This refers almost directly back to Currie-Alder et al. (2014) definition of development understood through a theoretical framework.

### *3.3.2 Criticism*

Conditionality as a strategy of allocating aid has been much criticized of being undemocratic and somewhat ironic. Some researchers argue that donor countries often lack knowledge about policy processes in the particular recipient countries, for that reason it is incredible that foreign aid remains successful (Singh 2002, p.301). Neumayer (2003, pp.11-15) argues that it is inexpedient assuming that poor and least developed countries would agree upon conditions to be improved in order of receiving development aid, as political as well as democratic decision-making processes is in most cases absent. Selbervik (2003, p.14) tends to support this view arguing that Norwegian bilateral aid has become more conditional, as a result of the

World Bank and the International Monetary Funds (IMF) introduction of structural-adjustment programs in the 1980s and 1990s. Whereas these projects have illustrated a different outcome than expected (referring to poverty reduction and economic growth). Inversely she argues that these policies that developing countries have to implement in favor of receiving development aid, have tended to be disadvantageous for least developed countries, as market oriented economies are better suited for developed countries. Crawford's (2007) study on effectiveness and consistency in terms of aid allocations targeting to improve human rights attainment, democratization and obstruct corruption is also an important contribution to the complex debate on conditionality. His study on foreign aid and political conditionality of four Northern donor countries implicates that violation of human rights, lacking progress towards democratization or/and corruption can be described as effects of political conditionality in particular recipient countries. Crawford further concludes by analyzing the effectiveness of aid conditionality that aid sanctions were successful only in a relatively few of the cases, thereby he argues that *ex ante* conditionality have a limited impact on the development pattern in least developed countries. Both these contradictory views i.e. whether political aid conditionality is contributing to good governance, or inversely prevent the democratic process needs to be further addressed while evaluating this strategy.

# 4. Methodological approach

This chapter discusses the particular methodological approach applied in this study. First, by justifying the choices that have led up to this methodological approach, and then I will move on to discussing the sample distribution and country selection. Furthermore, there will be provided a more in-depth description of the two analysis methods, respectively the document analysis and indicator predictions. Eventually, I will present the data processing related to the preparation of the results of this analysis, as well as discussing some limitations and other possible methodological approaches in answering the particular research question put forward.

## 4.1 Qualitative method

This study has been performed based on a *qualitative method*, this in order to answer the particular research question: *what characterizes Norwegian health aid strategies towards reducing maternal mortality in the world's least developed countries? Could Norway have prioritized differently in order to improve maternal health in 2013?* This including a secondary objective in answering these research questions aims to find whether or Norway can be considered a loophole donor compared to the other DAC members'. By applying such a methodical approach it occurs in Ringdal (2012) that qualitative methods and research often is inductive, which also proves to be the case with this study. The purpose of qualitative studies is often based on empirical hypothesis testing, which in some cases can lead to a possible theory. Using a qualitative method seeks to explain contexts rather than causes (Ibid.). In such matter, in particular two qualitative methods have been used in this study; respectively *document analysis* and *indicator prediction*.

The choice of method is a result of the principal sources of data and descriptive information available. This by using health indicators in order to define maternal health situations in the particular countries, as well as presenting information to determine the need of health-aid based on indicators predicted to indicate the need of resources in order to improve maternal health. This method of analysis is arguably awaited within global development research (Fretheim, 2013). Another advantage is that emphasis on public databases and information ensures that the final result can be reproduced, improved, validated and re-verified by implementing new data. However, I believe Bryman (1996, p.4) argued very well as he once stated "quantitative research is hard and reliable…qualitative research is deep and rich".

### 4.2 Criteria of country selection and sample distribution

A few selection criteria needed to be specified in order to determine a final distribution of countries to be included in this analysis. First and foremost, the selection had to consist of both countries that received health-related bilateral aid, and inversely some countries that did not. As being able to answer whether Norway has prioritized in accordance with the predicted need. Secondly, it was considered as crucial to include a concise categorization of those countries with the greatest apostasy of development. The final selection of countries is due to these criteria primary based on countries being defined and ranked as least developed on the Human Development Index of 2013 (UNDP, 2014:a). This based on the assumption that least developed countries should be prioritized as recipient countries considering their low level of human development. Furthermore, as these main criteria were determined a total selection of 36 out of the total 42 countries ranking as least developed countries remains a part of this analysis. [6]

*Sample distribution*

As this study attempts to find the relation between (or absence of) maternal health promotion and received development assistance. The sample distribution contains data representing women in the age 15-49, thus, reproductive women in a number of least developed countries. In order to classify time period and cause of maternal deaths a definition implemented by Hogan et al. (2010, p. 1610) has been adapted. This method distinguish between early maternal (<42 weeks) and late maternal (>42 weeks and <1 year). However, the indicator estimating the maternal mortality ratio only refers to early maternal deaths, late maternal deaths will therefore not be included in this analysis. In the process of collecting data on maternal mortality there are some challenges to be met. Both statistical numbers and analysis often exclude information on distribution of allocations, which makes it difficult to know if the allocation of funds are disposed to health in general or prioritized for improving maternal health conditions.

### 4.3 Document analysis

Document analysis is a type of content analysis, considered a frequently adapted method within social science in order to categorize, investigate, interpret and identify limitations of other sources or existing research. Use of document analysis as a research method refers to

[6] Papua New Guinea, Solomon Islands, Comoros, Mauritania, Gambia, Ethiopia, and Guinea-Bissau have been excluded from this study due to lacking data.

collection of data that are being analyzed to reveal important relationships and relevant information in relation to the given conditions examined. This method of generating data uses documents produced for other purposes than exclusively research. According to Tjora (2011, p.144) such studies are considered as *unobtrusive methods*, i.e. generating empirical data without non-investigative participants being involved. These analyzes often lead to procurement of information concerning case circumstances that is recorded at specific times and places, but with different purposes (Ibid). Within the field of political science this is most often performed by analyzing written documents, either in the public or private domain, perhaps referring to letters, official published or governmental documents, newspapers, journals and official statistics etc. The term 'document' is general and can refer to all written sources that are relevant to the researcher.

I have in this analysis interacted with primary sources, which represents public documents. The main sources are White Paper No. 11 (2011-2012), 2012) and White Paper No. 40 (2008-2009), 2009) and furthermore a descriptive, as well as empirical source concerning distribution of resources regarding Norwegian health-aid, published by the Norwegian Agency of Development Cooperation (Norad, 2013:c). However, this method implies in resemblance with others methods its strengths and weaknesses (Payne & Payne 2004, p.61). Weaknesses in the application of this method are mostly related to difficulties with accessing representativeness of the particular documents, which possibly can lead to challenges in terms of generalization. Inversely, Walliman (2006, p.84) points out that an "advantage of using this kind of data is that it has not been produced for the specific purposes of social research, and can therefore be the basis of a form of unobtrusive inquiry". This methodical approach was in part chosen as an alternative research method due to the lack of updated statistical data.

### *4.3.1 Pure document research*

In order to justify whether or not it can be argued that Norway have prioritized their aid allocations in relation to the objectives and priorities enshrined in the White Paper No. 11 (2011-2012), 2012) I have considered the relevance of examining public records with overview of health-related bilateral funds in the particular recipient countries in 2013. As previously mentioned the public record imposed in this study have thus been retrieved from the Norwegian Agency for Development Cooperation (Norad), this as a case-specific document used as supplemental empiricism.

The Ministry of Foreign Affairs has delegated the responsibility of publishing information regarding Norwegian assistance as one of the principal tasks of Norad. This involves publication of figures and reports in order to ensure transparency and quality assurance in the form of public documents (Lovdata, 2013). All relevant data from the document that has been included in this study can be found in the Appendix C (see Table 1. C). This includes a descriptive explanation of the purpose of the share, the main actors, sectors and subsectors of aid in the 27 countries that were awarded Norwegian bilateral health-aid in 2013.

### 4.4 Additional data prediction and indicator analysis

Within social science it is often imprecise relationships between different phenomena, which can make it difficult to draw concrete conclusions. Payne & Payne (2004) therefore points out the importance of adopting some key indicators in order to operationalize the phenomenon being researched. In this respect, this study has been based on an indicator-based approach that consists of some of the most explanatory indicators for health outcomes in the world's least developed countries. These indicators have been developed by arguably some the most recognized international organizations, then referring to the United Nations, the World Bank and the World Health Organization. Furthermore, these are principal indicators and measurements of a population's health condition.

#### *4.4.1 Variables and main predictors*

*Dependent variable*

The dependent variable in this analysis is *Norwegian health-related aid*. This while referring to the bilateral share of health-aid donated among a sample of 36 of the worlds least developed countries. The amount of health related aid has been measured and analyzed in accordance with the targets and priorities conveyed in the Norwegian White Paper No. 11 (2011-2012), 2012) were the government highlights improvement of maternal health and reproductive health as their main priorities due to the global initiative of the United Nations MDG 5. All contributions referred to are thus based on reported figures from 2013. These figures indicate health-based assistance that is mainly related to the prevention and improvement of maternal health according to the most recognized strategies (see strategies towards maternal survival, p.19). In this context, have all measurements been illustrated by the per capita share distributed in 2013, this based on generated figures from Norwegian

Agency for Development Cooperation (Norad, 2013:c). These figures have further been converted into US dollars against the specified exchange rate of December 31, 2013.[7]

**Table 1.** Predictors linked to maternal health conditions in LDCs

| Independent variables | Year | Description |
|---|---|---|
| Maternal Mortality Ratio [a] | 2013 | *Maternal Mortality Ratio (MMR) is a modeled estimate of the number of women who die per 100,000 live births, within 42 days of termination of pregnancy.* |
| Human Development Index [b] | 2013 | *Human Development Index (HDI) illustrates the measure of achievement that is indicating the level of human development in the population based on knowledge, health and other factors representing a decent living.* |

[a] The World Health Organization (2014:c, pp.74-87). [b] The United Nations Development Program (2014:a).

Table 1 illustrates the main predictors that have been assumed to indicate a country's need of health-aid in order to improve maternal health. Firstly, the Maternal Mortality Ratio (MMR) can be considered as the most important indicator in order to define mothers' health condition. Meanwhile, the Maternal Mortality Ratio is also the actual object measured by the United Nations while considering the development of maternal health in relation to the MDG 5. Furthermore, the MMR has been considered as one of the most important health outcomes for measuring health differences between developed and developing countries (Foster-Rosales 2010, p.279). In 2013 corresponded the minimum value of MMR to 1 death per 100 000 live births, while the maximum value were 1100 (WHO 2014:c, pp.74-87).

Furthermore, has the Human Development Index been included in this analysis, this based on the assumption that prosperity and living conditions influences population's health conditions. Accordingly the HDI composes three key aspects concerning achievement of human development, these includes a healthy life measured by life expectancy, knowledge based on mean and expected years of schooling, and eventually a decent living measured by gross national income per capita. In 2013 was the average value of countries considered as least developed estimated at 0.493, while the countries within this study ranges from the lowest score of 0.337 to the highest score of 0.540 (UNDP 2014:a).

[7] The US exchange rate were estimated at 1 US $ being relatively to 6.07003 NOK as of December 31, 2013. (Exchange Rates UK, 2013).

### 4.5 Data processing

The procedure of collecting and processing data has been performed in three steps. The first part consisted mostly of collecting data from a great number of health indicators (see Appendix 8 B, Table 1-3 B). These were gathered from acknowledge international institutions such as the United Nations, the World Health Organization and the World Bank. More specifically this included manually plotting of numbers from the original file, as well as listing tables in Excel. Some countries had missing values on a few indicators; these countries have been interpolated with values from other countries based on similar (or identical) values on the other independent variables (in these cases values has been marked by * behind the particular values).

The second step was to reorganize and generate descriptive information regarding the allocation of aid disbursements assigned to health related objectives, gathered from the Norwegian Agency for Development Cooperation (Norad, 2013:c). A lot of information had to be revised and removed in order to identify the total disbursements, this because a great amount of data included allocation that were not directly linked to health, e.g. cultural arrangements, arguably as it is reasonable to assume that cultural arrangements (i.e. social events such as music festivals) does not have any direct impact on improved maternal health. Simultaneously, all numbers have been converted from NOK (Norwegian Krone) into US dollar in sequence of having the same currency throughout this paper.

The third and final step consisted of processing and constructing the main figures in order to illustrate the distribution of health-related aid among the 27 LDCs. However, due to the considerable differences in the distributed share of aid were all figures calculated into *per capita* measurements, this in terms of discovering whether large or inversely rather small population figures could explain these varying allocations (see Appendix B, Table 2 B for exact figures). Furthermore, were the two predictors respectively the Maternal Mortality Ratio and the Human Development Index combined with the proportion of health aid *per capita* this in order to discover a possible pattern that could help explaining the priorities of Norwegian health-aid. Meanwhile also explaining the recipients' need, utilization and management of these resources. Additionally, a red regression was added to illustrate the particular relationship between Y i.e. the dependent variable (Norwegian health-aid) and X i.e. the explanatory variables (MMR and HDI). Moreover, this trend line also illustrates that those

countries placed furthest on the left side are more effective in order to exploit their resources, while countries to the right indicates rather inefficient utilization.

Furthermore, due to comparable measures were a similar figure constructed according to the DAC members' total distribution of health-aid resources in the 36 least developed countries. This in order to discover whether Norway have prioritized those countries receiving particulary less health aid from the other members, or oppositely if Norway has prioritized in accordance with the DAC members practice. In that context were figures obtained from the OECD Aid to Health Statistical Database, respectively all figures were based on health aid commitments as of 2012, while corresponding to the most recent numbers available (see Appendix A, Figure 8.1). In resemblance with the Norwegian figures were also these numbers calculated into per capita measurements. Eventually, both the Norwegian and the other DAC members' commitments were prepared into stacked bar charts in order to illustrate the main sectors prioritized, and seemingly discover whether these priorities corresponds.

### *4.5.1 Structure of presentation*

Furthermore, this study aims to answer the research questions based on two methods of implementation that forms the overall structure in the following chapters. The first method is primarily directed to the first research question regarding: *what characterizes Norwegian health-aid strategies towards reducing maternal mortality in the worlds least developed countries?* In order to answer this, I will in particular address this research question in Chapter 5, based on data and figures presented in the previous section in order to consider Norway's distribution of health-aid across the 36 countries (elaborated in this chapter, section 4.2). Furthermore these data will be considered in accordance to these countries progress toward MDG 5. The following chapter will also include an assessment of whether Norway has adopted the most effective strategies for reducing maternal mortality in these countries that are considered the most vulnerable and affected. This as well as comparing Norway's priorities with that of the other DAC members' related to the secondary objective of the research question, in order to discover whether or not Norway can be considered a loophole donor compared with other health-aid donors. These main findings discovered in this chapter will further be considered in Chapter 7. Furthermore, the second research question, respectively: *Could Norway have prioritized differently in order to improve maternal health in 2013?* Will mainly be discussed in accordance with the results discovered in Chapter 6

based on a rather theoretical approach, while also addressing the relevance of the existing research.

### 4.6 Limitations and other possible methodological approaches

Several methodical approaches were considered in advance of this particular study. Nevertheless, a few crucial limitations regarding time-perspective and data availability were taken into account, despite that this study is been primarily based upon those priorities and strategies conveyed in White Paper No. 11 (2011-2012), 2012). Furthermore, it was desired to discover whether the emphasized initiatives in the report were performed in order to improve maternal health, which implied the need of the most recent data (2013) available concerning maternal mortality. Moreover, the demarcation of countries implied that the possible data source had to include as many as possible of the least developing countries based on their Human Development Index score of 2013 (i.e. main selection criteria), corresponding to a total number of 42 countries.[8] A challenge occurring in this process responded to the overall lack of available data on least developed countries. However, mainly two datasets were considered as both included extensive collections of data on health development and maternal health, receptively the World Health Survey (WHO, 2004) and the Demographic Health Survey (USAID, 2012). The idea was to run a regression analysis as these two datasets includes data on household, maternal health, fertility, family planning, empowerment and HIV/AIDS as well as other unique indicators to be analyzed. However, neither of the datasets included data for such a large distribution of countries. For instance, many countries lacked basic and/or updated metadata covering the latest decade. Considering these shortcomings it were decided to rather focus on the public records and health indicators, as these data were considered as important as well as highly explanatory measures.

[8] A total overview of the Human Development Index 2013 can be adapted from the United Nations Development Program Report (UNDP, 2014:a).

# 5. Results

In this chapter I will present the main results of this study. The chapter is divided into four sections, based on the method of analysis described in chapter 4. The first section considers Norway's distribution of health-aid across the 36 countries included in this analysis (as discussed in chapter 4 section, 4.4 and 4.5). In the second section, this distribution is considered alongside a consideration of countries' progress towards MDG 5. As previously mentioned, these data helps us consider whether Norway's strategy of result-based funding has led to a prioritization of those countries that have managed to progress the most. Data presented in the third section aims to answer whether or not Norway as an bilateral health-aid donor has adopted the strategies argued to be the most effective in reducing maternal mortality (as previously described in Chapter 3, section 3.2). Finally, Norway's health-aid funding priorities will be compared to the DAC members' practices in order to illuminate whether Norway primarily has prioritized those countries that have yet not been covered by other donors, or whether these decisions coincide with the other DAC member's priorities.

## 5.1 The distribution pattern of Norwegian health-aid in 2013

Figure 2, Illustrates the total distribution of Norwegian health-related aid funds in 2013. The Y-axis demonstrates a country's score on the Human Development Index, ranging from 0,300 to 0,600, where a higher value corresponds to a higher level of development, and vice versa.[9] The X-axis illustrates a country's annually estimated maternal deaths (per 100 000 live births), ranging from 140 to 1120. The red regression line shows that there is almost a linear relationship between X and Y. In the same manner, it also indicates that the countries on the left side are more effective in exploiting their funds, compared with those placed on the right side. Meanwhile, an absolute distribution would illustrate a majority of the greatest bubbles placed on the upper left side, as those countries would represent both a higher level of human development and a lower MMR, based on the sample distribution. In this graph, bubbles size indicates the per capita amount of health aid received by a country in 2013 (see Appendix 8 B, Table 2. B for exact figures).

[9] A *higher* level of development in this sense does however not correspond to high human development, but rather higher than the other countries categorized as least developed countries.

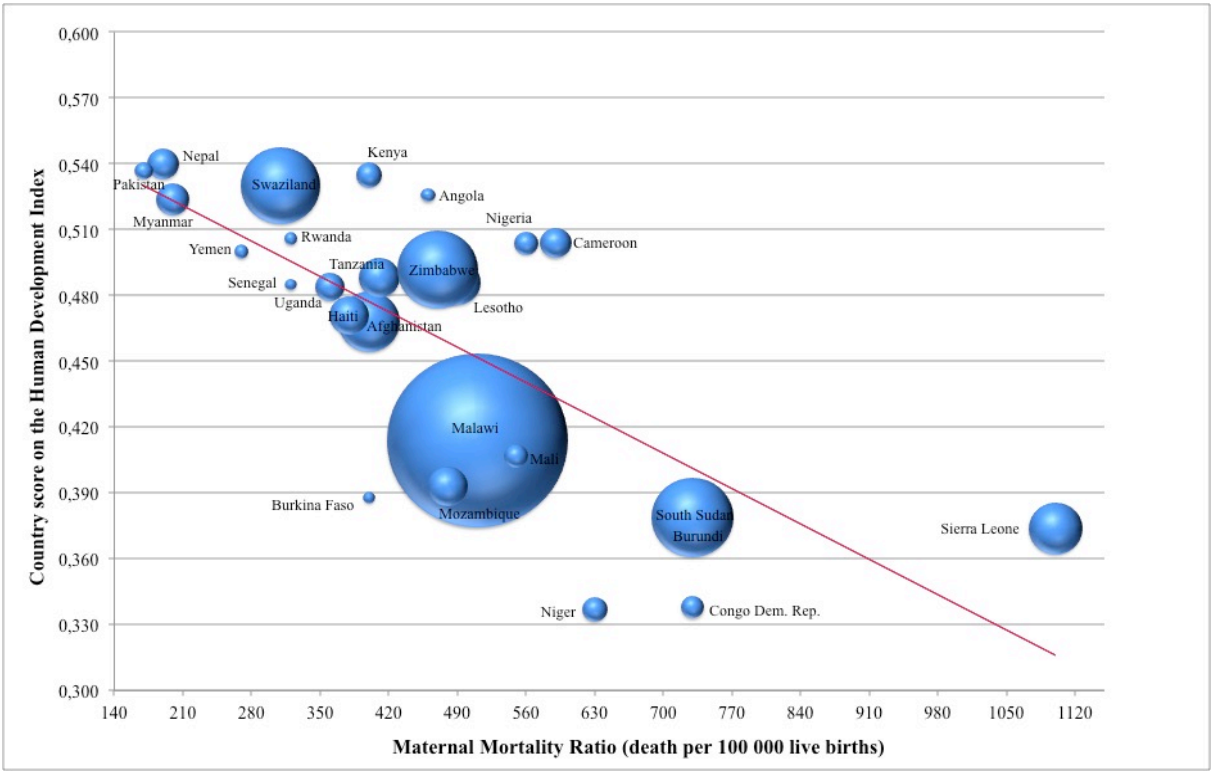


**Figure 2.** Total Norwegian aid allocated to health, donated per capita in 2013.

Bubble size = the amount of health related aid received per capita in 2013.

Of the 36 countries considered as being in the greatest need of health-related aid were a total of 27 countries recipients of Norwegian health-based aid in 2013 (see section 4.4.1, p.27). Figure 2 above illustrates that Norwegian health-related aid contributions were largely concentrated among a few countries. As can be seen, the largest bubbles are concentrated among five countries. Malawi proves to be the far greatest recipient, followed by South Sudan, Zimbabwe, Swaziland, Afghanistan and Sierra Leone. However, compared to Malawi these countries received approximately less than one fifth of the total allocations, measured in US dollar per capita in 2013 (see Appendix 8 B, Table 2.B). Figure 2 also demonstrates that there is an almost linear relationship between a higher Human Development value (relatively to the sample distribution) on the Y-axis and a lower Maternal Mortality Ratio value on the X-axis, while the opposite i.e. a lower HDI value on the Y-axis appears to be contiguous with a higher MMR value on the X-axis. The almost linear pattern between these two predictors supports the argument that those countries with the greatest lack of human development and correspondingly a high level of maternal deaths should be prioritized, while assuming that these countries are the most vulnerable and needy. A rather obscure pattern relates to a country's need of health-aid based on the two predictors and the total amount of aid received (ref. bubble size). Furthermore, this can be exemplified by comparing two countries with

similar rates on both indicators, respectively Malawi (HDI = 0.414, MMR = 510) and Mali (HDI = 0.407, MMR = 550). Malawi received in total 38.9 percent of the total Norwegian health-aid when accounting for the 27 countries in this study, while Mali only received 0.56 percent. However, taking into consideration their population of 16.8 million in Malawi and 15.7 million in Mali and the given predictors it would be reasonable to assume that they would be prioritized equally (World Bank, 2014). Although, while accounting for population figures, Malawi received $2.77 per capita compared to Mali only receiving $0.56 per capita. This forms the basis for assuming that other indicators might be more influential given Norway's priorities.

Furthermore, by looking at the countries that received the greatest percentage proportion of Norwegian health-aid these countries were as already mentioned Malawi 38.9 % (510) followed by Afghanistan 8.5 % (400), Nigeria 6.9% (560), Zimbabwe 6.6 % (470), Tanzania 5.8 % (450), South Sudan 5.4 % (310), Myanmar 4% (200), Pakistan 3.9 % (170), Mozambique 3 % (480) and finally the Democratic Republic of Congo received 2.5 % (730). The numbers in parenthesis illustrates the maternal mortality ratio of 2013. However, these figures provide further reason to conclude that the distribution has been relatively skewed and mainly concentrated in a few countries when considering the percentage amount. In total, these ten countries accounted for as much as 85 percent of the total Norwegian health-related aid allocations. When comparing these ten countries with the top ten countries having the highest maternal mortality ratios an interesting contradiction arises (see Appendix 8 B, Table 3 B). While discovering that five out of ten countries (Chad, Central African Republic, Côte d'Ivoire Guinea and Liberia) that holds the highest maternal mortality ratios did not receive any health-related aid at all. Meanwhile, the remaining five countries (Sierra Leone, South Sudan, Democratic Republic of the Congo, and Niger) together received approximately 12 percent of the total health-related allocations. Sierra Leone compared to the other countries appears as an outlier representing the world's highest MMR, as well as ranging among the countries with the lowest levels of human development. In similar manner, Figure 2 illustrates that Sierra Leone is being the least capable country of utilizing its allocated resources. Arguably, it is important to discover whether such a rough distribution is due to large differences related to population figures, this as the numbers appears to change slightly while accounting for the total distribution *per capita* in 2013.

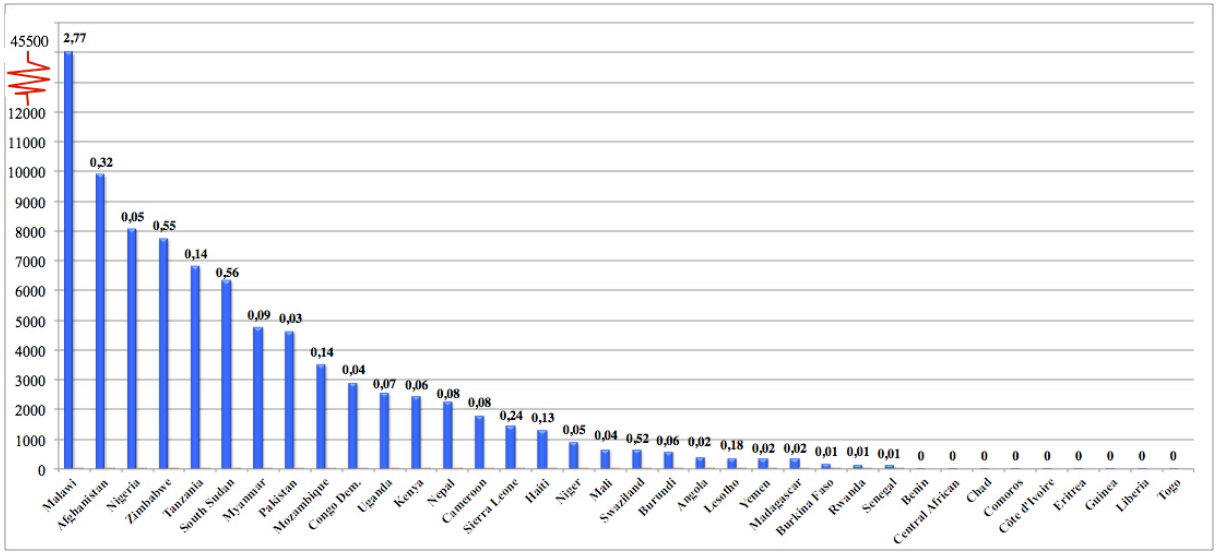


**Figure 3.** Per capita amount of health-related aid received in 2013 by country.

Y = the amount of health related aid received measured in (thousand) US dollar. X = the amount of health related aid received per capita by country.

Figure 3 illustrates Norwegian health-related aid allocations received by the particular least developed countries. The red break on the Y-axis demonstrates the distance between Malawi the greatest recipient of health-based aid, receiving about $45.3 million, and the second greatest recipient country, Afghanistan, receiving $9.8 million. However, Malawi still proves to be the greatest recipient while addressing the total allocations accounting for the per capita measurements receiving $2.77 per head. Arguably, the per capita measurements illustrated in Figure 2 demonstrate a more accurate perspective of the major differences from one recipient vis-à-vis another. The sequence of the greatest recipients has changed as following while controlling for per capita disbursements: Malawi $2.77 (510), South Sudan $0.56 (730), Zimbabwe $0.55 (470), Swaziland $0.52 (310), Afghanistan $0.32 (400), Sierra Leone $0.24 (1100), Lesotho $0.18 (490), Tanzania $0.14 (410), Cameroon $0.08 (590), Nepal $0.08 (190) and Uganda $0.07 (360). These numbers illustrates a negatively shift whereas five countries (Malawi, Afghanistan, Zimbabwe, Tanzania and South Sudan) of those representing the top ten highest maternal mortality ratios received the greatest *percentage* of health related aid, while merely three of these countries (respectively South Sudan, Sierra Leone and Cameroon) are among the greatest aid receiving countries when measuring the greatest per capita amount received. For instance, three of the remaining countries (Burundi, Niger and the Democratic Republic of Congo) received less than $0.06 per capita, while the other five countries (Chad, Central African Republic, Côte d'Ivoire, Guinea and Liberia) were not allocated Norwegian health-based aid in 2013. These numbers call attention to the amount of resources needed in

order to provide a significant amount per head. These results also supports the first hypothesis that there is no evident relationship between least developed countries aid requirements and the amount of aid received, taking into account their MMR and level of human development.

### 5.2 Health-aid linked to LDCs progress towards MDG 5

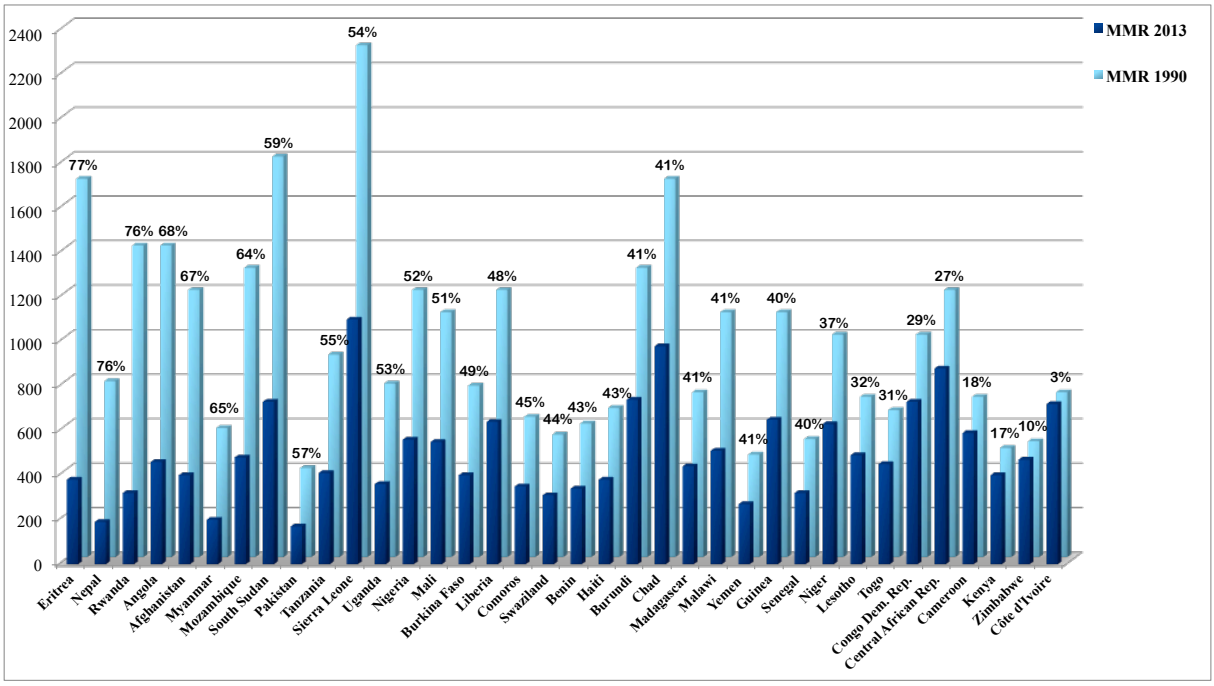


**Figure 4**. Diagram illustrating percentage achieved decline of maternal deaths since the 1990. The Y-axis shows the Maternal Mortality Ratio (death per 100 000 live births) ranking from 0-2400. The percentage on top of each column refers to the estimated decline toward MDG 5 relatively to the 1990 measurements.

Figure 4 illustrates each country's progress towards MDG 5, i.e. a 75-percent decline in maternal mortality rates. The light blue columns indicate the estimated MMR in 1990, while the dark blue bars refer to the estimated MMR in 2013. Looking at these figures helps us to consider whether Norway's strategy of result based funding has led to a prioritization of those countries that have managed to progress the most (WHO 2014:b, pp.36-43).

Meanwhile, repeating greatest recipients (Malawi, South Sudan, Zimbabwe, Swaziland, Afghanistan, Sierra Leone, Lesotho, Tanzania, Cameroon, Nepal and Uganda) these countries illustrate varying percentage decline in accordance to their MMR of 1990. However, with the exception of two countries, Zimbabwe and Cameroon, which represents significantly less progress towards MDG 5, the remaining countries illustrate an average decline of 58.7 percent. Countries not receiving Norwegian health-related aid in 2013 (respectively, Benin,

Central African Republic, Chad, Comoros, Côte d'Ivoire, Eritrea, Guinea, Liberia and Togo), by comparison only illustrate an average decline of 39.4 percent. Although, this group of countries also includes two exceptional countries, as maternal mortality declined in Côte d'Ivoire by only 3 percent, while inversely Eritrea managed to achieve the MDG 5, with a 77 percent decline.

Figure 4 also illustrates another interesting finding; those countries with an MMR below 800 in 1990 prove to be the least progressing countries toward meeting the United Nations MDG 5. However, when focusing on the remaining countries with an MMR between 800 and 2400 in 1990 most countries have managed a decline above 50 percent. Although it should be noted that Sierra Leone representing the worlds highest MMR of 1100, has been making significant progress, despite having an MMR of 2300 in 1990, corresponding to a 54 percent decline. Nevertheless, this study has discovered an evident pattern indicating that Norwegian health aid has been allocated in accordance with the particular countries progress towards achievement of MDG 5.

### 5.3 A significant focus on basic healthcare and infrastructure

This part of the analysis aims to answer whether or not Norway as an bilateral donor of health aid has been adopting strategies that has been proved to be the most effective in order to reduce maternal mortality. Figure 5 illustrates the distribution of health-aid based on the main sub-sectors of implementation.

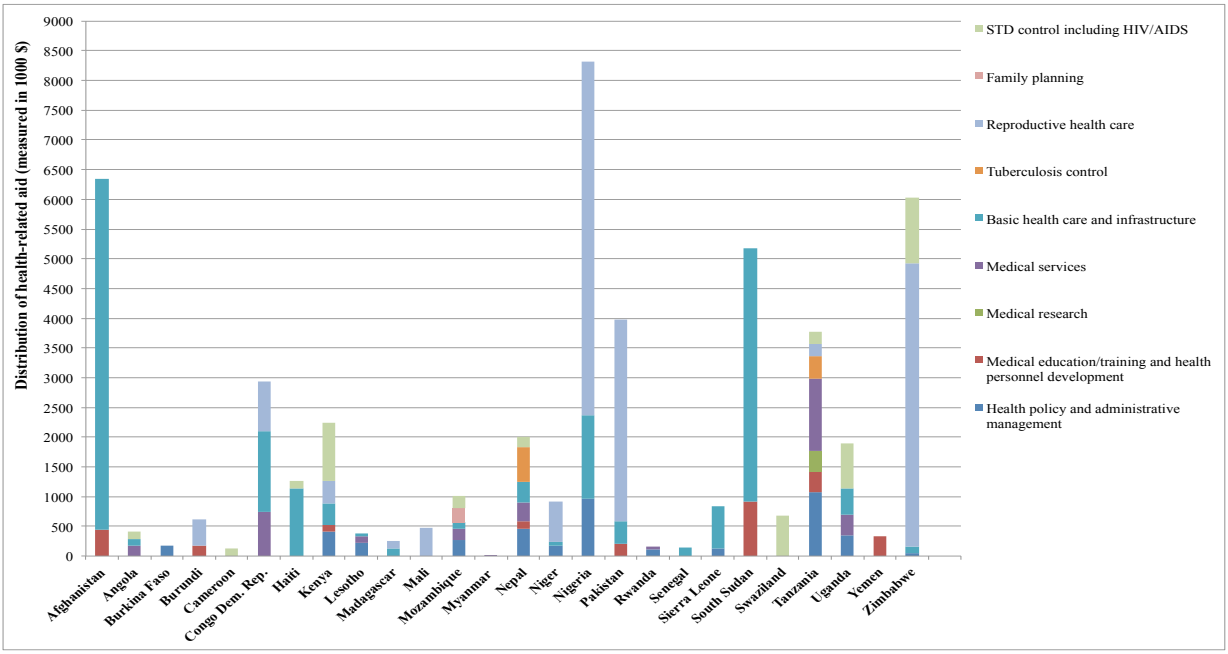


**Figure 5.** Illustrating the distribution of health related aid based on sub-sector, in 2013.

Figure 5 illustrates the 26 countries receiving health aid in order to improve maternal health (see Figure 6 for Malawi). The different colors refer to the share of health-aid that was provided in relation to the particular sub-sectors in 2013. From the figure it becomes clear that three main strategies were implemented significantly more often than the others. *Basic healthcare and infrastructure* proves to constitute the largest share of Norwegian health assistance. This as a majority of these countries have received (despite various) funds allocated to basic healthcare. These allocations were mainly distributes to sanitation, medical support, immunization, nutrition, as well as preventive measures in order to improve the population's health knowledge (see Appendix 8 C. Table 1. C). The second largest sub-sector prioritized concerns *reproductive health care.* Perhaps, one of the most direct measures linked to maternal health improvement (Donnay 2000, p.93). These funds were mainly allocated to the general improvement of accessible health care and services during pregnancy, reduction of post-partum bleeding, as well as to the improvement of sexual and neonatal health. Further, a great amount of resources were also allocated to female genital mutilation in these countries (see Appendix 8 C. Table 1 C). The third greatest sub-sector prioritized concerns STD control (i.e. sexually transmitted diseases) including HIV/AIDS testing and treatment, which is considered as one of the main *indirect* causes of maternal death (Kassebaum 2014, p.983). These funds were also directed towards preventive measures such as improving information and knowledge, as well as increasing access to contraception (see Appendix C. Table 1 C).

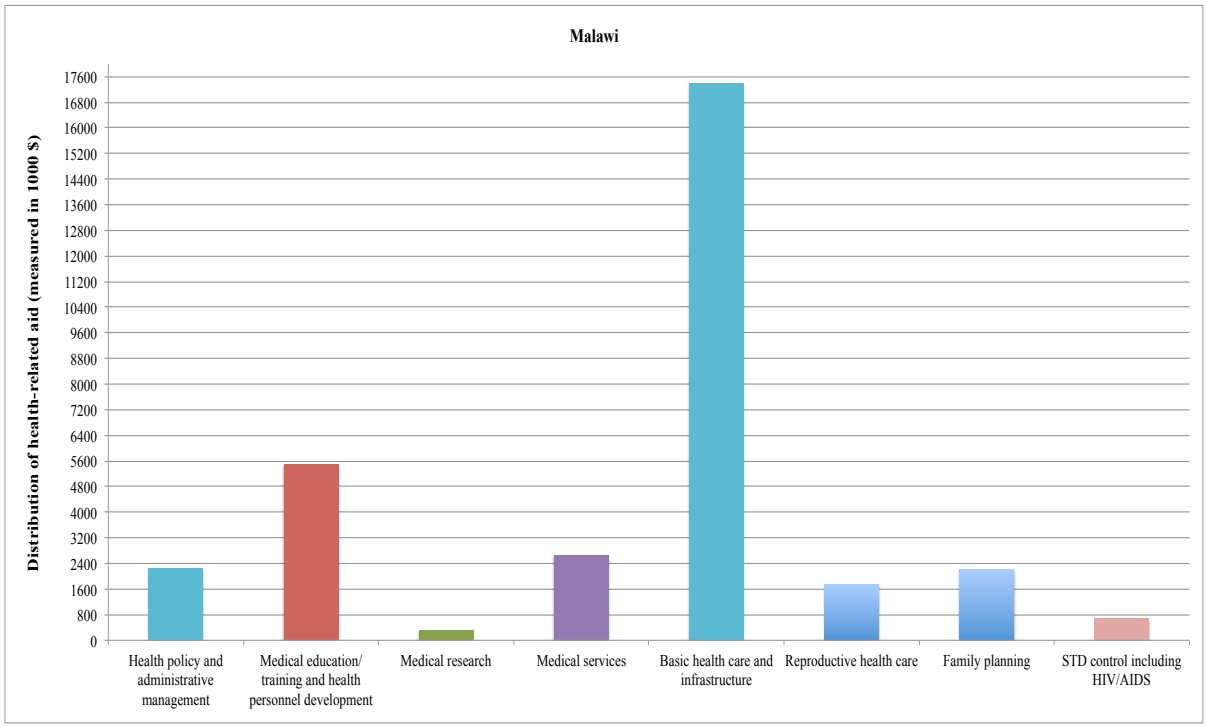


**Figure 6.** Distribution of health aid to Malawi based on sub-sector, in 2013.

Figure 5 also indicates a contradicting distribution pattern, whereas a few countries, in particular Kenya, Mozambique, Nepal, Tanzania, Uganda and Malawi (see figure above) appear to have received a rather equitable distribution of health-aid as the funds were covering most of the sub-sectors related to improvement of maternal health. However, with one exception referring to Malawi, these countries were not among the greatest recipients. This while the greatest recipients mostly received health aid distributed to one or two of the sub-sectors. Again Figure 6 illustrates that Malawi was the only country receiving bilateral health aid within all sub-sectors.

### 5.4 Norway's versus the other DAC members' priorities

This part of the analysis includes a comparison of Norwegian health related aid allocations, compared to the absolute distribution of the other DAC members.[10] This data is considered in order to determine whether Norway can be considered a loophole donor, or alternatively in order to determine Norway tends to follow a similar distribution pattern as other bilateral actors. An equivalent model related to Figure 2 above has been constructed (referring to Appendix 8 A, figure 8.1 A) in order to illustrate the total distribution of health-related aid allocated by the DAC member countries.[11]

A comparison of Norwegian health-related aid *per capita* and the total health allocations per capita of the other DAC members indicates that a similar distribution pattern whereas six of the top ten Norwegian recipients (Malawi, Zimbabwe, Swaziland, Afghanistan, Lesotho and Uganda) also appear as the top ten DAC recipients. This while six of the countries that received least or no health-related assistance from Norway (Chad, Côte d'Ivoire, Guinea, Yemen, Pakistan and Niger) also proved to be among the countries that received least health aid from DAC countries (see Appendix 8 B, Table 2. B for exact figures).

Further, a figure equivalent to Figure 5 illustrates the DAC member's strategies in order to improve maternal health (see Appendix 8 A, Figure 2. A). This figure shows clearly that the same three sub-sectors have been highly prioritized. However, the DAC countries prioritized

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10 The other DAC members constitutes of 29 actors: Australia, Austria, Belgium, Canada, Czech Republic, Denmark, the European Union, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Japan, Korea, Luxemburg, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, United Kingdom and the United States.

11 Figure 9 A is estimated based on the total amount of bilateral aid allocated to health in 2012 being the most recent year available by the OECD statistical database.

STD control including HIV/AIDS treatment above all sectors, whereas a majority of countries received a significant proportion of funds in order to combat sexually transmitting diseases. This followed by similar distribution of resources allocated to basic health care and infrastructure. Meanwhile Norway prioritized the greatest share of health-related aid to reproductive health, the figure shows that the DAC countries allocated a somehow smaller proportion. The remaining sub sectors where rather not prioritized significantly by the DAC countries.

### 5.5 Main findings

This study has discovered that the greatest share of Norwegian health-related aid in 2013 was mainly distributed among a few recipients of those countries representing the highest maternal mortality rates. Simultaneously there were major differences concerning the per capita amount of health-based aid received. In this way, the Norwegian distribution of bilateral health-aid in 2013 can be described as skewed and concentrated. Further evidence seems to indicate that the strategy of result-based proves to cause that those countries in greatest need of health-related aid are being ignored. Moreover, mainly three sub sectors related to maternal health were significantly prioritized, respectively basic health care and infrastructure, reproductive health and STD control including HIV/AIDS treatment. Eventually, this study has discovered that Norway proves to adhere to the DAC practice, this whereas the same strategies and countries have been prioritized in order to improve maternal health. In such manner this study finds no support of concluding that Norway has been acting as a loophole donor. However, these findings will be further discussed in Chapter 6, thus in line with prevailing research and theories.

# 6. Discussion and concluding remarks

This chapter addresses the main results discovered in the previous chapter. First and foremost, I will be discussing the first objective of the research question concerning the main characteristics of Norwegian strategies towards reducing maternal mortality in least developed countries. This mainly by referring to the distribution pattern of health-related commitments donated in 2013. Furthermore, I will provide a rather theoretical view concerning Norway's priorities in order to ensure improved maternal health conditions, by discussing whether Norway could have prioritized differently.

## 6.1 A skewed and concentrated distribution

In the previous chapter (see section 5.1, p.32) it was discovered that the per capita distribution of Norwegian health-aid funds were skewed and mainly concentrated within a few countries, respectively; Malawi, South Sudan, Zimbabwe, Swaziland, Afghanistan, Sierra Leone, Lesotho and Tanzania. Whereas Malawi outlined as the major recipient compared to other recipients by receiving as much as 38.9 percent of the funds allocated to the improvement of maternal health. However there were not fund any evident relation between greater health-aid resources and a higher level of maternal deaths. Nevertheless, this study has discovered that five of the countries that are in the greatest need, while holding the highest MMR, respectively Chad, Central African Republic, Côte d'Ivoire, Guinea and Liberia were not receiving any health-aid from Norway at all in 2013. These findings give further reason to discuss health inequality in accordance with the Norwegian effort towards improving maternal health. First and foremost, these findings are in line with Tudor-Harts development theory (see Chapter 3, section 3.1, pp.17-18) the *Inverse Care Law*, which in particular is based on the principal that "the availability of good medical and social care tends to vary inversely with the need of the population served" (1971, p.405). This despite that those in the greatest need of health care are less likely to receive it. Tudor-Harts theory explains the status quo related to maternal health, whereas MDG 5 remains the least successful of the eight Millennium Development Goals to be achieved within 2015. This paradox has received broad attention in relation to attaining an international effort towards improving maternal health. Several recent studies (Filippi et al. 2006; Deleye & Lang 2014; Thomsen et al. 2011; and Riddell 2007) provides attention to the lack of resources devoted to the most needy and vulnerable LDCs in relation to their remarkably high maternal death rates.

This lack of resources in order to improve maternal health in the most affected countries gives further reason questioning health inequality in terms of the distribution of development aid in order to promote maternal health. However, as emphasized throughout this paper there is an increased need for donors such as Norway to ensure health equity, while it is not possible to achieve progress without prioritizing the most vulnerable and needy countries. Similar to previous research also this study finds a lack of health equality linked to the distribution of health-aid resources. Thomsen et al. (2011) argues that a utilitarian approach towards the MDG 5 has caused an overall focus were donor countries aims to have the greatest impact possible with the least amount of resources. Their argument directly relates to a secondary objective of this study concerning the structure of implementation linked to the distribution of resources in order to improve maternal health to the most vulnerable and needy populations. Simultaneously whether health efficiency and health outcomes tends to be overestimated.

### *6.1.1 A conditionally approach of results-based health aid*

In the Norwegian White Paper No. 40 (2008-2009), 2009, p.13) the government conveys that development aid should be based on "the international principles of *humanity*, *neutrality* and *independence*". However, this study argues that these principles have been somewhat set aside as a result of an increased international pressure of attaining efficiency within health-aid. However, as already mentioned has Norway in line with other health-aid donors implemented result-based aid funding as an implementation structure in accordance with the increased pressure concerning aid efficiency within the health sector. Although, RBF as a structure has been criticized while not favoring those countries that is not able to attain progress towards sustainable development. This despite that this strategy has been considered advantageous in terms of health-aid funding it can also be considered as a strategy that benefits those countries being able to achieve results, while less sufficient countries would not be prioritized to the same extent (Klingebiel & Janus, 2014).

In Chapter 5 (see section 5.2) it was fund that *those countries receiving a significant proportion of Norwegian health aid proves to have attained greater progress toward MDG 5, compared with those countries that were not allocated health-aid.* This finding supports the argument throughout this thesis while assuming that Norway's commitment to results-based aid funding causes that least developed countries receives least aid. Thus, it should be taken into consideration that such an interpretation is not explanatory for all countries within the sample distribution, considering that Malawi received the largest share of funds related to

maternal health improvements, while Chad did not receive any funds at all, both countries have reduced their MMR with 41 percent due to the 1990 estimates. However, Norway's experience with RBF a structure of aid distribution linked to maternal health improvements still remains lacking. Although it should be mentioned that Malawi reported the lowest average percentage of women's self reported poor health in Witvliet et al. study (2013). Which perhaps could be a result of increased health-aid in terms of improving maternal health. Meanwhile, in the case of Malawi, the Norwegian Agency of Development Cooperation (Norad, 2014 translated from Norwegian) reports that taken into consideration that

> *The pilot project is at an early stage it is too early to report on results, the collaboration on results-based funding for maternal and child health are already showing signs of being able to offset great importance for the reduction of maternal mortality in Malawi.*

Norad's preliminary assessment of health-aid related to maternal health improvements in Malawi provides further reason to demand evaluations on such bilateral health funds in order to find whether result-based aid tends to increase the efficiency of improved maternal health and a faster decline towards MDG 5.

However, such implementation of result-based funding in the health sector can further be understood through a conditionality approach. This as the implementation of health-aid due to improvement of maternal aid is a result of *ex ante* conditionality, meaning that a country needs to fulfill certain conditions in order to receive health aid. Thus the Norwegian White Paper No. 40 (2008-2009), 2009) also refers to economic policies, good governance and investment in the population, as the most favorable conditions in terms of contributing and promoting development in the countries that are most effective in utilizing their funds towards sustainable maternal health (2004, p.114). These criteria relates directly to the main perks of adopting a result-based structure. Although it should be taken into consideration that these criteria perhaps would be more effective in relation to resolve countries out of poverty and secure development due to improvements in other in contexts rather than those related to health, and specifically the improvement of maternal health. Seemingly, Olsen (2012, p.11) argues based upon an evaluation of result-based aid in five developing countries that it has yet not been possible to document more rapid or increased development in accordance with the MDG initiative. In such matter, this study suggests that health-aid in order to improve health

and more precisely maternal health should be based upon indicators directly related to each country's need of aid e.g. MMR, in terms of reducing its maternal death rates. This regardless of other processes or objectives related to sustainable development.

### 6.2 Most implemented strategies

In Chapter 5 (see section 5.3) it was fund that Norway in particular has prioritized three sectors in order to improve maternal health. *Basic health care and infrastructure* constituted the far greatest share of Norwegian health-aid. Although, it should be taken into consideration that this sub-sector involves health improvements and services beyond measures aimed at maternal health. Although, basic health in terms of sanitation, health control, immunization and nutrition covers important as well as preventive healthcare.

Furthermore reproductive healthcare where highly prioritized in most of the countries this while relating to preventive measures, genital mutilation, immunization as well as treatment of sexually transmitted diseases. These priorities has been further emphasized in the White Paper No. 11 (2011-2012), 2012, p.16) by conveying that "legislation on reproductive health must safeguard women's right to contraception, provide protection against early marriage, violence and female genital mutilation, and establish the right to safe abortions." Such preventive measures have also been highly addressed as one of the most effective strategies towards improving maternal health (Bullough et al. 2005; Donnay 2000). However, the great amount of resources devoted to reproductive healthcare proves that Norway has prioritized this strategy in accordance with the expectations put forward in the White Paper. Indeed, the substantial focus on reproductive health corresponded largely with UN prioritization of addressing reproductive health as a separate underlying objective related to MDG 5. Eventually, STD control including HIV/AIDS testing and treatment were also one of the most prioritized sub-sectors in 2013. Even though HIV has been addressed as an indirect cause of maternal death (Khan et al. 2006, p.1068), i.e. causes that could complicate or aggravate maternal health based upon other causes, however this thesis has primarily focused on the direct causes related to maternal mortality. Although, as addressed in Chapter 2 (see section 2.2.1, p.13) a previous research have conveyed that HIV constitutes to approximately as much as 6 percent of maternal deaths in Africa (Khan et al. 2006, p.1072). Seemingly, Sub-Saharan Africa constitutes the highest total percentage of HIV infections in the world, corresponding to 70 percent (Avert 2014). Thus HIV/AIDS also constitutes a greater threat to maternal health in those countries included in this study.

However, the distribution of resources when accounting to all sub-sectors (see Figure 1, section 5.3) tends to vary significantly among the recipient countries. While only thee countries (Tanzania, Nepal and Malawi) have received resources in all sub-sectors. Nevertheless, this study cannot find whether this varying distribution of resources relates to the recipients need within these sectors, or whether it remains a cause of the overall strategy to focus on particular sub-sectors. However, another interesting funding refers the lack of resources assigned to medical services and medical research in most countries, which perhaps should be prioritized further in the future.

### 6.3 Norway adheres to the DAC members' practice

As stated in Chapter 5, this study finds no evidence arguing that Norway has prioritized those countries that have received least resources from other donors. Rather this study fund evidence supporting that Norway *adheres* to the DAC members' strategies. The link between Norway's and the other DAC members strategies and appropriations can possibly be attributed by some commonalities. Arguably, it is reasonable to assume that Norway's membership in the OECD/DAC is a crucial explanation considering that Norway has recognized to act according to a joint international cooperation structure based on common agreements, standards and recommendations through its membership.

Although Norway seems to follow the other DAC members' priorities, there are two exceptions. Firstly, South Sudan was the second greatest recipient of Norwegian health-related aid in 2013, while remaining as the twelfth greatest recipient of health-related aid from the DAC countries. Secondly, Haiti was the greatest recipient of health related aid from the DAC countries in 2012. However, Norway has developed close relations with South Sudan (and former Sudan) through development projects mainly provided by Norwegian People's Aid and Norwegian Church Aid projects during the past half century. Such long-term involvement might explain increased disbursements to some countries and the complexity of reducing or withdraw aid. Although in the case of Haiti, it should be taken into consideration that the country was affected by several natural disasters during 2012, referring to among others the tropical storm Isaac and hurricane Sandy. Health related aid provided under such circumstances often rather relates to short-term emergency improvements (humanitarian aid) rather than long-term health improvements (development aid) such as MDG 5. Nevertheless, these findings reject the assumption concerning whether or Norway tends to be a loophole actor compared to the other DAC countries.

### 6.4 Could Norway have prioritized differently?

Priorities' concerning aid policies and resources often remains quite complex, especially in terms of long-term development projects such as the Millennium Development Program. This as there is always a desire to achieve improvement, accordingly as a lot of resources are being committed during the process. In terms of the global initiative towards reducing maternal mortality several studies have concluded that there have been an overall lacking effort towards attaining a 75 percent decline (Barot 2012; Filippi et al. 2006). The Norwegian effort that is emphasized in White Paper No. 11 (2011-2012, 2012, p.17) provides attention to maternal mortality, as being among the government's main priorities, as it conveys

> *MDG 5, «Improve Maternal Health», is the goal which is furthest from attainment by 2015. In the run-up to the UN summit on the MDGs in 2010, the UN Secretary-General launched the Global Strategy for Women's and Children's Health in order to increase focus on MDGs 4 and 5. The strategy concurs with the Norwegian emphasis on women's and children's health, and will provide a guideline for Norwegian priorities in the years to come.*

According to the following statement Norway gives attention to the less sufficient progress towards MDG 5, while simultaneously expressing maternal health as a main priority. A recent debate brought attention to this complex pattern while pointing at Norway's principles and self-interest in accordance with the possible recipient's need for assistance. In such relation did the Norwegian doctor and former director of the neutral and independent aid organization Medicines Sans Frontiers (MSF), Atle Fretheim contribute by emphasizing the importance of providing assistance where the need is greatest. In such manner, he pointed at an important issue in an article published in the Norwegian newspaper Aftenposten (2013):

> *First it is conspicuous that some of the world's worst humanitarian crises are not receiving help, or receive only imperceptible amounts of aid. In Chad, every fifth child is malnourished before birth. There are 500 medical doctors dispersed on 12 million people in the country, and the highest maternal mortality is found here. Norway's direct humanitarian aid given to Chad in 2012? None.*

Fretheim makes a good point by his statement, as of 2013 were Chad rated as the country with the second highest maternal mortality rate (see Appendix 8 B, Table 3 B), still without receiving any health-aid at all. Fretheim is concluding that if only need would determine the distribution of Norwegian humanitarian funds today, then should not Chad has been forgotten. He also concludes that political interests rather than human needs motivate Norwegian aid

policy. However, Chad together with the Central African Republic, Côte d'Ivoire, Guinea and Liberia still remains examples of countries that should receive health-aid in order to improve maternal health, whereas these five countries have some of the highest MMR, as well as lacking prevalence of contraception and skilled birth attendance (see Appendix 8 B, Table 3 B). These are measures that need to be improved in order to comply with the Norwegian strategy put forward in White Paper No. 11 (2011-2012), 2012, p.17) which reads as follows; "the strategy focuses on the most vulnerable groups, such as pregnant women, newborn babies and young people (…) in the 49 poorest countries. Norway played a part in developing the strategy, and following it up will be one of the Government's priorities."

Although, this study does not find any obvious relation that can explain the pattern of countries being prioritized it is therefore reasonable to assume that the recently implemented strategy of result-based aid funding has led to increased aid to countries that has been progressing development, and seemingly decrease the aid to countries with insufficient progress, this in order to increase the measured effectiveness of health-related aid.

*Complexity of development aid*

When discussing how donor countries could have prioritized their commitments differently it should be emphasized that development aid in terms of promoting health improvements such as the MDG 5 appears very difficult and complex. Considered that most of the countries that are receiving such aid often are affected by unstable conditions such as conflicts, corruption or other situations that could prevent donors from providing aid. In the recently published book *Norway in Sudan – On the Bottom of the Sun* (tittle translated from Norwegian) the author and journalist Bibiana Dahle Piene (2014) reflects on difficulties and challenges that has been influencing Norwegian development and health aid in Sudan. Stories about sabotage, refused entrance, kidnapping and killing of aid workers are among the challenges and the accidents that constitute the history of Norway in Sudan.

### 6.5 Conclusion

Initially, I presented the following research question: *What characterizes Norwegian health-aid strategies towards reducing maternal mortality in the world's least developed countries? Could Norway have prioritized differently in order to improve maternal health in 2013?* Furthermore, a secondary objective in answering these questions aimed to answer whether or not Norway could be considered a loophole donor compared to the other DAC members.

Summing up then, this study has fund that a greater share of Norwegian health-aid targeting to improve maternal health in 2013 were predominantly concentrated among a few recipients, with some relatively large differences in the per capita amount received. This when accounting for health-aid provided to LDCs representing the highest incidence of maternal mortality. Of the 27 recipients did Malawi outlined as the superior recipient, while receiving 38.9 percent of these funds equivalent $2.77 per capita. Seemingly it was also discovered that several of the most affected countries were actually receiving a minor portion of the total amount of health-aid allocated to combat maternal mortality, while five of these countries did not receive any health-aid at all. Accordingly, it was fund that a greater proportion of health-aid was provided to those countries that have managed to attain greater decline towards achievement of the United Nations MDG 5. Moreover, predominately three sub-sectors of reducing maternal deaths where prioritized, respectively basic health care, reproductive health and sexual transmitted diseases including HIV/AIDS. In terms of the second objective related to the research question it was fund that Norway does not seem to behave as a loophole actor, but inversely it was rather fund that Norway adheres to the other DAC members' practice and strategies towards reducing maternal mortality.

Furthermore, this study has been focusing on result-based funding as the overall strategy and structure when determining the distribution of Norwegian health-aid in 2013, this in terms of reducing maternal mortality in the worlds least developed countries. By considering the major differences related to health-aid allocated to the countries within this analysis, this study provides further reason to conclude that there are indications that result-based funding appears to lead to inequality rather than health equality. This is in conjunction with previous studies (Filippi et al. 2006; Barot, 2011), among others Thomsen et al. (2011, p.177) also finds that lack of equality constitutes one of the greatest issues linked to the slow progress towards MDG 5. Seemingly this distribution pattern provides further reason to strengthen the first hypothesis put forward at the beginning of this thesis: *there is no evident relationship between least developed countries health-aid requirements and the amount received*. These findings are in the line with Tudor-Harts (1971, p.405) theory the Inverse Care Law indicating "the availability of good medical and social care tends to vary inversely with the need of the population served". This despite that those in the greatest need of healthcare are less likely to receive it. In accordance with previous research and literature, this study finds that this issue remains status quo.

Furthermore, another theoretical perspective concerning this issue has been addressed in order to provide further understanding of this strategy of project implementation this through a theoretical perspective by adopting a *conditionality approach*, this whereas health-aid is needed most in those countries that is not able to utilize it well. This while *ex-ante* conditionality has inversely led to that those countries that achieve progress towards sustainable development or pre-defined goals such as the MDGs are being prioritized. Moreover, the distribution pattern of Norwegian health-aid related to maternal health improvements fund in this paper, supplemented with the theory concerning aid conditionality strengthen the second hypothesis put forward in this study; *Norway's commitment to results-based aid causes that those countries with the greatest need of health-aid receives the least*.

Eventually, the second research question concerning whether or not Norway could have prioritized differently were particulary evaluated based on the countries need of health-aid predicted by their maternal death rates. In such matters, based upon the lack of resources provided to some of those countries with the highest maternal death rates, this study suggests that future health-aid allocations ought to include these countries, respectively; Chad, Central African Republic, Côte d'Ivoire Guinea and Liberia. Nevertheless, this study concludes that Norway has prioritized in accordance with those strategies and priorities put forward in the White Paper No.11 (2011-2012), 2012, pp.17-19), in particular strengthen women's access to basic healthcare, promote sexual-and reproductive health and family planning. Moreover, the White Paper addresses in particular the poorest countries among their prioritized recipients, although this study suggests that first and foremost health indicators concerning maternal death rates and human development should be prioritized coincidently with economic indicators measuring poverty in order to ensure a greater effort towards MDG 5. Indeed, these indicators should be included in the foreign policy assessment regarding the allocation of future health-aid linked to improvement of maternal health.

### *6.5.1 Suggestions for further research*

This thesis has emphasized the lack of donor-evaluations, and additional updated data concerning maternal health and reproductive health, such information remains essential in order to evaluate and reveal the most effective strategies of improving maternal health in the most affected countries. For that reason this study suggests that further research should continue to focus on the development of corresponding data. Furthermore, this study has revealed some findings that form the basis for future research. First and foremost, it would be

interesting to provide more attention to the bilateral relationship between Norway and Malawi, this in order to discover why Norway has prioritized such a large share of health-aid targeting to improve maternal health in particular one country? And furthermore there is need for further research concerning whether result-based aid in terms of improving maternal health requires more centered resources of full implementation within the particular health sub-sectors?

## 7. Bibliography


Ahmed, S. Creanga, AA. Gillespie, DG. & Tsui, AO. (2010). 'Economic Status, Education and Empowerment: Implications for Maternal Health Service Utilization in Developing Countries', *Journal Article PLoS One,* vol. 5, issue 6, pp.1-5.

Alesina, A. & Dollar, D. (2000). 'Who Gives Foreign Aid to Whom and Why?' *Journal of Economic Growth,* vol. 5, issue 1, pp.33-63.

Anand, S. & Sen, A. (2000). 'Human Development and Economic Sustainability', *World Development*, vol. 28, no. 12, pp.2029-2049.

Avert, (2014). *HIV and AIDS in Sub-Saharan Africa*. Available from: <http://www.avert.org/hiv-aids-sub-saharan-africa.htm>. [13 January 2015].

Barot, S. (2011). 'Unsafe Abortion: The Missing Link in Global Efforts to Improve Maternal Health', *Guttmacher policy Review,* vol. 14, no. 2, pp.24-28.

Beaglehole, R. & Benita, R. (2009). *Global Health: A New Era*, 2nd edition, Oxford University Press: New York. Available from: Google Books. [28 November 2014].

Bryman, A. (1996). *Quantity and Quality in Social Research.* London: Routledge.

Bullough, C. Meda, N. Makowiecka, K. Ronsmans, C. Achadi, EL. & Hussein, J. (2005). 'Current strategies for the reduction of maternal mortality'. *International Journal of Obstetrics and Gynaecology,* vol. 112, issue 9, pp.1180-1188.

Campbell, OMR. & Graham, WJ. (2006). 'Strategies for reducing maternal mortality: getting on with what works', *The Lancet*, vol. 368, no.2, pp.1284-1299.

Central Intelligence Agency (2013). *The World Factbook -Total Fertility Rate*. Available from: <https://www.cia.gov/library/publications/the-world-factbook/fields/2127.html>. [30 September 2014].

Crawford, G. (2007). 'Foreign Aid and Political Conditionality: Issues of Effectiveness and Consistency', *Democratization,* vol. 4, no. 3, pp.69-108.

Currie-Alder, B. Kanbur, R. Malone, DM. & Medhora, R. (2014). *International Development Ideas, Experience and Prospects*. Oxford University Press: United Kingdom. Available from: Google Books. [28 November 2014].

Deleye, C. & Lang, A. (2014). 'Maternal health development programs: comparing priorities of bilateral and private donors', *BMC International Health and Human Rights,* vol. 14, issue 31, pp.1-11.

Donnay, F. (2000). 'Maternal survival in developing countries: what has been done, what can be achieved in the next decade', *International Journal of Gynecology & Obstetrics*, vol. 70, issue 1, pp.89-97.

Exchange Rates UK (2013). *US Dollar (USD) to Norwegian Krone (NOK) exchange rate history*. Available from: <http://www.exchangerates.org.uk/USD-NOK-exchange-rate-history.html>. [3 October 2014].

Filippi, V. Ronsmans, C. Campbell, OMR. Graham, WJ. Mills, A. Borghi, J. Koblinsky, M. & Osrin, D. (2006). 'Maternal health in poor countries: the broader context and a call for action', *The Lancet*, vol. 368, issue 9546, pp.1535-1541.

Foster-Rosales, A (2010). 'Maternal Mortality: The Eye of the Storm' in P Murthy & CL Smith (eds) *Women's Global Health And Human Rights.* John and Bartlett Publishers, Sudbury, Massachusetts, pp. 279-285.

Fretheim, A. (2013). 'Der nøden er størst?' *Aftenposten*. Available from: <http://www.aftenposten.no/meninger/kronikker/Der-noden-er-storst-7404602.html>. [23 November 2014].

Gates, S. & Hoeffler, A. (2004). 'Global Aid Allocation: Are Nordic Donors Different?' Centre for the Study of Civil War, PRIO and the Norwegian University of Technology

Gasser, NA. Dresden, E. Keeney, GB. & Warren, N. (2004). 'Status of Women and Infants in Complex Humanitarian Emergencies', *Journal of Midwifery & Women's Health*, vol. 49, no. 4, pp.7-13.

Grittner, AM. (2013).'Results-Based Financing: Evidence from Performance-Based Financing in the Health Sector', *German Development Institute*. Discussion Paper 6/2013, pp.1-49.

Haffeld, J. (2013). 'Sustainable development goals for global health: facilitating good governance in a complex environment', *Reproductive Health Matters,* vol. 21, no. 42, pp.43-49.

Hagan, MC. Foreman, KJ. Naghavi, M. Ahn, SY. Makela, SM. Lopez, AD. Lozano, R. & Murray, CJL. (2010). 'Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5', *The Lancet*, vol. 375, no. 9726, pp.1609-1623.

Hart, JT. (1971). 'The Inverse Care Law', *The Lancet*, vol. 1, no. 7696, pp.405–412.

Hildenwall, V. Sjöberg, P. & Öbrand, IW. (2008). 'Challenges, opportunities and approaches for increasing joint donor programming of evaluations', Swedish Agency for Development Evaluations, pp.1-23.

Hilson, M. (2005). 'Advocacy for a new global health development paradigm: building alliances for global public health', *Global Health Promotion*, vol. 12, no. 3, pp.65-67.

Humanitarian Coalition, (2014). *Humanitarian and development aid.* Available from: <http://humanitariancoalition.ca/info-portal/factsheets/humanitarian-and-development-aid>. [23 November 2014].

Johannessen, B. & Leraand, D. (2014). *Utviklingssamarbeid*. Store Norske Leksikon. Available from: <https://snl.no/utviklingssamarbeid>. [9 December 2014].

Kassebaum, NJ. (2014). 'Global, regional, and national levels and causes of maternal mortality during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013', *The Lancet,* vol. 384, no. 9947, pp.980-1004.

Khan, KS. Wojdyla, D. Say, L. Gülmezoglu, AM. & Van Look, PFA. (2006). 'WHO analysis of causes of maternal death: a systematic review', *The Lancet,* vol. 2, no.6, pp.1066-11074.

Klingebiel, S. (2012).'Results-Based Aid (RBA): New aid approaches, limitations, and the application to promote good governance', *German Development Institute*, Discussion Paper 14/2012, pp.1-35.

Klingebiel, S. & Janus, H. (2014). 'Results-Based Aid: Potential and Limits of an Innovative Modality in Development Cooperation', *International Development Policy*, No. 6.

Lovdata, (2013). *Instruks for Direktoratet for utviklingssamarbeid (Norad)*. Available from: <https://lovdata.no/dokument/INS/forskrift/2013-12-13-1498#§7>. [11 December 2014].

Ministry of Foreign Affairs, (2013). *Proposal for Parliamentary Decision*. Available from: <http://www.regjeringen.no/nb/dep/ud/dok/regpubl/prop/2013-2014/prop-1-s-20132014-.html?id=741609>. [23 November 2014].

Ministry of Foreign Affairs, (2014). *Utenriksdepartementets Tilskuddsportal.* Available from: <http://udtilskudd.regjeringen.no/#/nb/country/details?sectorGroup=6&year=2014>. [5 October 2014].

Neumayer, E. (2003), *The Pattern of Aid Giving. The impact of good governance on development assistance*. London: Routledge Tyler & Francis Group.

Norad, (2011). *Resultatbasert finansiering innenfor helse (RBF)*. Available from: <http://www.norad.no/no/tema/helse/helsesystem/resultatbasert-finansiering>. [25 November 2014].

Norad, (2012). *Bistand i helsesektoren*. Available from: Accessed from: <http://www.norad.no/no/tema/helse/helsesystem/bilateralt-helsesamarbeid>. [25 November 2014].

Norad, (2013:a). *Oppfølgingen av bistandsmidler til helsesektoren I Malawi må forbedres*. Available from: <http://www.norad.no/no/aktuelt/nyheter/norsk-helsebistand-til-malawi-er-revidert>. [31 October 2014].

Norad, (2013:b). *Hvor gikk pengene i 2013?*. Available from: <http://www.norad.no/no/aktuelt/nyheter/hvor-gikk-pengene-i-2013>. [28 September 2014].

Norad, (2013:c). *Norwegian aid geographically allocated in 2013*. Available from: <http://www.norad.no/no/om-bistand/norsk-bistand-i-tall>. [13 October 2014].

Norad, (2014). *Malawi*. Available from: <http://www.norad.no/no/om-bistand/landsider/afrika/malawi>. [28 December 2014].

Norwegian Department of Foreign Ministry (2014). *Nærmere tre milliarder kroner til global helse*. Available from: <http://www.regjeringen.no/nb/dep/ud/pressesenter/pressemeldinger/2014/pm_globalhelse.html?id=770734>. [12 October 2014].

Olsen, IT. (2012). 'Erfaringer med resultatbasert finansiering i helsektoren i lav- og mellominntektsland', *Department of Health at the Norwegian Agency for Development Cooperation*, pp.3-12.

Pattinson, R. Say, L. Souza, JP. Van den Broek, N. & Rooney, C. (2009). 'WHO maternal death and near-miss classifications', *Bulletin of the World Health Organization*, vol. 87, no. 10, pp.733-804

Payne, G. & Payne, J. (2004). *Key Concepts in Social Research,* London, England: SAGE Publications. Available from: SAGE Journals. [2 November 2014].

Riddell, RC. (2007). *Aid architecture and aid effectiveness - challenges to Norway*. Available from: <http://www.regjeringen.no/nb/dep/ud/kampanjer/refleks/innspill/engasjement/riddell.html?id=493359>.[6 October 2014].

Ringdal, K. (2012). *Enhet og mangfold: samfunnsvitenskapelig forskning og kvantitativ metode*, 3rd edition, Bergen: Fagbokforlag.

Rose, J. O'Keefe, P. Jayawickrama, J. & O'Brien, G. (2012). 'The challenge of humanitarian aid: an overview', *Environmental Hazards*, vol. 12, no. 1, pp.74-92.

Sedgh, G. Singh, S. & Hussain, R. (2014). 'Intended and Unintended Pregnancies Worldwide in 2012 and Recent Trends', *Studies in Family Planning*, vol. 45, issue 3, pp.301-314.

Selbervik H (2003). *Power of the Purse? Norway as a donor in the conditionality epoch 1980-2000*. PhD Thesis, University of Bergen.

Singh, A. (2002). 'Aid, Conditionality and Development', *Development and Change,* vol. 33, no. 2, pp.295-305.

Stokke, O. (1995). *Aid and Conditionality.* In association with The European Association of Development Research and Training Institutes (EADI), Frank Class, London.

Thomsen, S. Phong Hoa, DT. Målqvist, M. Sanneving, L. Saxena, D. Tana, S. Yuan, B. & Byass, P. (2011). 'Promoting equity to achieve maternal and child health', *Reproductive Health Matters,* vol. 19, issue 39, pp.176-182.

Tjora, A. (2010). *Kvalitative forskningsmetoder i praksis.* Norway, Oslo: Gyldendal.

Tvedt, T. (2007). *Utviklingshjelp, Utenrikspolitikk og Makt – Den norske modellen*. Oslo: Gyldendal Akademisk.

Tvedt, T. (2009). 'International Development Aid and Its Impact on a Donor Country: A Case Study of Norway', *The European Journal of Development Research,* vol. 19, no. 4, pp.614-635.

United Nations, (2013). *The Millennium Development Goals Report 2013*. New York: United Nations. Available from: <http://www.un.org/millenniumgoals/pdf/report-2013/mdg-report-2013-english.pdf>. [2 October 2014].

United Nations, (2014). *Development Aid at Highest Level Ever in 2013*. Available from: <http://esango.un.org/ldcportal/development/news/-/blogs/development-aid-at-highest-level-ever-in-2013>. [15 January 2015].

UNDP (2014:a). *Human Development Index 2013*. Available from: <http://hdr.undp.org/en/content/human-development-index-hdi>. [2 November 2014].

UNDP (2014:b) *Human Development Report.* New York: United Nations Development Program.

UNEG (2012). 'Professional Peer Review of the Evaluation Function UN-Habitat'. United Nations Evaluation Group. Available form: <http://unhabitat.org/90686/>. [2 December 2014].

UNFPA (2014). A Universal Pathway. A Woman's Right to Health. New York: United Nations Population Fund.

USAID (2010). *DHS Survey Indicators: Maternal and Child Health.* Available from: <http://dhsprogram.com/data/DHS-Survey-Indicators-Maternal-and-Child-Health.cfm>. [2 September 2014].

Waage, J. Banerji, R. Campbell, O. Chirwa, E. Collender, G. Dieltiens, V. Dorward, A. Godfrey-Faussett, P. Hanvoravongchai, P. Kingdon, G. Little, A. Mills, A. Mulholland, K. Mwinga, A. North, A. Patcharanarumol, W. Poulton, C. Tangcharoensathien, V. & Unterhalter, E. (2010).'The Millennium Development Goals: a cross-sectoral analysis and principles for goal setting after 2015', *The Lancet*, vol. 376, issue 9745, pp.991-1023.

Walliman, N. (2006). *Social Research Methods.* London, England: SAGE Publications. Available from: SAGE Journals. [2 November 2014].

White Paper No. 11 (2011-2012). (2012). *Global health in foreign and development policy*. Oslo: Ministry of Foreign Affairs.

White Paper No. 29 (1971-1972). (1972). *Om enkelte hovedspørsmål vedrørende Norges samarbeid med utviklingslandene*. Oslo: Ministry of Foreign Affairs.

White Paper No. 35 (2003-2004). (2004). *Fighting poverty a comprehensive development policy.* Oslo: Ministry of Foreign Affairs.

White Paper No. 40 (2008-2009), (2009). *Norwegian humanitarian policy.* Oslo: Ministry of Foreign Affairs.

Windheim, I. (2012). *Global helse – både en menneskerett og utenrikspolitikk.* Norwegian Foreign Policy Institute. Available from: <http://hvorhenderdet.nupi.no/content/download/367088/1249545/version/4/file/HHD11_GlobalHelse.pdf>. [2 October 2014].

Witvliet, MI. Arah, OA. Stronks, K & Kunst, AE. (2013). 'A Global Study on Lone Mothers' in *Can Your Country Make You Sick?* Multi-level Explorations of Populations Health and Human Rights in a Global Perspective. Amsterdam: Uitgeverij BOXPress.

World Bank, (2013). *World Bank, Global Fund, Partner to Expand Results-Based Financing for Maternal and Child Health.* Available from: <http://www.worldbank.org/en/news/press-release/2013/12/11/world-bank-global-fund-results-based-financing-maternal-child-health>. [14 January 2015].

World Bank, (2014*). Population, in total 2013*. Available from: <http://data.worldbank.org/indicator/SP.POP.TOTL>. [5 November 2014].

WHO (2004). *Health statistics and information systems: WHO World Health Survey.* Available from: <http://www.who.int/healthinfo/survey/en/>. [14 September 2014].

WHO (2012). *The WHO Application of ICD-10 to deaths during pregnancy, childbirth and the puerperium: ICD-MM*. Geneva: World Health Organization.

WHO (2014:a). *The Global Health Observatory.* Available from: <http://www.who.int/gho/maternal_health/mortality/maternal_mortality_text/en/>. [16 October 2015].

WHO (2014:b*). Trends in Maternal Mortality 1990-2013*. Geneva: World Health Organization.

WHO (2014:c). *World Health Statistics 2014*. Switzerland, Geneva: World Health Organization.

# 8. Appendices

# 8. Appendices

## 8.1 Appendix A

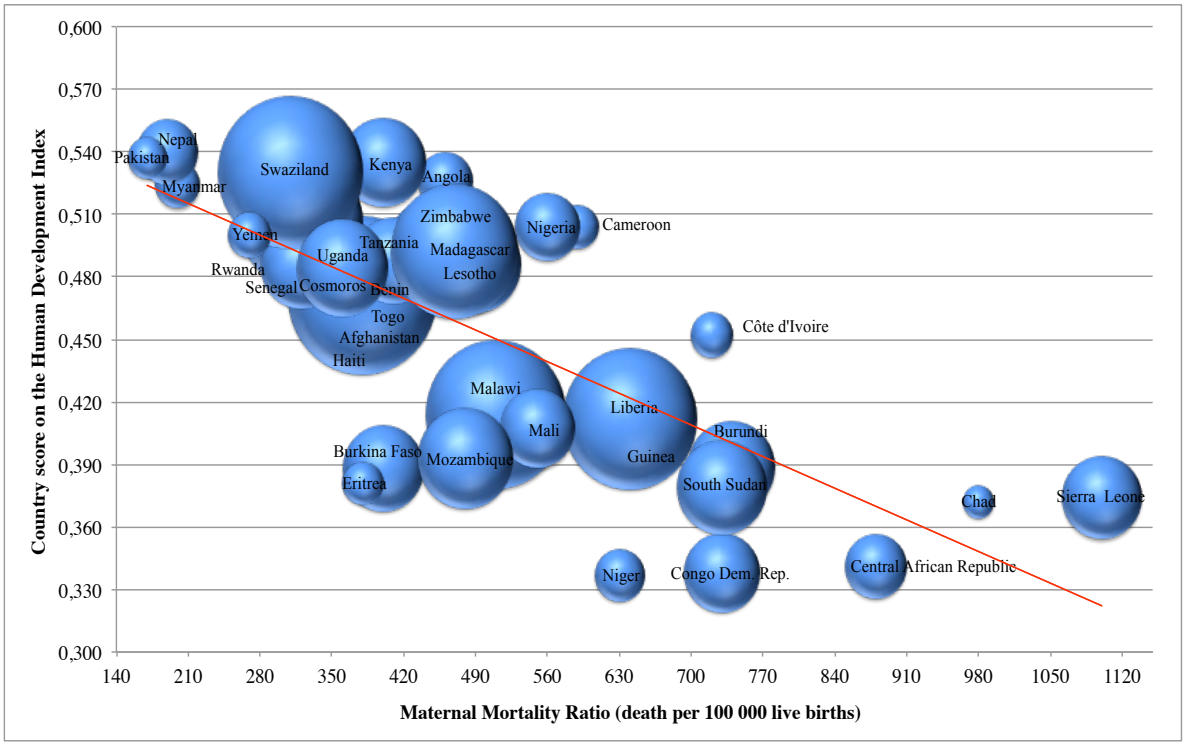


**Figure 1. A:** Total health related aid, by all OECD countries in 2012

Y = Human Development Index 2013, X = Maternal Mortality Ratio 2013. The red regression line indicates the linear relationship.

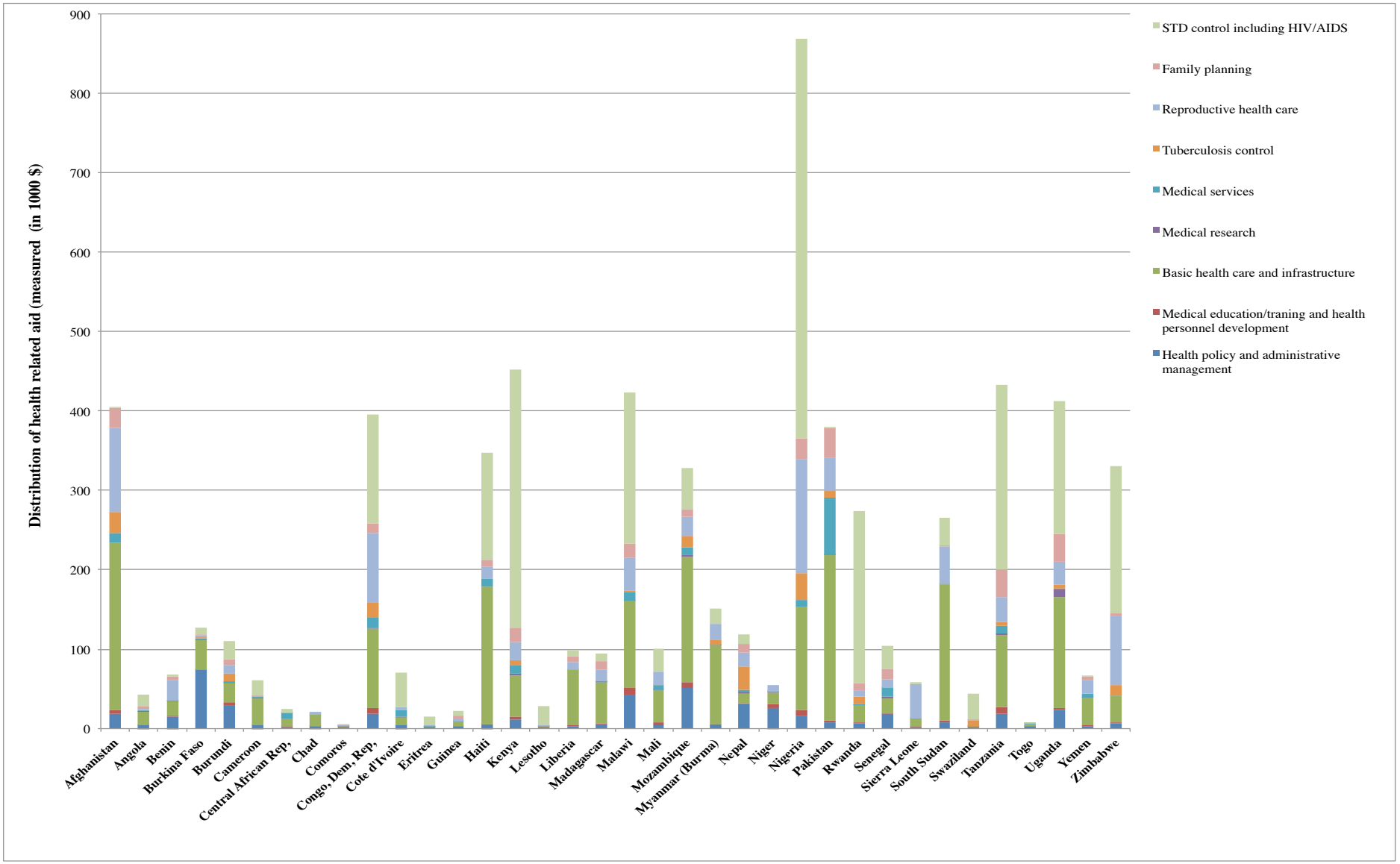


**Figure 2. A:** Illustrating the DAC member's distribution of health related aid based on sub-sector, in 2012

## 8.2 Appendix B

**Table 1. B** Socio-economic indicators measured in 2013.

| **Countries** (sorted in alphabetically order) | **Gross national income per capita, atlas method $ 2013**[a] | **Corruption Perceptions Index 2013**[b] | **Human Development Index 2013**[c] | **CPIA Country Policy and Institutional assessments 2013**[d] |
|---|---|---|---|---|
| Afghanistan | 700 | 8 | 0,468 | 3 |
| Angola | 5010 | 23 | 0,526 | 2,7 |
| Benin | 790 | 36 | 0,476 | 3,5 |
| Burkina Faso | 670 | 38 | 0,388 | 3,8 |
| Burundi | 280 | 21 | 0,389 | 3,2 |
| Cameroon | 1270 | 25 | 0,504 | 3,2 |
| Central African Rep. | 320 | 25 | 0,341 | 2,5 |
| Chad | 1020 | 19 | 0,372 | 2,6 |
| Comoros | 880 | 28 | 0,488 | 2,8 |
| Congo Dem. Rep. | 400 | 22 | 0,338 | 3,3 |
| Côte d'Ivoire | 1380 | 27 | 0,452 | 3,2 |
| Eritrea | 490 | 20 | 0,381 | 2 |
| Guinea | 460 | 24 | 0,392 | 3 |
| Haiti | 810 | 19 | 0,471 | 3,2 |
| Kenya | 930 | 27 | 0,535 | 3,9 |
| Lesotho | 1550 | 49 | 0,486 | 3,5 |
| Liberia | 410 | 38 | 0,412 | 3,5 |
| Madagascar | 440 | 28 | 0,498 | 3 |
| Malawi | 270 | 37 | 0,414 | 3,1 |
| Mali | 670 | 28 | 0,407 | 3,4 |
| Mozambique | 590 | 30 | 0,393 | 3,6 |
| Myanmar | 702 | 21 | 0,524 | 3,7 |
| Nepal | 730 | 31 | 0,540 | 3 |
| Niger | 410 | 34 | 0,337 | 3,5 |
| Nigeria | 2760 | 25 | 0,504 | 4,1 |
| Pakistan | 1380 | 28 | 0,537 | 2,8 |
| Rwanda | 620 | 53 | 0,506 | 3,9 |
| Senegal | 1070 | 41 | 0,485 | 3,8 |
| Sierra Leone | 680 | 30 | 0,374 | 3,3 |
| South Sudan | 1120 | 14 | 0,379* | 2,1 |
| Swaziland | 3080 | 39 | 0,530 | - |
| Tanzania | 630 | 33 | 0,488 | 3,8 |
| Togo | 530 | 29 | 0,473 | 3 |
| Uganda | 510 | 26 | 0,484 | 3,4 |
| Yemen | 1330 | 18 | 0,500 | 3,2 |
| Zimbabwe | 820 | 21 | 0,492 | 2,3 |

[a] The World Bank (2013). Accessed on August 28, 2014 from: http://data.worldbank.org/indicator/NY.GNP.PCAP.CD
[b] Transparency International (2013). Corruption Perceptions Index 2013. Germany, Berlin: International Secretariat. Accessed on August 15, 2014 from: http://www.transparency.org/whatwedo/pub/cpi_2013
[c] The United Nations Development Program (2014). Human Development Report. New York: PBM Graphics pp. 160-163.[d] African Development Bank (2014). Country Policies and Institutional Assessments. Accessed on November 3, 2014 from: http://www.afdb.org/en/documents/project-operations/country-performance-assessment-cpa/country-policy-and-institutional-assessment-cpia/
* The HDI of South Sudan is gathered from the United Nations Country Profile. Accessed on November 4, 2014 from: http://www.ss.undp.org/content/south_sudan/en/home.html

**Table 2. B** Figures on Norway's and the other DAC members' health-aid.

| **Countries** (sorted in alphabetically order) | **Norwegian health-related aid in million US $ as of 31/12/2013**[a,d] | **Total ODA (from all countries) in million US $ 2012**[c] | **Total ODA (from all OECD countries) per capita in US $ 2012**[c] | **Total Norwegian health-related aid per capita, in US $ as of 31/12/2013**[a,d] |
|---|---|---|---|---|
| Afghanistan | 9,9 | 6725 | 14,90 | 0,32 |
| Angola | 0,4 | 242 | 4,82 | 0,02 |
| Benin | 0,0 | 511 | 8,59 | 0,00 |
| Burkina Faso | 0,2 | 1159 | 10,68 | 0,01 |
| Burundi | 0,6 | 523 | 12,40 | 0,06 |
| Cameroon | 1,8 | 596 | 2,84 | 0,08 |
| Central African Rep. | 0,0 | 227 | 5,99 | 0,00 |
| Chad | 0,0 | 479 | 1,47 | 0,00 |
| Comoros | 0,0 | 69 | 5,64 | 0,00 |
| Congo Dem. Rep. | 2,9 | 2859 | 9,27 | 0,04 |
| Côte d'Ivoire | 0,0 | 2636 | 2,88 | 0,00 |
| Eritrea | 0,0 | 134 | 2,56 | 0,00 |
| Guinea | 0,0 | 340 | 3,82 | 0,00 |
| Haiti | 1,3 | 1275 | 37,09 | 0,13 |
| Kenya | 2,4 | 2654 | 11,95 | 0,06 |
| Lesotho | 0,4 | 283 | 13,84 | 0,18 |
| Liberia | 0,0 | 571 | 29,78 | 0,00 |
| Madagascar | 0,4 | 379 | 7,31 | 0,02 |
| Malawi | 45,4 | 1175 | 33,09 | 2,77 |
| Mali | 0,7 | 1001 | 9,10 | 0,04 |
| Mozambique | 3,5 | 2097 | 15,02 | 0,14 |
| Myanmar | 4,8 | 504 | 3,12 | 0,09 |
| Nepal | 2,3 | 770 | 6,08 | 0,08 |
| Niger | 0,9 | 902 | 4,00 | 0,05 |
| Nigeria | 8,1 | 1916 | 6,77 | 0,05 |
| Pakistan | 4,6 | 2019 | 2,46 | 0,03 |
| Rwanda | 0,2 | 879 | 25,09 | 0,01 |
| Senegal | 0,1 | 1080 | 10,21 | 0,01 |
| Sierra Leone | 1,5 | 443 | 10,26 | 0,24 |
| South Sudan | 6,3 | 1578 | 13,01 | 0,56 |
| Swaziland | 0,7 | 88 | 34,93 | 0,52 |
| Tanzania | 6,8 | 2832 | 11,09 | 0,14 |
| Togo | 0,0 | 241 | 1,54 | 0,00 |
| Uganda | 2,6 | 1655 | 13,88 | 0,07 |
| Yemen | 0,4 | 709 | 2,94 | 0,02 |
| Zimbabwe | 7,7 | 1001 | 26,43 | 0,55 |

[a] The Norwegian Agency of Development Cooperation (2013). Norwegian aid geographically allocated 2013. Accessed on October 13, from: http://www.norad.no/no/om-bistand/norsk-bistand-i-tall

[b] The World Bank (2014). 6.11 World Development Indicators: Aid Dependency. Accessed on November 5, 2014 from: http://wdi.worldbank.org/table/6.11#

[c] OECD (2015). Statistics on aid to health, by recipient, commitments 2012. Accessed on January 9, 2015 from: http://www.oecd.org/dac/stats/aidtohealth.htm

[d] World Currency Exchange Rate (2013). US Dollar exchange rate of December 31, 2013 against currencies in Europe. Accessed on October 13, from: http://www.exchange-rates.org/HistoricalRates/E/USD/12-31-2013

**Table 3. B** Women's health and access to health services

| Countries (sorted in alphabetically order) | Prevalence of under-nourishment % of total population 2012-2014[a] | Life expectancy at birth female (years) 2012[b] | Maternal Mortality ratio (per 100 000 live births) 2013[c] | Total fertility rate (TFR) as of 2013[d] | Contraceptive prevalence (% of women in the age 15-49) MDG 5 2013[e] | Antenatal care coverage (%) at least one visit MDG 5 2006-2013[e] | Births attended by skilled health personnel (%) MDG 5 as of 2006-2013[e] |
|---|---|---|---|---|---|---|---|
| Afghanistan | 24,7 | 62 | 400 | 5,43 | 22 | 46 | 36 |
| Angola | 18 | 53 | 460 | 5,43 | 18 | 68 | 49 |
| Benin | 9,7 | 61 | 340 | 5,04 | 13 | 86 | 84 |
| Burkina Faso | 20,7 | 56 | 400 | 5,93 | 16 | 95 | 67 |
| Burundi | 67 | 56 | 740 | 6,14 | 22 | 99 | 60 |
| Cameroon | 10,5 | 56 | 590 | 4,82 | 23 | 85 | 64 |
| Central African Rep. | 37,6 | 51 | 880 | 4,46 | 19 | 55 | 40 |
| Chad | 34,8 | 52 | 980 | 4,68 | 26 | 43 | 17 |
| Comoros | 65,3 | 62 | 350 | 3,76 | 26 | 92 | 82 |
| Congo Dem. Rep. | 37,6** | 51 | 730 | 4,80 | 18 | 89 | 80 |
| Côte d'Ivoire | 14,7 | 51 | 720 | 3,63 | 18 | 89 | 57 |
| Eritrea | 61 | 65 | 380 | 4,14 | 8 | n.a. | n.a. |
| Guinea | 18,1 | 57 | 650 | 4,93 | 6 | 85 | 45 |
| Haiti | 51,8 | 65 | 380 | 2,79 | 35 | 90 | 37 |
| Kenya | 24,3 | 63 | 400 | 3,54 | 46 | 92 | 44 |
| Lesotho | 11,5 | 49 | 490 | 2,78 | 47 | 92 | 62 |
| Liberia | 29,6 | 61 | 640 | 4,81 | 11 | 96 | 61 |
| Madagascar | 30,5 | 66 | 440 | 4,28 | 40 | 86 | 44 |
| Malawi | 21,8 | 55 | 510 | 5,66 | 46 | 95 | 71 |
| Mali | 7,3 | 54 | 550 | 6,16 | 8 | 74 | 58 |
| Mozambique | 27,9 | 51 | 480 | 5,27 | 12 | 60 | 19 |
| Myanmar | 16,7 | 67 | 200 | 2,18 | 46 | 83 | 71 |
| Nepal | 13 | 69 | 190 | 2,30 | 50 | 58 | 36 |
| Niger | 11,3 | 58 | 630 | 6,89 | 14 | 83 | 29 |
| Nigeria | 6,4 | 52 | 560 | 5,25 | 14 | 61 | 38 |
| Pakistan | 21,7 | 67 | 170 | 2,86 | 27 | 73 | 52 |
| Rwanda | 33,8 | 65 | 320 | 4,62 | 52 | 98 | 69 |
| Senegal | 16,7 | 65 | 320 | 4,52 | 13 | 95 | 51 |
| Sierra Leone | 25,5 | 46 | 1100 | 4,83 | 11 | 91 | 61 |
| South Sudan | 24,5*** | 56 | 730 | 5,43 | 4 | 40 | 17 |
| Swaziland | 26,1 | 48 | 310 | 2,88 | 65 | 97 | 82 |
| Tanzania | 34,6 | 62 | 410 | 4,95 | 34 | 88 | 49 |
| Togo | 15,3 | 57 | 450 | 4,53 | 15 | 51 | 44 |
| Uganda | 30 | 59 | 360 | 5,97 | 30 | 95 | 58 |
| Yemen | 25,7 | 64 | 270 | 4,09 | 28 | 65 | 34 |
| Zimbabwe | 31,8 | 59 | 470 | 3,56 | 59 | 90 | 66 |

[a] The Food and Agriculture Organization of the United Nations (2014). Accessed on October 10, 2014 from: http://www.fao.org/hunger/en/

[b] The United Nations Development Program (2014). Human Development Report. New York: PBM Graphics pp. 160-163.

[c] World Health Organization (2014). World Health Statistics 2014. Switzerland, Geneva: WHO Press pp. 72-86.

[d] The World Fact Book (2014). Total Fertility Rate. Accessed on September 30, 2014 from: https://www.cia.gov/library/publications/the-world-factbook/rankorder/2127rank.html

[e] The World Health Organization (2014). The World Health Statistic. Health Service Coverage pp. 106-112.

** Not accurate measurement. The Value of Dem. Rep. Of Congo has been measured based on the mean prevalence generated from Congo in the period 1990-2012.

*** Not accurate measurement. The value of South Sudan has been estimated as the mean value of undernourishment in the former Sudan in the period 2008-2011 as there has not been conducted any recent rate.

## 8.3 Appendix C

**Table 1. C** Norwegian development aid distributed to health and social services in 2013

| Implementing Partner | Description of Agreement | Main Sector | Sub Sector | Recipient Country | Extending Agency | Disbursements (1000 $) |
|---|---|---|---|---|---|---|
| Undefined | Establishment of drinking water, through improved systems, rehabilitation, sanitation facilities and hygiene promoters. | 140 - Water and sanitation | 30 - Basic drinking water supply and basic sanitation | Afghanistan | Norad | 303,47 |
| IAM - International Assistance Mission | Provide rehabilitation services for disabled people, treating patients, promote awareness of and action by and for the disabled, family understanding and participation. | 121 – General health | 81 - Medical education and training | Afghanistan | Norad | 117,39 |
| DACCAR - Danish Committee for Aid to Afghan Refugees | Improvement of livelihoods, health, life quality and social relationship on a sustainable and equitable basis. | 140 - Water and sanitation | 30 - Basic drinking water supply and basic sanitation | Afghanistan | Ministry of Foreign Affairs | 2551,89 |
| IAM - International Assistance Mission | Provide services (professional treatment) to patients concerning mental health in, capacity building facility, medical staff, and training opportunities with medical students. | 121 – General health | 81 - Medical education and training | Afghanistan | Norad | 130,17 |
| DACCAR - Danish Committee for Aid to Afghan Refugees | The aim is to ensure water supply - both drinking water and irrigation to selected districts. In addition there will be sanitation facilities (latrines) and hygiene education. Projects will build new and repair excising water points and irrigation system. As well as conducting surveys regarding the water situation, and establishment of databases. | 140 - Water and sanitation | 30 - Basic drinking water supply and basic sanitation | Afghanistan | Ministry of Foreign Affairs | 2482,67 |
| Undefined | Establishment of drinking water pipe schemes, rehabilitation of wells, establishment of demonstration sanitation facilities and training of hygiene promoters. | 140 - Water and sanitation | 30 - Basic drinking water supply and basic sanitation | Afghanistan | Norad | 43,69 |
| Norwegian Church Aid - local office | Drinking water and irrigation in selected rural areas. Program to be developed in co-operation with communities. | 140 - Water and sanitation | 30 - Basic drinking water supply and basic sanitation | Afghanistan | Norad | 161,69 |
| Council of Christian Churches in Afghanistan | Treatment of drug addicted patients, health education and awareness/information about HIV/AIDS. | 122 - Basic health | 20 - Basic health care | Afghanistan | Norad | 349,1 |
| Institute of Health Science in Jalalabad | Midwife education and Reproductive health. | 130 - Population policies/programs and reproductive health | 81 - Personnel development for population and reproductive health | Afghanistan | Norad | 202,88 |

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| ANCAA - Angola National Association of the Blind | Improving eye health services and reducing the number of patients who become blind due to avoidable conditions for the cause of blindness. | 121 – General health | 91 - Medical services | Angola | Norad | 176,81 |
| IEBA - Igreja Evangelica Baptista em Angola | To promote human dignity for people affected by HIV and AIDS. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Angola | Norad | 128,05 |
| Norwegian Church Aid - local office | Providing clean and safe water to the local communities. | 140 - Water and sanitation | 20 - Water supply and sanitation - large systems | Angola | Norad | 109,76 |
| WFP - World Food Program | JPO Peter M Jourdan WFP | 121 – General health | 10 - Health policy and administrative management | Burkina Faso | Ministry of Foreign Affairs | 174,77 |
| CARE Norway | Improved prevention of and protection over sexual gender based violence (SGBV) through sustainable access to equitable and quality SGBV service and the transformation of socio-cultural barriers. Provide information and knowledge about SRH (sexual and reproductive health). Improvement of sexual and reproductive health through sustainable access to equitable and quality SRH services and the transformation of socio-cultural barriers. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Burundi | Norad | 446,75 |
| National Red Cross/Red Crescent Society | Burundi Red Cross Community Based Health and First Aid (CBHFA) programs (mother/child health and HIV/Aids). Community based and participatory approach. | 122 - Basic health | 61 - Health education | Burundi | Norad | 169,25 |
| EELC - Evangelical Lutheran Church of Cameroun | The project aims to fight against HIV/AIDS by mobilizing the population to take necessary preconditions. In addition the project will assist HIV-positives to establish activities at the 'Centre D'ecoute' to help them establish income generating activities | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Cameroon | Norad | 123,14 |
| HEAL Africa | Improve women's autonomy in reproductive health and reduce neonatal and maternal mortality among women and children. Form Safe Motherhood Solidarity Groups (SMIG) to tackle problems causing maternal and neonatal death, as well as management of funds for maternity insurance. Community leaders to be mobilized to promote changes for the protection of women. | 122 - Basic health | 20 - Basic health care | Congo, Dem. Rep. | Norad | 493,37 |
| Communaute Baptiste du Congo | Provide information about citizens' rights and obligations, particular emphasis women's rights. | 160 - Other social infrastructure and services | 50 – Multi-sector aid for basic social services | Congo, Dem. Rep. | Norad | 131,26 |
| SOFEPADI - Solidarité Féminine pour | Provide direct assistance to SGBV survivors and improvement of psychosocial care, legal assistance and mobilization of the community, as well as providing family planning, follow-up of | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Congo, Dem. Rep. | Ministry of Foreign Affairs | 340,25 |

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| la Paix et le Développement Intégral | STDs and HIV-testing. | | | | | |
| HiA - Hope in Action | Overall objective is to reduce the child and maternal mortality significantly in the project in North Kivu by improving the quality and coverage of the health services in existing health institutions, and by increasing the access to health services in areas with limited/no health services using mobile teams. | 122 - Basic health | 20 - Basic health care | Congo, Dem. Rep. | Norad | 1361,01 |
| HiA - Hope in Action | Securing continuous provision of quality health services, in particular focus on women, and strengthening the financial sustainability of Kyeshero Hospital. This by establishing advanced laboratory services aiming to improve the availability of medicine and medical material, establishing a medical technical workshop and a unit for training at Kyeshero. These activities will also deliver services to external costumers, and be a source of income for the hospital. | 121 – General health | 91 - Medical services | Congo, Dem. Rep. | Norad | 738,01 |
| Norwegian Church Aid - local office | Salary Expatriate Wash Coordinator | 140 - Water and sanitation | 30 - Basic drinking water supply and basic sanitation | Haiti | Norad | 164,59 |
| Salvation Army - local office | Goal: To reduce and reverse the spread of HIV/AIDS by providing testing, treatment and educational training sessions on HIV/AIDS prevention. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Haiti | Norad | 113,05 |
| Cuba Ministry of Foreign Trade and Foreign Investment | Improve the qualities of health services in the South Department of Haiti. Contribute to control the spread of cholera. Improve communication and the dissemination of public health information. | 122 - Basic health | 30 - Basic health infrastructure | Haiti | Ministry of Foreign Affairs | 850,63 |
| Norwegian Church Aid - local office | Water, sanitation, and biogas. | 140 - Water and sanitation | 30 - Basic drinking water supply and basic sanitation | Haiti | Norad | 128,62 |
| Norwegian Church Aid - local office | Gender and Gender-based violence program. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Kenya | Norad | 31,09 |
| UNFPA - UN Population Fund | Reproductive Health. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Kenya | Ministry of Foreign Affairs | 132,13 |
| Volda kommune | Focus on preventive health care for the target group, both physical and mental health. | 121 – General health | 10 - Health policy and administrative management | Kenya | Fredskorpset | 107,09 |
| RACIDA - The Rural Agency for Community Development and Assistance | The district of Mandera experiences perennial drought situations. Support to rainwater harvesting initiatives like underground water tanks etc. | 140 - Water and sanitation | 30 - Basic drinking water supply and basic sanitation | Kenya | Norad | 54,86 |

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| FPFK - Free Pentecostal Fellowship Kenya | Control the spread of HIV/AIDS among the age group 13-24. The project has a lot of activities to make the people aware of the ways of infections. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Kenya | Norad | 345,58 |
| MSF - Médecins Sans Frontères | HIV/AIDS treatment and integrated district health services. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Kenya | Norad | 493,37 |
| UBS - The United Bible Societies - local office | Anti HIV courses to combat stigma and renew the Kenyan churches diaconal responsibility towards the infected and affected. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Kenya | Norad | 47,5 |
| UN-HABITAT - United Nations Human Settlements Program | JPO Helene Opsal UN-HABITAT Nairobi | 130 - Population policies/programs and reproductive health | 10 - Population policy and administrative management | Kenya | Ministry of Foreign Affairs | 158,02 |
| NLM - Norwegian Lutherian Mission - Local Office | The project will work to improve the water security and health- and sanitation conditions in Tana North District with a focus on community based development work. | 140 - Water and sanitation | 30 - Basic drinking water supply and basic sanitation | Kenya | Norad | 222,83 |
| ELCK - Evangelical Lutheran Church in Kenya | The main focus will be on education, reduction of HIV/AIDS and FGM in Pokot and capacity building of ELCK-NWD. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Kenya | Norad | 13,61 |
| UN-HABITAT - United Nations Human Settlements Program | JPO Jo Tore Berg UN-Habitat | 130 - Population policies/programs and reproductive health | 10 - Population policy and administrative mng | Kenya | Ministry of Foreign Affairs | 142,95 |
| STCC - St. John's Community Centre | To build capacity of partners through the skills exchange that would enable improved delivery of quality health services | 122 - Basic health | 20 - Basic health care | Kenya | Fredskorpset | 84,55 |
| ELCK - Evangelical Lutheran Church in Kenya | The main focus will be on education, reduction of HIV/AIDS and FGM in Pokot and capacity building of ELCK-NWD. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Kenya | Norad | 15,61 |
| YWCA - World Young Women's Christian Association | Combating FGM Kenya. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Kenya | Norad | 103,88 |
| United Bible Societies | HIV courses to educate on HIV, fight of stigma and renew the African Churches diaconal responsibility | 122 - Basic health | 61 - Health education | Kenya | Norad | 120,42 |
| KFUK-KFUM | Maternal and reproductive health, particularly female genital | 130 - Population | 20 - Reproductive health | Kenya | Fredskorpset | 9,74 |

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|---|---|---|---|---|---|---|
| Global | mutilation. | policies/programs and reproductive health | care | | | |
| Norwegian Church Aid - local office | Awareness creation, mobilization and action on Female Genital Mutilation (FGM). | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Kenya | Norad | 64,01 |
| ELCK - Evangelical Lutheran Church in Kenya | The main focus will be on education, reduction of HIV/AIDS and FGM. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Kenya | Norad | 51,9 |
| HI - Habiba International | Female Genital Mutilation (FGM) awareness creation and mobilization. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Kenya | Norad | 36,58 |
| Lesotho Ministry of Health | Running of Eye Clinic. | 121 – General health | 91 - Medical services | Lesotho | Norad | 109,8 |
| BLOEM WATER BOARD | Water Management in the areas of bulk and retail water supply and sewer collection and disposal. | 140 - Water and sanitation | 20 - Water supply and sanitation - large systems | Lesotho | Fredskorpset | 12,69 |
| Lesotho Ministry of Health | CBR, a project for disabled people in Lesotho. | 160 - Other social infrastructure and services | 10 - Social/welfare services | Lesotho | Norad | 70,74 |
| BLOEM WATER BOARD | Water Management in the areas of bulk and retail water supply and sewer collection and disposal. | 140 - Water and sanitation | 20 - Water supply and sanitation - large systems | Lesotho | Fredskorpset | 38,49 |
| UNFPA - UN Population Fund | Junior professional officer Borghild Berge UNFPA Madagascar 2012-2015 | 130 - Population policies/programs and reproductive health | 10 - Population policy and administrative management | Madagascar | Ministry of Foreign Affairs | 127 |
| FLM - Fiangonana Loterana Malagasy Eglise Luthérie | Through education, training and professional support enable the rural population in Madagascar to be capable of engaging their own economic and social development by promoting a full participation of the women and other marginalized groups, improved production. | 122 - Basic health | 20 - Basic health care | Madagascar | Norad | 124,03 |
| CHAI - Clinton Health Access Initiative | Training institutions and the health sector to deliver maternal and child health services, particularly emergency obstetric care and family planning services, more effectively by increasing availability of nurse midwives, community midwives and community health workers throughout the continuum of care. | 122 - Basic health | 81 - Health personnel development | Malawi | Ministry of Foreign Affairs | 2602,93 |
| MCoM - Malawi College of Medicine | Continuation of support to Malawi College of Medicine. Contribute to implementation of the strategic plan to produce doctors of excellence in service delivery, training and research. | 121 – General health | 81 - Medical education and training | Malawi | Ministry of Foreign Affairs | 1481,8 |
| Save the Children - local | Reduction of high maternal mortality rates and rates of premature delivery, as well as reducing teenage pregnancy, and | 130 - Population policies/programs and | 30 - Family planning | Malawi | Norad | 1361,01 |

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| partner | keeping girls in school. | reproductive health | | | | |
| Haukeland University Hospital | Exchange of personnel in the supporting field of infantile and maternal care, radiology and pathology between Norway and Malawi | 1121 – General health | 91 - Medical services | Malawi | Fredskorpset | 129,41 |
| Haukeland University Hospital | Improved tertiary level maternity care and orthopedic and surgery services for the population. | 121 – General health | 91 - Medical services | Malawi | Fredskorpset | 952,31 |
| National Organization of Nurses and Midwives of Malawi | Strengthen and empower National Organization of Nurses & Midwives of Malawi as an effective, sustainable professional and trade union organization for nurses & midwives. | 121 – General health | 10 - Health policy and administrative management | Malawi | Norad | 406,06 |
| Georgina Falesi Chinula | The Health Consultant will have a specific responsibility in the field of maternal, reproductive, sexual and neonatal health in line with Norwegian support in this field. The Health Consultant will also be working with global health initiatives in Malawi (GAVI, The Global Fund), especially documenting activities on community level. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Malawi | Ministry of Foreign Affairs | 45,05 |
| MSF - Médecins Sans Frontères | HIV/AIDS treatment and integrated district health service. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Malawi | Norad | 493,37 |
| Sophies Minde Ortopedi AS | Capacity building in prosthetic and orthotic educational centers and services in low income countries | 121 - Health, general | 91 - Medical services | Malawi | Fredskorpset | 42,99 |
| ECM - The Episcopal Conference of Malawi | This project aims at integrating HIV & Aids activities in Nsanje district | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Malawi | Norad | 36,58 |
| Sophies Minde Ortopedi AS | Capacity building in prosthetic and orthotic educational centers and services in low income countries | 121 – General health | 81 - Medical education and training | Malawi | Fredskorpset | 108,34 |
| University of Malawi | The main objective is to train a critical mass of surgeons in Malawi to sustain future training programs in surgery at Kamuzu Central Hospital and Queen Elisabeth Central Hospital in close collaboration with College of Medicine at University of Malawi | 121 – General health | 81 - Medical education and training | Malawi | Norad | 323,24 |
| MCoM - Malawi College of Medicine | A postgraduate specialist education in gynecology and obstetrics for Malawi. This by educating highly competent Malawian obstetricians/gynecologists able to provide high quality clinical care that meets international standards. | 130 - Population policies/programs and reproductive health | 81 - Personnel development for population and reproductive health | Malawi | Ministry of Foreign Affairs | 586,93 |
| Oslo University Hospital Helse | Establish neurosurgery services at the Queen Elizabeth Central Hospital. | 121 – General health | 91 - Medical services | Malawi | Fredskorpset | 6,47 |

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| Fonna | | | | | | |
| UNICEF-United Nations Children's Fund | The project aim at immunization and deliver critical public health services in all districts of Malawi. In addition the project will implement the Every Child Approach. This will contribute full immunization for about 750,000 children, 830,000 pregnant women will receive tetanus vaccines and 225,000 children will access to prompt treatment for common childhood illnesses. | 122 - Basic health | 20 - Basic health care | Malawi | Ministry of Foreign Affairs | 6805,04 |
| Haukeland University Hospital | Exchange of personnel in the supporting field of infantile and maternal care, radiology and pathology between Norway and Malawi | 121 – General health | 91 - Medical services | Malawi | Fredskorpset | 423,17 |
| SOS Children's Village of Malawi Trust | Basic health services to households with orphans and vulnerable children, medical support, immunization, nutrition, household food security, information and training to improve health knowledge and practice, including HIV/AIDS prevention and health enhancing environment measures | 122 - Basic health | 20 - Basic health care | Malawi | Norad | 169,31 |
| Oslo University Hospital Helse Fonna | Feasibility Study Oslo University Hospital - Malawi | 121 – General health | 91 - Medical services | Malawi | Fredskorpset | 3,23 |
| EAM - Evangelical Association of Malawi | HIV and Aids project at local community level, including care and support to affected families. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Malawi | Norad | 36,58 |
| Malawi Ministry of Health | Increase support to development of the health sector in Malawi through a Sector Wide Approach, the Health Sector Strategic Plan (HSSP). | 121 – General health | 10 - Health policy and administrative management | Malawi | Ministry of Foreign Affairs | 10207,55 |
| UNICEF-United Nations Children's Fund | Donor support for an emergency procurement of drugs and supplies. The request states that CMS will be the responsible procurer and distributer of the items. | 122 - Basic health | 20 - Basic health care | Malawi | Ministry of Foreign Affairs | 9059,9 |
| HLF - Hearing Impaired Association | Exchange of knowledge to assure that hard of hearing children will be early identified and given the opportunity to use their residual hearing. | 121 – General health | 91 - Medical services | Malawi | Fredskorpset | 196,39 |
| BLOEM WATER BOARD | Water Management in the areas of bulk and retail water supply and sewer collection and disposal | 140 - Water and sanitation | 20 - Water supply and sanitation - large systems | Malawi | Fredskorpset | 12,69 |
| MCoM - Malawi College of Medicine | The College of Medicine (CoM) of the University of Malawi has partnered with among others the University of Bergen, Norway, on a research study aimed to assess and evaluate the quality impact on the interventions directly targeted by Performance Based Financing (PBF) interventions and other relevant maternal and child care services (antenatal, postnatal & newborn care) and impact of the RBF intervention. | 121 – General health | 82 - Medical research | Malawi | Ministry of Foreign Affairs | 319,98 |
| Haukeland University Hospital | Exchange in the field of pediatrics, internal medicine and detoxification between Norway and Zanzibar | 121 – General health | 91 - Medical services | Malawi | Fredskorpset | 148,69 |

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| Oslo University Hospital Helse Fonna | Establishing a sustainable Neurosurgery Service and Training program in Malawi and giving Norwegian nurses important training | 121 – General health | 91 - Medical services | Malawi | Fredskorpset | 85,06 |
| University of Malawi | Health and Information Systems- Two integrated parts at the University of Malawi | 122 - Basic health | 61 - Health education | Malawi | Norad | 169,75 |
| Malawi Ministry of Health | This is a pilot initiative aiming at reducing maternal mortality using results based financing. The initiative is co-funded by the German Government. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Malawi | Ministry of Foreign Affairs | 1701,26 |
| Haraldsplass Diaconal Hospital | Competences building in emergency and critical care. | 122 - Basic health | 81 - Health personnel development | Malawi | Fredskorpset | 209,32 |
| Undefined | Malawi Network of Religious Leaders Living with or Personally Affected with HIV/AIDS (MANARELA) is a voluntary network of about one hundred Christians and Moslem leaders. MANARELA is working to fight stigma, shame, discrimination, denial and inaction. | 130 - Population policies/programs and reproductive health | 10 - Population policy and administrative management | Malawi | Norad | 36,58 |
| Kirkens Nødhjelp | Improving access to quality health care in communities of Malawi, implemented from 2012 to 2015. The program aims at improving health and environment of the mother and child through the provision of quality maternal, neonatal, child health, psychosocial support services and improving the quality of health workers in Malawi by 2015. | 122 - Basic health | 20 - Basic health care | Malawi | Ministry of Foreign Affairs | 2235,66 |
| UNDP - UN Development Program | The overall goal of the project is to improve the capacity of the Ministry of Health to deliver quality health services to all people living in Malawi. The purpose of the contribution of MFA to the mentioned Project is to support the continuation, recruitment and deployment of doctors for 7 months. | 121 – General health | 10 - Health policy and administrative management | Malawi | Ministry of Foreign Affairs | 1735,28 |
| SOS Children's Village of Malawi Trust | Preventions of abandonment, particularly targeted HIV/AIDS affected households, including social, legal and economic assistance, support to child-headed/granny-headed households due to HIV/AIDS: HR training, food security including environmental friendly crops, income generating activities. | 160 - Other social infrastructure and services | 64 - Social mitigation of HIV/AIDS | Malawi | Norad | 76,18 |
| Lions Aid Norway | Eye care infrastructure building, competence building and information dissemination about treatment for eye deceases. | 121 – General health | 91 - Medical services | Malawi | Norad | 470,4 |
| BLOEM WATER | Water Management in the areas of bulk and retail water supply and sewer collection and disposal. | 140 - Water and sanitation | 20 - Water supply and sanitation - large systems | Malawi | Fredskorpset | 38,49 |

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| BOARD | | | | | | |
| Norwegian Church Aid - local office | Capacity Building, Program Personnel costs for Health, HIV & Aids projects | 121 – General health | 10 - Health policy and administrative management | Malawi | Norad | 64,01 |
| MIAA - The Malawi Interfaith AIDS Association | Secretariat for Coordination Committee of ECM, MCC,EAM,ACEM and CHAM, Quadaria Muslim Association of Malawi on HIV/AIDS: Interfaith Advocacy and capacity development on HIV and AIDS. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Malawi | Norad | 36,58 |
| BLM - Banja la Mtsogolo | The long-term objective is to create an understanding and practice of safer sexual and reproductive behavior. The main input activities are promoting family planning and FP services to avoid unwanted pregnancies and illegal abortions. | 130 - Population policies/programs and reproductive health | 30 - Family planning | Malawi | Ministry of Foreign Affairs | 850,63 |
| STCC - St. John's Community Centre | To build capacity of partners through the skills exchange that would enable improved delivery of quality health services | 122 - Basic health | 20 - Basic health care | Malawi | Fredskorpset | 84,63 |
| HLF - Hearing Impaired Association | Exchange of knowledge to assure that hard of hearing children will be early identified and given the opportunity to use their residual hearing. | 121 – General health | 91 - Medical services | Malawi | Fredskorpset | 170,13 |
| Medecins du Monde | Training of Malian staff to perform rehabilitative surgery on fistula patients at the regional hospital in Mopti. Awareness raising and information on how to prevent fistula in the surrounding areas. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Mali | Norad | 137,16 |
| Norwegian Church Aid - local office | Competence building NCA and partners and support to small projects. Special focus on follow-up study of FGM in Northern Mali from 2004 | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Mali | Norad | 23,79 |
| Apaf Muso Danbe | Awareness building HIV/AIDS and FGM, targeting rural girls working in cities. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Mali | Norad | 91,44 |
| Norwegian Church Aid - local office | Awareness building and lobbying against FGM, targeting men and women, religious and community leaders | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Mali | Norad | 128,62 |
| AMSS - Association Malienne pour la Survie au | Mobilization of local groups to fight against FGM and early marriage. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Mali | Norad | 91,04 |

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| Sahel | | | | | | |
| Pathfinder International | Partnership in Sexual and Reproductive Health and rights, focusing on Family planning and safe abortion. This by integrating a comprehensive package of prevention and response to gender-based violence (GBV) with SRH (sexual and reproductive health) services, including safe abortion care. | 130 - Population policies/programs and reproductive health | 30 - Family planning | Mozambique | Ministry of Foreign Affairs | 250,43 |
| SOS Children's Villages of Mozambique | Preventions of abandonment, particularly targeted HIV/AIDS affected households, including social, legal and economic assistance, support to child-headed/granny-headed households due to HIV/AIDS. | 160 - Other social infrastructure and services | 64 - Social mitigation of HIV/AIDS | Mozambique | Norad | 48,66 |
| Mozambique Ministry of Health | Running of Eye Clinic/training of Ophthalmologists | 121 – General health | 91 - Medical services | Mozambique | Norad | 178,51 |
| Undefined | In cooperation with 5 partners contribute to a multi sectorial system to protect children from violence and abuse, through capacity development and awareness raising | 160 - Other social infrastructure and services | 10 - Social/welfare services | Mozambique | Norad | 275,6 |
| SOS Children's Villages of Mozambique | Basic health services to households with orphans and vulnerable children, medical support, immunization, nutrition, household food security, information and training to improve health knowledge and practice, including HIV/AIDS prevention and health. | 122 - Basic health | 20 - Basic health care | Mozambique | Norad | 108,15 |
| ICDP - International Child Development Program | Applying the ICDP method of psychosocial intervention in training of workers (social workers, teachers, parents) to vulnerable children. | 160 - Other social infrastructure and services | 64 - Social mitigation of HIV/AIDS | Mozambique | Norad | 154,08 |
| Case Medical Centre | To enhance the capacity of clinicians in the areas of medicine, surgery and nursing care | 121 - Health, general | 91 - Medical services | Myanmar | Fredskorpset | 25,1 |
| National Red Cross/Red Crescent Society | Nepal Red Cross Community Development Program: improvement of community and personal hygiene, construction of sanitation facilities and education in hand washing practices. | 122 - Basic health | 61 - Health education | Nepal | Norad | 85,48 |
| Nepal Ministry of Health | Implementing TB control by DOTS strategy gradually to the whole country, with technical, and administrative assistance as well as financial support for the training and supervision of the program. | 122 - Basic health | 63 - Tuberculosis control | Nepal | Norad | 585,24 |
| Nepal Association of the Blind | The objective of the rehabilitation project is to improve the living conditions of visually impaired people living in the target areas. | 160 - Other social infrastructure and services | 10 - Social/welfare services | Nepal | Norad | 164,87 |
| United Mission to Nepal | Strengthening primary health care by making maternal and child health available to marginalized groups in peripheral villages. Emphasis on building women's groups and management | 122 - Basic health | 20 - Basic health care | Nepal | Norad | 254,71 |

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| | committees to ensure sustainable local ownership. | | | | | |
| Plan International | Given support, the program will promote the right of all children in Nepal to be recognized as citizens, protected from harm, and access to health and education services. | 130 - Population policies/programs and reproductive health | 10 - Population policy and administrative management | Nepal | Norad | 291,3 |
| Save the Children - local partner | Care and support for HIV/AIDS affected children. | 160 - Other social infrastructure and services | 64 - Social mitigation of HIV/AIDS | Nepal | Norad | 61,42 |
| Koshish | The proposed project titled 'Mainstreaming Mental Health into general health system in Nepal through self advocacy' emphasizes on awareness and advocacy on mental health to influence government on including mental health into the general health system. | 122 - Basic health | 20 - Basic health care | Nepal | Norad | 16,29 |
| Haukeland University Hospital | Feasibility Study, Blood Bank, Nepal | 121 – General health | 91 - Medical services | Nepal | Fredskorpset | 3,53 |
| RECPHEC - Resource Centre for Primary Health Care | Employee Exchange Program among South Asian NGOs working on Health and Environment with focus on Health Rights of the people | 122 - Basic health | 61 - Health education | Nepal | Fredskorpset | 36,72 |
| RECPHEC - Resource Centre for Primary Health Care | Feasibility Study on South Asian NGOs working on Health and Environment with focus on Health Rights of the People | 122 - Basic health | 61 - Health education | Nepal | Fredskorpset | 1,09 |
| Dhulikhel Hospital | Contribution to procurement of a new CT scanner at Dhulikhel hospital, for better diagnostic services and in support of cooperation with NTNU to establish a neurosurgical treatment service as well as ongoing research cooperation. | 121 – General health | 91 - Medical services | Nepal | Ministry of Foreign Affairs | 306,23 |
| United Mission to Nepal | UMN currently capacity builds the technical and organizational ability of local partner organizations including NGOs, government institutions and Faith Based Organizations targeting poor, marginalized and vulnerable people. | 122 - Basic health | 20 - Basic health care | Nepal | Norad | 74,45 |
| National Red Cross/Red Crescent Society | Nepal Red Cross' Youth HIV/ Aids prevention program: peer-to-peer education amongst students, advocacy for people living with HIV/ Aids, prevention of social discrimination as well as trafficking. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Nepal | Norad | 117,96 |
| FO - Union of child welfare workers, and Social Workers | Services for persons with intellectual disabilities: Habilitation, rehabilitation, health care, vocational work, integration, quality of life, empowerment of parents and guardians. | 122 - Basic health | 81 - Health personnel development | Nepal | Fredskorpset | 9,71 |

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| WFP - World Food Program | Junior professional officer Christian Hammer WFP | 121 – General health | 10 - Health policy and administrative management | Niger | Ministry of Foreign Affairs | 173,2 |
| Health and Development International, Norway | The project aim at reducing maternal mortality and prevent obstetric fistula in the Tillaberi Region. This by practicing and training volunteers (women) in the villages by counseling and providing information to pregnant women families. Organize transportation to hospital in cases of life threatening births. Refer women with fistula to the hospital for free treatment. | 122 - Basic health | 20 - Basic health care | Niger | Norad | 68,05 |
| Health and Development International, Norway | The project is aiming at decreasing mortality rates among women due preventing post partum bleeding by 50% by 2016. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Niger | Norad | 680,5 |
| The Health Alliance | The goal of the project is to facilitate the adoption and sustainable use of mobile technology as well as information and communication technology (ICT) - namely mHealth and eHealth – under Nigeria's initiative to save 1 million lives. Saving One Million Lives (SOML) is a nationwide, strategic, government-led initiative to strengthen the maternal and child health care system and to reduce maternal and under-5 mortality to save 1 million lives by 2015. | 122 - Basic health | 20 - Basic health care | Nigeria | Norad | 1416,3 |
| DFID - Department for International Development | The goal of the program is to improve maternal, newborn and child health in Northern Nigeria. The purpose of the program is to achieve improved quality and access to MNCH services in three States: Katsina, Yobe and Zamfara. The program will revitalize primary health care in poorly served states in northern Nigeria, with a particular focus on improving maternal, newborn and child health (MNCH). Norway will support the initaitive through a delegated cooperation with DFID. | 130 - Population policies/program and reproductive health | 20 - Reproductive health care | Nigeria | Ministry of Foreign Affairs | 5945,66 |
| CHAI - Clinton Health Access Initiative | Access to ORS and zinc for the treatment of diarrhea in Nigeria is stymied by failures in the local market for diarrhea treatments. These failures constitute a "market trap" that renders zinc and ORS unaffordable and unavailable for the majority of Nigerians. This Project will address this by increasing demand, increased investment in production and promotion, and increased competition and economy of scale in production. | 121 – General health | 10 - Health policy and administrative management | Nigeria | Norad | 956,93 |
| IFRCRCS - International Federation of Red Cross and Red Crescent Societies | Pakistan Red Crescent Health. Community Based Health and First Aid (CBHFA) and Basic Health activities. Training of volunteers and increasing capacities in local communities. | 122 - Basic health | 61 - Health education | Pakistan | Norad | 86,76 |
| Rahma Islamic Relief, Pakistan | Pakistan | 122 - Basic health | 30 - Basic health infrastructure | Pakistan | Norad | 85,06 |

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| National Red Cross/Red Crescent Society | FATA Health. Community Based Health and First Aid (CBHFA) and Basic Health activities. Training of volunteers and increasing capacities in local communities. | 122 - Basic health | 61 - Health education | Pakistan | Norad | 46,7 |
| UNICEF-United Nations Children's Fund | MDG 4 and 5 | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Pakistan | Ministry of Foreign Affairs | 3402,52 |
| Friends of the Mind - Local office | Community Mental Health Care Centre at District of Peshawar | 122 - Basic health | 81 - Health personnel development | Pakistan | Norad | 42,53 |
| National Red Cross/Red Crescent Society | Jacobabad Branch Dev - health. Community Based Health and First Aid (CBHFA) and Basic Health activities. Training of volunteers and increasing capacities in local communities. | 122 - Basic health | 61 - Health education | Pakistan | Norad | 24,38 |
| AMDF - AL Munir Development Foundation | IHSG is a Norwegian NGO of Pakistani diaspora established in 1994 by professionals within health and social sector in Norway. The project is related to running of a clinic in the Mandi-Bahuddin district Pakistan, and support to medical equipment. | 122 - Basic health | 30 - Basic health infrastructure | Pakistan | Norad | 42,53 |
| Aga Khan Foundation | Retrofitting of Tehsil Headquarters Hospital, Garamchshma, Chitral under public-private partnership between Aga Khan Foundation and Department of Health, Government of Khyber Pakhtunkhwa | 122 - Basic health | 30 - Basic health infrastructure | Pakistan | Ministry of Foreign Affairs | 255,19 |
| Case Medical Centre | To enhance the capacity of clinicians in the areas of medicine, surgery and nursing care | 121 – General health | 91 - Medical services | Rwanda | Fredskorpset | 50,21 |
| RNMA - Rwanda Nurses and Midwives Association | Rwanda Nurses and Midwives Association. Appropriation and establishment of continued support | 121 – General health | 10 - Health policy and administrative management | Rwanda | Norad | 110,11 |
| Ker Yaakaar | The project basically aims at improving the livelihood of the poorest part of the population in the two departments Kaolack and Kaffrine. | 140 - Water and sanitation | 31 - Basic drinking water supply | Senegal | Norad | 137,46 |
| FORUT - Local partner | Develop a model of addressing children's vulnerability to alcohol and drug use in urban areas, to use to advocate for institutionalization and scaling-up. Working with schools. Increased participation of children and youth in community groups, and understanding among police and Ministry of Education | 121 - Health, general | 10 - Health policy and administrative management | Sierra Leone | Norad | 125,26 |
| FORUT - Local partner | Improve the child's right to education, participation and healthy home environment. Improve knowledge on CR among parents and teachers. Improve economic situation poor families reduces the child's vulnerability to lack of education, trafficking and child labour. | 160 - Other social infrastructure and services | 50 – Multi-sector aid for basic social services | Sierra Leone | Norad | 317,33 |

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| FORUT - Local partner | Increased control and benefit from economic and social resources for previously economically inactive women from extremely poor families. Reduction in water and sanitation borne diseases, improved pre- and post-natal care and nutrition for mothers and children, safer sexual practices. Rural areas | 160 - Other social infrastructure and services | 50 – Multi-sector aid for basic social services | Sierra Leone | Norad | 392,49 |
| Norsk Folkehjelp | The overall objective is to educate competent and reliable nurses, midwives and laboratory technicians working in the health sector in Southern Sudan and the three areas: Abiey, South Kordofan and Blue Nile. | 121 – General health | 81 - Medical education and training | South Sudan | Norad | 697,52 |
| Norwegian Church Aid - local office | Funding to cover 7 area that NCA focuses on in South Sudan | 122 - Basic health | 20 - Basic health care | South Sudan | Norad | 4253,15 |
| National Red Cross/Red Crescent Society | South Sudan Red Cross Community Based Health and First Aid (CBHFA) and Basic Health activities. Training of volunteers and increasing capacities in local communities. | 122 - Basic health | 61 - Health education | South Sudan | Norad | 226,1 |
| Salvation Army - local office | Approach the aids epidemic in Swaziland from SA's three clinics. Includes information, home based care, support to orphans, counseling. Operates in 14 peri-urban areas covering a population of 58,000 people. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Swaziland | Norad | 183,69 |
| MSF - Médecins Sans Frontères | HIV/AIDS treatment and integration of district health services-Mbabane in Swaziland Referenced agreement: GLO-07/231 - Medicines sans Frontiers - Multi annual agreement 2007-2009 | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Swaziland | Norad | 493,37 |
| Mukikute - The fight against TB and HIV in Temeke | Involving TB patients and community through the patient organization MUKIKUTE to reduce TB morbidity and mortality to a level where it is no longer a public health problem | 122 - Basic health | 63 - Tuberculosis control | Tanzania | Norad | 245,03 |
| Ifakara Health Research Development Centre | Ifakara Health Institute (IHI) will carry out an end line survey of the P4P pilot in Pwani Region, which will include an Impact Evaluation and a Cost-Effectiveness Analysis. IHI has earlier been contracted by the Norwegian Embassy in Tanzania to carry out the baseline survey for the impact evaluation, the process evaluation as well as an economic evaluation. This End line Survey generally uses the same methodology and the same trained personnel. | 121 – General health | 82 - Medical research | Tanzania | Norad | 340,25 |
| Dogodogo Centre | Most vulnerable children's rights to education and care, and education for Pastoralist Girls. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Tanzania | Norad | 137,2 |
| Haukeland University Hospital | Exchange of health personnel between Ocean Road Cancer Institute and dept. of Oncology, Haukeland University Hospital | 121 – General health | 91 - Medical services | Tanzania | Fredskorpset | 112,12 |

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| The Temeke Municipal Council | Community based HIV/TB treatment in Temeke district Dar Es Salaam | 122 - Basic health | 63 - Tuberculosis control | Tanzania | Norad | 118,54 |
| Ifakara Health Research Development Centre | Budget support to Ifakara Health institute (IHI) under a joint Memorandum of Understanding with other development partners, focusing capacity improvement for health systems development related to MDG 4, 5 and 6 | 121 – General health | 10 - Health policy and administrative management | Tanzania | Norad | 680,5 |
| Haydom Lutheran Hospital | The Block Grant Support will provide co-financing for HLH's continuation of existing hospital and outreach services for the period 2010-2014, with particular emphasis on effective maintenance of maternal, newborn and child health services. | 121 – General health | 91 - Medical services | Tanzania | Ministry of Foreign Affairs | 2943,18 |
| Sophies Minde Ortopedi AS | Capacity building in prosthetic and orthotic educational centers and services in low income countries | 121 – General health | 81 - Medical education and training | Tanzania | Fredskorpset | 144,46 |
| Ilula Orphan Program | HIV/AIDS awareness creation targeting local communities, particularly youth. Advocacy towards local authorities. Support to affected families | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Tanzania | Norad | 73,17 |
| Undefined | Talk for Change: A Comprehensive Sexual and Reproductive Health and Rights Education for Women and aAolescent Girls in Tanzania. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Tanzania | Norad | 59,86 |
| Academy in Bergen | Strengthen BSc Program in Physiotherapy at Ahfad University for Women and develop regional cooperation in rehabilitation and physiotherapy education | 121 – General health | 91 - Medical services | Tanzania | Fredskorpset | 22,45 |
| Haukeland University Hospital | Feasibility Study planning to implement drug abuse component to the excisting Helse-Bergen projects in Zanzibar, Mnazi Moja Hospital | 121 – General health | 91 - Medical services | Tanzania | Fredskorpset | 9,48 |
| Academy in Bergen | Strengthen BSc Program in Physiotherapy at Ahfad University for Women and develop regional cooperation in rehabilitation and physiotherapy education | 121 – General health | 91 - Medical services | Tanzania | Fredskorpset | 2,21 |
| CHAI - Clinton Health Access Initiative | The objectives of the grant are: 1.To maintain the gains and increase performance of Pwani Region with regards to maternal and child health services with minimal PMT support: 2. To provide support for further development of a functional management system and structure in MOHSW | 121 – General health | 10 - Health policy and administrative management | Tanzania | Norad | 394,59 |
| Haukeland University Hospital | Exchange in the field of pediatrics and internal medicine between Norway and Zanzibar | 121 – General health | 91 - Medical services | Tanzania | Fredskorpset | 584,42 |
| MUHAS - Muhimbili University of | Regional master in nursing | 121 – General health | 81 - Medical education and training | Tanzania | Norad | 152,35 |

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| Health and Allied Sciences | | | | | | |
| Sophies Minde Ortopedi AS | Capacity building in prosthetic and orthotic educational centers and services in low income countries | 121 – General health | 91 - Medical services | Tanzania | Fredskorpset | 54,03 |
| Haukeland University Hospital | Exchange of health personnel between Ocean Road Cancer Institute and dept. of Oncology, Haukeland University Hospital | 121 – General health | 91 - Medical services | Tanzania | Fredskorpset | 317,68 |
| SIAC - Singida Inter African Committee | Combating FGM in the Singida region | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Tanzania | Norad | 140,47 |
| Sørlandet Hospital Helse Fonna | Exchange of personnel between SSHF and HLH in bilateral competence building, Norway - Tanzania | 121 – General health | 91 - Medical services | Tanzania | Fredskorpset | 124,79 |
| Women's Promotion Centre | Talk for Change: A Comprehensive Sexual and Reproductive Health and Rights Education for Women and Adolescent Girls in Tanzania. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Tanzania | Norad | 12,8 |
| Academy in Bergen | Secure a sustainable BSc Program in Physiotherapy at Ahfad University for Women and to develop a regional cooperation in rehabilitation and physiotherapy education. | 121 – General health | 81 - Medical education and training | Tanzania | Fredskorpset | 51,89 |
| Adina Foundation | Rehabilitation of former abducted children and children with disabilities in Northern Uganda. | 121 – General health | 91 - Medical services | Uganda | Norad | 119,09 |
| Case Medical Centre | To enhance the capacity of clinicians in the areas of medicine, surgery and nursing care | 121 – General health | 91 - Medical services | Uganda | Fredskorpset | 34,76 |
| HAU - Health Alert Uganda | Mitigate the impact of HIV and AIDS on children and their families, improved access to quality HIV and AIDS prevention, care and treatment services, including mother to child transmission of HIV, for children and their families. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Uganda | Norad | 92,21 |
| Caritas - local partner | Strengthen grassroots' organizations and local communities in order to prevent HIV and mitigate the consequences of AIDS. | 160 - Other social infrastructure and services | 64 - Social mitigation of HIV/AIDS | Uganda | Norad | 119,6 |
| Pentecostal Churches of Uganda | Information and promotion of behavior change to fight the spread of HIV/AIDS. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Uganda | Norad | 176,16 |
| Uganda National Association of the Blind | Regional offices of Uganda National Association of the Blind. | 160 - Other social infrastructure and services | 10 - Social/welfare services | Uganda | Norad | 128,62 |
| IOM - International Organization for Migration | Response to national trafficking of women, young girls and their children with a special focus on Karamoja sub-region | 160 - Other social infrastructure and services | 50 – Multi-sector aid for basic social services | Uganda | Ministry of Foreign Affairs | 510,38 |

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| DII - Development Initiatives International | A program with the aim to mitigate the impact of HIV/AIDS in targeted informal business communities in local markets. This will be done though programs to increase knowledge and awareness of HIV/AIDS, foster the adoption of safer sexual behavior in target communities and conduct voluntary counseling and testing, coupled with capacity building for market based CBOs. This will be done using the Market Vendors Aids Project Model that has been successfully developed by Development Initiative | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Uganda | Ministry of Foreign Affairs | 368,55 |
| Uganda Nurses And Midwives Union | Strengthen and empower Uganda Nurses and Midwives Union as an effective, sustainable professional and trade union organization for nurses & midwives. | 121 – General health | 10 - Health policy and administrative management | Uganda | Norad | 342,62 |
| GUSCO - Gulu Support the Children Organization, Uganda | Child protection - Save the Children in Uganda is a broad range of child protection work. The strategic objectives aim at strengthening community based child protection systems to prevent and respond to abuse, exploitation and violence against children and advocacy for increased government capacity to prevent and respond to child protection issues. | 160 - Other social infrastructure and services | 10 - Social/welfare services | Uganda | Norad | 315,41 |
| Case Medical Centre | To enhance the capacity of clinicians in the areas of medicine, surgery and nursing care | 121 – General health | 91 - Medical services | Uganda | Fredskorpset | 75,31 |
| Lions Aid Norway | Eye care infrastructure building, competence building and information dissemination about treatment for eye deceases in Uganda. | 121 – General health | 91 - Medical services | Uganda | Norad | 125,04 |
| National Red Cross/Red Crescent Society | Capacity building of Yemen Red Crescent in Community Based Health and First Aid (CBHFA) with focus on community health development and OD targeting vulnerable women and children. | 122 - Basic health | 61 - Health education | Yemen | Norad | 338,5 |
| Sabona | Community Health Care and Awareness Project with a focus on HIV/AIDS in Zimbabwe | 121 – General health | 10 - Health policy and administrative management | Zimbabwe | Norad | 51,04 |
| SOS Children's Villages Association Zimbabwe | Preventions of abandonment, particularly targeted HIV/AIDS affected households, including social, legal and economic assistance, support to child-headed/granny-headed households due to HIV/AIDS: HR training, food security including environmental friendly crops, income generating activities, | 160 - Other social infrastructure and services | 64 - Social mitigation of HIV/AIDS | Zimbabwe | Norad | 46,31 |
| SOS Children's Villages Association Zimbabwe | Basic health services to households with orphans and vulnerable children, medical support, immunization, nutrition, household food security, information and training to improve health knowledge and practice, including HIV/AIDS prevention and health enhancing environment measures | 122 - Basic health | 20 - Basic health care | Zimbabwe | Norad | 102,91 |
| Zimbabwe district administration | Strengthening the capacity within the community to protect children against the impact of HIV and AIDS. More young people know how to protect themselves against HIV infection. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Zimbabwe | Norad | 728,31 |

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| National Red Cross/Red Crescent Society | The Zimbabwe Red Cross HIV/AIDS program focus on vulnerable children and orphans and their caretakers, in order to reduce HIV/AIDS transmission and stigmatization. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Zimbabwe | Norad | 73,26 |
| ZIM Sports and Recreation Commission | Develop a nation wide community sport systems and the capacity of local communities to deliver sport programs and to use sport in addressing social issues such as HIV/ AIDS. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Zimbabwe | Norad | 221,16 |
| UNICEF-United Nations Children's Fund | The Health Transition Fund is a multi-donor pooled fund, managed by UNICEF, to support the Ministry of Health and Child Welfare (MoHCW) in Zimbabwe to achieve the highest possible level of health and quality of life for vulnerable mothers and children under-five years. | 130 - Population policies/programs and reproductive health | 20 - Reproductive health care | Zimbabwe | Ministry of Foreign Affairs | 4763,53 |
| The United Methodist Church Zimbabwe | The project main goal is the fight against HIV/AIDS. | 130 - Population policies/programs and reproductive health | 40 - STD control including HIV/AIDS | Zimbabwe | Norad | 45,03 |