Norad

2013

RESULTS REPORT
HEALTH AND EDUCATION

One of the targets of Millennium Development Goal 3 is full gender equality at all levels of education by 2015. Study programmes supported by Norway have gender balance as a goal. The picture is from Universitas Gadjah Mada (UGM) in Indonesia, where the number of female students in the master's degree programme has increased for each student cohort. Read about the results of UGM's cooperation with Norwegian universities and university colleges on pages 52-53.

Photo: Ken Opprann

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FOREWORD

Investment in health and education is a basic requirement for all countries that desire economic growth and a high standard of living. One of the reasons for Norway's high ranking on the United Nations Human Development Index every year is that we have a healthy and well-educated population.

Since 2000, the Norwegian commitment to health and education has largely been focused on the UN Millennium Development Goals. The Norwegian contribution has been a combination of political leadership, funding, innovation and knowledge. The poverty reduction target has been achieved ahead of schedule. In developing countries, 90 per cent of children now have access to schooling, while child and maternal mortality rates have been halved.

At the same time, not all the Millennium Development Goals will be met by the deadline. In some areas, progress is too slow. Far too many women still die in childbirth because they do not have the assistance of skilled birth attendants. With simple means, many more newborn lives could have been saved every day. Although many children have access to schooling, the standard of teaching is often poor. Of the world's young people, 123 million cannot read and write, and it is estimated that 34 million of the children who started school in 2011 will leave before completing primary education.

To develop skills that countries need for their own development and to take part in a global economy increasingly dependent on knowledge, developing countries need their own academic institutions and the capacity to educate their own human resources. The report presents several examples of cooperation that have built up such capacity.

As in previous years, Norad's results report is neither a research report nor an evaluation. It presents a selection of results as examples within this year's theme. The examples are based on evaluations, research, project reports, and assessments by the Norwegian Foreign Service as well as by Norad. More information about the results of development cooperation is presented in the Norwegian government budget for 2014, Report No. 1 to the Storting (2013-2014), Chapter 12. Documentation of positive and negative effects of Norwegian development cooperation provides important lessons learned to inform future efforts.

Oslo, 11 December 2013

Villa Kulild,
Director General of Norad

SUMMARY

A selection of 15 examples of results in education and 12 in health provides a glimpse of Norwegian development cooperation in these areas.

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Burundi's oldest school is Stella Matutina Elementary in Bujumbura, the capital city. It was built in 1958 and has more than 1,000 students enrolled from grades 1 to 6. Burundi experienced a rapid increase in the number of children enrolled in primary school after the government introduced free and compulsory primary education in 2005. Read about the results of Norway's development cooperation in primary education in Burundi on pages 40-41.

Photo: Ken Opprann

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The primary aim of Norway's development cooperation in health and education is to help to achieve five of the eight UN Millennium Development Goals set for 2015. Since they were adopted in 2000, governments and partners in civil society and the private sector have been working together to support these goals. Great progress has been made in both health and education, where a number of countries are in the process of achieving several of the Millennium Development Goals. Combined international efforts have yielded positive results.

1. More children than ever before are attending school. Today, nine out of ten children in developing countries start primary school.
2. Girls' attendance in primary school has increased, and girls and boys have almost equal access to schooling on a worldwide basis. However the trend has not been equally positive in all countries.
3. The three infectious diseases with the greatest impact on poor people – HIV/AIDS, malaria and tuberculosis – make up a dwindling share of the world's total disease burden. From 1990 to 2010, the proportion was reduced from 47 to 35 per cent of the global disease burden, with millions of lives saved.[1]
4. Better health services and interventions for children, such as vaccines and mosquito nets, have halved child mortality in Africa from 1990 to 2013. Such a rapid decline in child mortality has never happened before in history.
5. The maternal mortality rate was halved from 1990 to 2010. The Millennium Development Goal of a 75 per cent reduction cannot be achieved by 2015, but the decline is expected to accelerate in the coming years. Increased resources have been mobilized for lifesaving interventions including access to essential medicines and equipment.
6. Quality of services is a shared challenge for further work in health and education. In school, the learning environment and learning outcomes for children are not good enough. Improved quality of systems for health information and service delivery is vital to enable essential services to reach more people and to sustain the results that have already been achieved.

The examples in this report describe the results of 27 interventions in Africa, Asia and Latin America. In all the examples, lessons learned are delineated as a reference for future work. It is important to learn from initiatives that work, and not least, from those that do not work.

EDUCATION FOR ALL IS POSSIBLE

Great strides have been made towards ensuring education for all. In Afghanistan, the number of children in primary education has increased from one million to 9.2 million since 2001 – of which 3.6 million are girls. Norway was one of the initiators of the Global Partnership for Education (GPE), which has helped to realize children's right to schooling. Today, the GPE is a partnership between 59 developing countries, donor countries, the UN, the World Bank, civil society organizations and the private sector. The countries that participate in GPE have enrolled twice as many children in primary education as countries outside the GPE partnership. It is estimated that since the GPE was launched in 2002, 21.8 million more children have gained the opportunity to go to school because of the added capacity to which the GPE has provided. However, ten per cent of children in developing countries are still out of school.

The most important factors keeping children out of school are war and conflict, household poverty, lack of resources in the community to develop adequate schooling, or belonging to a discriminated group. These children in the last ten per cent are often considered the hardest to reach. Examples in this report show however that this is possible, but requires a determined effort with sufficient will and resources.

EFFORTS FOR MARGINALIZED GROUPS

In Colombia, the efforts of the Norwegian Refugee Council have increased school attendance rates for children and young people affected by conflict. For many years, Norway has supported the authorities in Nepal in working to provide all children access to school and learning of high quality. The last three years of available data (2008-2011) show an increase in primary school enrolment from 83 to 91 per cent. For girls, the increase was from 81 to 90 per cent. In Vietnam, 60 per cent of all children with disabilities are out of school. However, cooperation with local authorities, schools and the Norwegian Mission Alliance has helped to increase school coverage for children with disabilities to 85 per cent in one province of Vietnam. The work of Save the Children Norway in Uganda shows how a locally adapted and flexible curriculum and school services can increase school attendance in nomadic communities. In a number of countries, girls are still more likely to be out of school than boys. An example of the Norwegian commitment to girls' education is the support for the Forum for African Women Educationalists (FAWE), which is working systematically to improve learning environments for both genders.

SCHOOLING QUALITY IS TOO LOW

Droping out of primary school before reaching the last grade and poor learning outcomes in schools are major challenges in a number of countries. Efforts to increase access to primary education have not been followed up with corresponding efforts to ensure quality in the learning environment and learning outcomes for children. Such change processes take time and demand resources. UNICEF's commitment in Burundi shows that great progress can be achieved through cooperation in areas with low school enrolment and poor examination results. The efforts of Save the Children Norway to improve teachers' skills in several African countries illustrate the key role of teachers. ILO's programme for classroom construction in Madagascar shows that a better physical school environment improves also teaching practices and thus the students' participation and results.

HIGHER EDUCATION PROVIDES A QUALIFIED WORKFORCE AND CONTRIBUTES TO DEMOCRATIC DEVELOPMENT

Countries in development need qualified labour in all sectors of industry and commerce. Universities and higher education institutions are providers of these resources. They are also important arenas for public debate that may provide the basis for democracy and better protection of human rights. Growing numbers of young people seeking higher education create a need for strengthening and expanding the provision of higher education in developing countries. Makerere Uni-

1 Includes maternal and neonatal health, as well as nutrition disorders. Lawrence Haddad, New Global Burden of Disease Analysis, IDS, Jan 2012

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versity in Uganda has developed programmes in several disciplines that are important to the community. The commitment to the Centre for Women's Law at the University of Zimbabwe shows how higher education can contribute to safeguarding the rights of girls and women in legislation and legal practice. Norwegian cooperation with Universitas Gadjah Mada in Indonesia supports the role of academia in the development of democracy. The support to the African Economic Research Consortium shows the importance of educating African researchers in economics, social development and governance. Cooperation with the fishery sector in Vietnam illustrates the contribution of higher education and research to skills that are important for commercial development and sustainable management of natural resources.

GLOBAL INITIATIVES SAVE LIVES

Through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Norway has contributed to the great decline in mortality related to AIDS. This has been achieved through both prevention and treatment of HIV. Mortality rates from tuberculosis and malaria have also been reduced. Through its support to the Vaccine Alliance GAVI, Norway has helped to prevent more than 5.1 million deaths. Although major challenges remain, Norway's contribution through the bilateral initiative in Malawi has helped to reduce maternal mortality by 31 per cent from 2004 to 2010. Thanks to a focus on the education of physicians and nurses, Malawi now educates 60 doctors per year, compared with 20 in 2004. The number of newly graduated nurses has also increased significantly.

PROJECTS AND INSUFFICIENT PROGRESS

The report also describes interventions that have not achieved planned results. The reduction in neonatal deaths is much slower than for older children. One of the reasons is that advanced and expensive health services are needed to reduce these deaths. Good maternal health and nutrition are also important for infant survival. Despite the progress in education in Afghanistan, half the schools have inadequate or no buildings and many of the teachers lack the required skills and training, resulting in considerable problems. The initiative for maternal and child health in Sindh province of Pakistan shows that it may sometimes be necessary to phase out a project when it does not yield the expected results.

INNOVATION IMPROVES HEALTH SERVICES

Results-Based Financing (RBF) produces good results. In Rwanda, this funding method led to 23 per cent more deliveries of babies in clinics where payment was made after services had been provided compared to other clinics. Through its work for the Commission on Information and Accountability, Norway has helped to ensure that commitments made to maternal and child health by countries and donors are followed up, and that they yield good results. The University of Oslo has taken the lead in establishing systems for health data acquisition and reporting in a number of countries through its Health Information Systems Programme (HISP). Electronic and mobile-based solutions have also been piloted in new areas of the health sector. The price of the contraceptive implants Jadelle and Implanon has been halved thanks to guarantees that any surplus implants would be purchased. The need for implants has been met, and future supply has been improved. A partnership between India and Norway has provided added value to India's extensive public health initiatives for women and children. A result of this cooperation has been that more than 20,000 children have received intensive care in hospitals, while 500,000 women have received care during childbirth, and about one million children have received follow-up care in their homes after birth.

CHANGE IN ATTITUDES AND BEHAVIOUR

Together with partners, Norway is working at both political and practical levels to combat female genital mutilation. In 2012, the UN unanimously adopted a resolution against the practice, after a proposal from several African countries. The impact of genital mutilation on health has become more widely recognized, thanks to the efforts of UNICEF, UNFPA, World Health Organization and civil society organizations. In East Africa, the focus area for Norwegian support, a study showed reduced prevalence of genital mutilation among girls aged 15 to 19 compared with 45- to 49-year-old women in Eritrea, Ethiopia, Kenya, and Tanzania. In Kenya and Tanzania, the practice has almost been eliminated in several ethnic groups. Efforts against HIV/AIDS among lesbian, homosexual, bisexual and transgender people in Southern Africa have influenced attitudes and living conditions for vulnerable groups. Although abortion is a sensitive topic in many places, the work of the organization Ipas in Nepal has achieved significant results. Unsafe abortions have been reduced and many lives have been saved.

At a café for young people in Hue, Vietnam, guests receive information about HIV/AIDS.

Education and knowledge – a prerequisite for HIV prevention

Every day, 6,800 people are infected by HIV/AIDS. Education and knowledge are important in the fight against the disease. At school and in higher education, children and young people can learn how they can reduce their risk of getting HIV. A survey conducted in 32 countries found that women who receive education after primary school had five times more knowledge about HIV/AIDS than women who can not read and write.

Education for girls also empowers them to resist sexual pressure.

UNAIDS has established that education is important for preventing HIV, and knowledge is also needed to reduce the discrimination and stigma that many people living with HIV experience. Studies suggest that sex education causes young people to delay their sexual début, to have fewer sexual partners and to have less unprotected sex.

In Sub-Saharan Africa, many young people still have insufficient knowledge about HIV, but the proportion with accurate and comprehensive knowledge has increased by five percentage points from 2002 to 2011. It is now 36 per cent for men and 28 per cent for women. Many countries have not introduced adequate sexual education for young people.

Even where measures against HIV are not taken, education provides important protection against becoming infected. The Global Campaign for Education has estimated that education for all would prevent 700,000 new cases of HIV per year.

Source: The UNESCO web pages on Education for All, combating HIV/AIDS, malaria and other diseases

KEY MESSAGES

The lessons learned from development cooperation in health and education provide direction for further efforts. The 27 result examples presented in the report contribute to this knowledge. A recurring theme throughout the report is that international cooperation on health and education is critical to solving global challenges.

Burundi is one of the countries in which GAVI is working to vaccinate children. Three days a week, mothers bring their children to the vaccination centre in Rumonge. Health records that show which vaccines the children have received are carefully checked. Worldwide, more than 390 million children were fully vaccinated with support from GAVI from 2000 to 2012. Read more on pages 68–69.

1. DEVELOPMENT COOPERATION LEADS TO BETTER HEALTH AND EDUCATION FOR POOR PEOPLE

Never before has the world seen such progress in health and education as in the past 25 years. From 1999 to 2011, the number of children of primary school age who did not go to school decreased from 108 to 57 million, despite significant population growth. The HIV epidemic has been reversed and the number of new cases is declining. Child mortality in Africa has been halved. Such a rapid decline in mortality rates has never before occurred on any continent. In several countries, development cooperation has played a decisive role in this progress. Such achievements become possible when development assistance is used to support national priorities. Combined with resource mobilization and international agenda setting, development cooperation has yielded positive results.

2. STABILITY, NATIONAL LEADERSHIP AND LOCAL EXPERTISE ARE VITAL TO ACHIEVING POSITIVE LONG-TERM RESULTS

A hallmark of countries that have succeeded in improving health and education in their own population is that they have given priority to these sectors in their budgets. National ownership through coordination of international and national resources is also important, with guidelines for how and where efforts should be focused. International statistics[2] show that countries that have received significant aid for education have also increased their domestic funding for education. Supporting national ownership is a key principle for effective development cooperation. Stability, safety and security are prerequisites for development. During crises and conflicts, humanitarian aid channelled through the UN and NGOs has contributed to meeting essential health and education services. Among fragile states that have experienced war and conflict since 2000, progress towards the UN Millennium Development Goals has been much slower than in other countries, even though 20 fragile states have now achieved one or more of the goals.[3]

3. JOINT EFFORTS LEAD TO BETTER RESULTS

The UN Millennium Development Goals have led to political mobilization and a focus of national and international efforts on priority areas. The progress in health and education shows that a joint set of clear and simple targets can lead to impressive improvements. The Millennium Development Goals have been criticized for not focusing strongly enough on equity and on how to achieve the goals. Development cooperation has provided a tool to direct efforts towards the poorest and most marginalized people. Despite progress on all of the goals, many of them will not be achieved by the 2015 deadline. Political will and leadership will be vital for further progress.

4. INVESTMENT IN GIRLS' EDUCATION AND HEALTH HAS POSITIVE RIPPELING EFFECTS

Girls with education have fewer children, and give birth later in life. This reduces child and maternal mortality and helps to curb population growth. Children of educated mothers are more likely to attend school, are better nourished and healthier. Extending girls' education beyond primary school is one of the most profitable investments a country can make. Educating girls is also key to ensuring women's participation in politics and society.

5. A CLEAR VOICE FOR HUMAN RIGHTS IS NEEDED TO GIVE MARGINALIZED GROUPS ACCESS TO HEALTH AND EDUCATION SERVICES

Lack of respect for human rights affects marginalized groups and reinforces inequality. Minorities and discriminated segments of the population do not get the services they need. Norway raises sensitive issues in international forums and with national government agencies, on topics such as women's rights to contraception and safe abortion, protection against genital mutilation and sexual violence, rights for lesbian, gay, bisexual and transgender people, as well as for people with disabilities. Reduced maternal mortality is clearly related to women's ability to decide over their own body, for example through access to contraception and safe abortion. Focusing on the right to health and education for all can make it easier for stigmatized groups to gain access to such services.

2 EFA Global Monitoring Report. UNESCO, 2012.
3 Twenty Fragile States Make Progress on Millennium Development Goals, World Bank, home page, 1 May 2013

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6. THE LAST TEN PER CENT OF THE POPULATION IS THE HARDEST TO REACH.

Today, ten per cent of the world's children do not have an opportunity to attend school. About half of these live in countries in conflict. Four of ten out-of-school children have disabilities. Within countries, the poorest groups, various minorities and those living in the most remote areas have the most limited access to health and education services. Until now, much of the progress in health and education coverage has been achieved by extending the services to reach many, but not all. Future programmes must be developed and adapted to include the hardest to reach. UNICEF has documented that focusing on the most vulnerable and marginalized groups can increase progress towards the Millennium Development Goals.[4]

7. DEVELOPMENT COOPERATION MUST BE ADAPTED TO A CHANGING WORLD

Of the world's 1.2 billion poorest people, 70 per cent now live in middle-income countries, primarily India and China. Middle-income countries have the highest proportion of the world's out-of-school children and the highest rates of child mortality. At the same time, population growth in low-income countries is high; Africa's population is expected to double by 2050. Urban populations in low-income countries are increasing. The World Bank has estimated that at current growth rates more than 70 per cent of the people living in extreme poverty will be found in Sub-Saharan Africa by 2030. All countries are responsible for their citizens' education and health. Middle-income countries have greater capacity than low-income ones to ensure their citizens receive the services they need. In the search for effective solutions, knowledge sharing, technical cooperation and dialogue with and between developing countries are important in addition to financial contributions. It is important to concentrate financial aid and technical cooperation where it has the greatest benefit and effect.

8. YOUTH BULGES CREATE A NEED FOR A STRONGER COMMITMENT TO THE ENTIRE EDUCATION CYCLE AND IMPROVED SCHOOL QUALITY

Due to population growth, the poorest countries are facing a major youth bulge. Children and young people make up nearly half of the population in many of these countries. In addition to increasing school enrolment, education quality and relevance must be improved. Some 250 million children can neither read nor write when they begin fourth grade. The World Bank has estimated that at least 600 million new jobs will be needed in the world during the next 15 years.[5] To create meaningful jobs and solve the challenges facing society, young people must gain access to the whole education cycle from primary to secondary and higher education. International development cooperation has largely been focused on primary education, while secondary and higher education as well as vocational training have received less funding and attention.

9. NEW GLOBAL INITIATIVES HAVE LED TO MORE AND BETTER USE OF RESOURCES

The best results of the global commitment to health and education have been found where different actors have gathered to pool their resources in targeted efforts with clearly defined allocation of tasks. The Global Partnership for Education has contributed to more comprehensive and coherent planning of education initiatives and strengthened national education systems. In the health sector, development assistance has been used to ensure development of vaccines and medicines, provide guarantees for markets that increase volumes for producers and buy large quantities of medicines. This has increased access and reduced prices. However, global initiatives – especially in health – may have undermined local priorities in some cases by building parallel systems that make initiatives less sustainable. The large number of new actors and partnerships may also have weakened the UN agencies' position and coordinating role in some cases. As a whole, however, the resources available and the results indicate that the initiatives are now more effective than before.

10. RISK MANAGEMENT AND MONITORING IS ESSENTIAL IN THE MANAGEMENT OF AID PROJECTS

Experience emphasizes the importance of effective monitoring of project progress, robust risk analyses in advance, and risk mitigating strategies. However, certain factors will always be difficult to predict. Transparency, accountability, responsibility and willingness to learn and innovate all help to make results reporting more effective. Financial controls combined with long-term investment in statistics systems and measurement methods are essential to combat corruption, launch effective initiatives, and achieve the stated objectives.

11. INNOVATION AND INCREASED USE OF TECHNOLOGY CAN IMPROVE QUALITY AND ACCESS TO SERVICES

In the health sector, payments based on delivered services have helped to increase and improve services for children and mothers. Examples of results-based financing include paying hospitals according to the number of women who give birth there, or cash transfers to women after they have given birth in health centres. These initiatives have increased the number of women who give birth in safe conditions. This report provides examples of the development of new and improved health products. In education, new approaches have made it possible to reach marginalized children, keep girls in school, and improve learning environments. The Internet, mobile phones and ICT solutions have created new opportunities in the delivery and organization of services. Innovation in development cooperation requires evaluation, local adaptation and standardization of new initiatives.

12. LOCAL LEADERSHIP IS ESSENTIAL FOR CHANGE

Experience from efforts to combat female genital mutilation and the spread of HIV/AIDS has highlighted the need to support local organizations, religious leaders and respected individuals in the community in order to change attitudes and behaviour in a population. Legislation is needed to counter discrimination and promote safe communities, but often it is not enough. Several of the result examples show that civil society organizations play a key role as initiators and facilitators, often in combination with service delivery. Health and education initiatives are strengthened by better interaction between public authorities, local leaders, businesses, and the population itself.

4 Progress for Children, Achieving the MDGs with Equity, UNICEF, 2010.
5 World Development Report 2013: Jobs. The World Bank.

Education

The Global Partnership for Education ((GPE) Since 2002, 21.8 million more children have been able to go to school because of the increased capacity GPE has contributed to its member countries – 1.9 million of these children have been supported with Norwegian funding.

Higher education

East Africa – From having too few experts in economics, African countries have gained relevant knowledge via researchers educated at the African Economic Research Consortium (AERC).

HEALTH

Infant mortality – Increased efforts by government agencies, donors, and other actors in development cooperation have helped to reduce infant mortality from 56 per 1000 live births in 2000 to 35 per 1000 live births in 2012.

The vaccine alliance GAVI has prevented 5.1 million deaths through new vaccines and increased immunization coverage during the period 2000-2012 – the Norwegian share is 510,000 prevented deaths.

The Global Fund to Fight AIDS, Tuberculosis and Malaria has saved 8.7 million lives through treatment for HIV and tuberculosis as well as insecticide-treated mosquito nets to prevent malaria – the Norwegian share is 174,000 lives saved.

A volume guarantee for the purchase of contraceptive implants resulted in a halving of the price and a 50 per cent increase in orders.

Increased cooperation between countries today enables access to HIV/AIDS treatment and services in sexual and reproductive health for 50,000 migrants in Southern Africa.

Colombia – From 2010 to 2012, 32,160 internally displaced children and young people received schooling through a flexible education model developed by the Norwegian Refugee Council.

Sierra Leone – Software for health information and planning resulted in more women giving birth in clinics and hospitals.

Afghanistan – Government agencies and donors have jointly ensured that primary school enrolments have increased from one million to 9.2 million since 2001 – including 3.6 million girls.

Pakistan – The initiative to promote child and maternal health in Sindh province suffered under poor project management by the UN, as well as delays and failure to take measures for sustainability. The support was phased out.

Uganda – A flexible education programme adapted to local conditions has provided schooling for 265,000 nomadic children since 1998 – Makerere University has developed from not being able to educate graduates in several sectors of society to become an internationally recognized university with more extensive programmes of study and research portfolios.

India – 500,000 women have received care during childbirth and more than 20,000 children have received intensive care treatment in hospital. Mortality has declined.

Nepal – A joint commitment to schools by government agencies and donors has increased school attendance from 89 to 95 per cent since 2008.

Ethiopia – Improved learning outcomes and reading skills after training of teachers supported by Save the Children Norway in Ethiopia, Zambia, Zimbabwe and Mozambique.

Vietnam – With support from the Norwegian Mission Alliance, school coverage for children with disabilities has increased from 40 to 85 per cent in one of the provinces
– The fisheries sector needed greater knowledge and improved profitability. Support to higher education and research collaboration has contributed to knowledge-based and sustainable fisheries management.

Kenya and Tanzania – The risk of genital mutilation has been reduced to a third for girls aged 15-19 compared with women aged 45-49.

Burundi – UNICEF's targeted efforts in three provinces with the poorest school results has increased school attendance, reduced early school-leaving and improved examination results. From 2009 to 2012, school participation in one of the provinces increased from 44 to 74 per cent.

Indonesia – More knowledge is needed about how democracy functions locally and nationally. Cooperation between Universitas Gadjah Mada (UGM) and Norwegian universities has strengthened skills important for the development of good governance in Indonesia.

Madagascar – The learning environment has improved after 21,000 new classrooms were built during the past five years through cooperation between ILO and the local community. Ten per cent more students passed the school-leaving examination.

Malawi – HIV treatment to prevent mother-to-child transmission increased from three to 66 per cent between 2004 and 2010
– Increased capacity for continuing and further education contributed to an increase in the number of doctors from 43 in 2004 to 450 in 2012, and the number of nurses from 3,450 to 4,800.

Zambia – The Forum for African Women Educationalists (FAWE) is making a systematic effort to achieve adaptation of learning environments to both girls and boys. School achievement levels for girls have improved considerably after adaptation of the learning environment.

Zimbabwe – From having no study programmes in women's rights, the University of Zimbabwe has educated 200 experts in women's rights in twelve countries, which is important to safeguard girls' and women's rights in legislation and legal usage – Results-based financing increased the number of antenatal care visits by more than 100 per cent in one year.

STATUS OF THE MILLENNIUM DEVELOPMENT GOALS AND THE TARGETS FOR HEALTH AND EDUCATION

1. ERADICATE EXTREME POVERTY AND HUNGER

1c: By 2015, halve the proportion of the world's population who suffer from hunger.

Status: The hunger reduction target is within reach by the deadline. About 850 million people are still undernourished, and 100 million children are undernourished and underweight.

2. ACHIEVE UNIVERSAL PRIMARY EDUCATION

Status: In developing countries, the percentage of children attending school rose from 82 to 90 per cent between 1999 and 2010 despite population growth. In Sub-Saharan Africa, the percentage of children attending school increased from 58 to 76 per cent between 1999 and 2010.

3. PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Ensure gender equality and provide greater opportunities for women. Target: Eliminate gender disparity in primary and secondary education, preferably by 2005 and in all levels of education by 2015.

Status: Globally, there are now 97 girls per 100 boys in primary education. This means achievement of the Millennium Development Goal is within reach. In some regions, there are still great differences in the school enrolment ratios of girls and boys. In Southern Asia, Western Asia and Northern Africa respectively, 55 per cent, 65 per cent and 79 per cent of children out of school are girls. The disparity is greatest at the tertiary level. In Southern Asia, there are 77 women per 100 men in tertiary education, and in Sub-Saharan Africa, the proportion of women decreased from 66 women per 100 men in 2000 to 61 in 2011.

4. REDUCE CHILD MORTALITY

Reduce child mortality and reduce the under-five mortality rate by two thirds from 1990 to 2015.

Status: In 1990, twelve million children died before they turned five. In 2012, the corresponding figure was 6.6 million children. Despite increased population growth, the reduction in the death toll is 41 per cent. Infant mortality has been reduced from 63 to 35 per 1000 live births.

5. IMPROVE MATERNAL HEALTH

5a: Between 1990 and 2015, reduce the maternal mortality ratio by three quarters.

Status: In 1990, 540,000 women died during pregnancy and childbirth. The corresponding figure for 2010 was 287,000. This is a reduction of 47 per cent. Access to skilled birth attendants has increased from 55 per cent in 1990 to 65 per cent in 2010.

5b: Achieve universal access to reproductive health services.

Status: The unmet need for (contraception) in developing countries was reduced from 13.5 per cent in 2000 to 12.8 per cent in 2010. The birth rate among girls aged 15-19 has fallen in most regions, but remains almost unchanged in Sub-Saharan Africa (120 per 1000 girls).

6. COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

6a: Halt and reverse the spread of HIV and AIDS by 2015.

Status: In 2001, a total of 3.2 million people became newly infected. The corresponding figure for 2012 was 2.3 million people. This is a reduction of 33 per cent.

6b: By 2010, achieve universal access to treatment for HIV/AIDS for all those who need it.

Status: In 2011, 56 per cent of all people living with HIV in Sub-Saharan Africa received treatment.

6c: By 2015, halt and begin to reverse the incidence of malaria and other deadly diseases.

Status: In 2010, 216 million people contracted malaria; 660,000 people died of the disease. This is a decline of 25 per cent in the number of deaths since 2000.

7. ENSURE ENVIRONMENTAL SUSTAINABILITY

7c: Halve the proportion of people without access to safe drinking water by 2015.

Status: Five years ahead of schedule, the proportion of people without access to safe drinking water has been halved. Between 1990 and 2010, two billion people gained access to improved sources of drinking water.

8. DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

8e: Provide access to affordable medicines in developing countries through cooperation with pharmaceutical companies.

Status: Despite the economic downturn, resources for providing essential medicines through some disease-specific global health funds increased in 2011.

Source: UN progress report for the Millennium Development Goals. Global Monitoring Report 2012

Photo: Ken Opprann

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Immunization is an important intervention in Norway's development cooperation strategy for reducing child mortality, the target of Millennium Development Goal 4. Brigitte Raroaganimina has taken little Faratiana to the Ambohipo clinic outside Antananarivo, the capital of Madagascar. Nurse Christine Tombosoq is preparing the syringe with the vital vaccine. Read about results of the efforts to improve infant health on pages 68-69.

part 1

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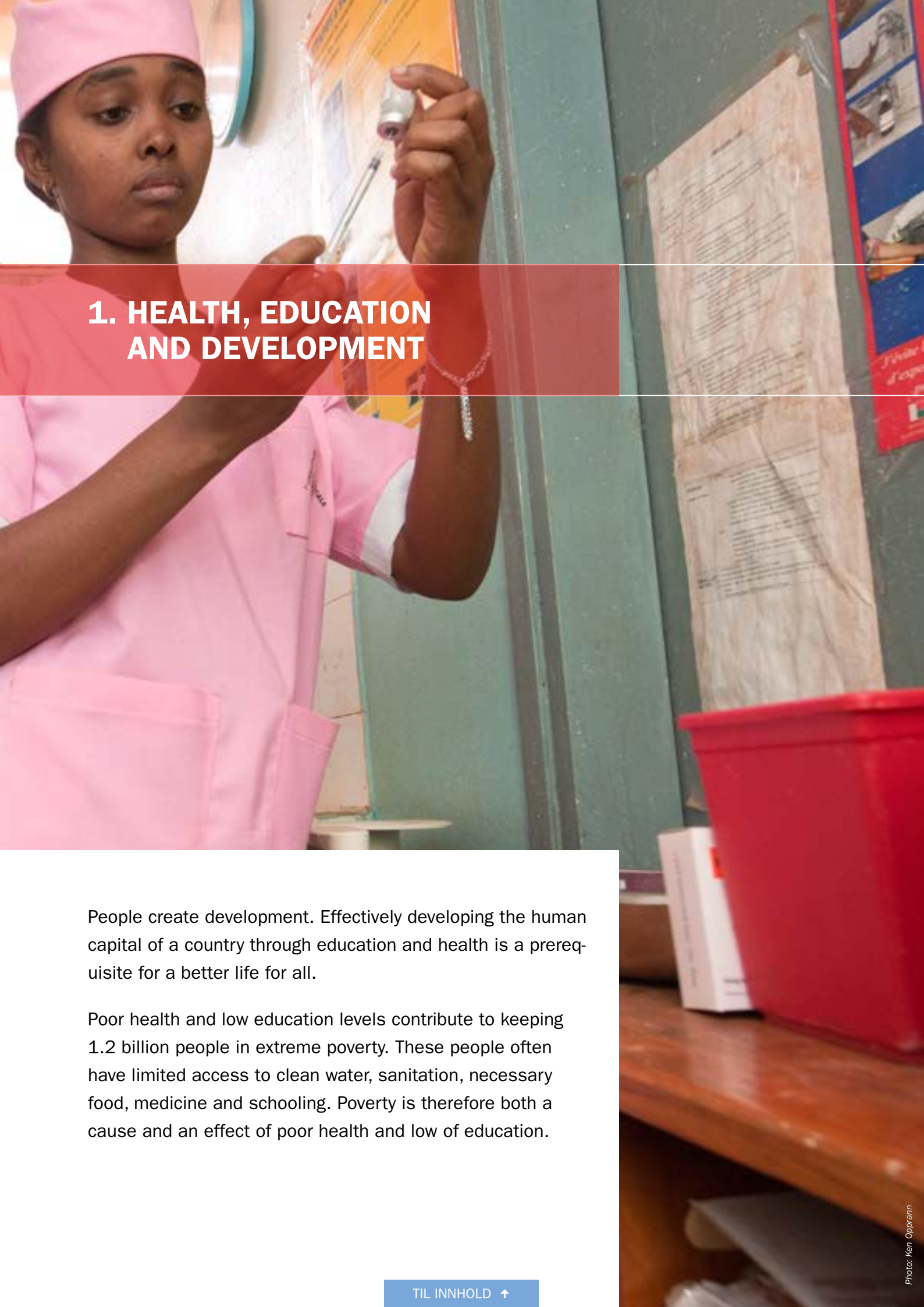
1. HEALTH, EDUCATION AND DEVELOPMENT



People create development. Effectively developing the human capital of a country through education and health is a prerequisite for a better life for all.

Poor health and low education levels contribute to keeping 1.2 billion people in extreme poverty. These people often have limited access to clean water, sanitation, necessary food, medicine and schooling. Poverty is therefore both a cause and an effect of poor health and low of education.

Photo: Ken Opprann

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WHY INVEST IN HEALTH AND EDUCATION?

Good health and education are among the basic human rights. All 193 UN Member States have recognized the importance of basic human rights. The UN's Universal Declaration of Human Rights obliges countries to arrange for basic social services for all, regardless of who provides the services. States are responsible for preventing health problems and removing barriers to schooling and health care. To achieve this, states must establish conditions that support investments in health and education systems. This applies to infrastructure, health professionals, teachers and equipment. The prerequisite is well-functioning states, as well as adequate resources.

The return on investment in health and education is high. Not only do investments save lives as well as improving individuals' prospects and quality of life – they also contribute to social development and economic growth. One example is South Korea's rapid financial development. In the 1970s, South Korea and Ghana had virtually the same income per capita and 40 per cent had access to secondary school. South Korea invested heavily in education in the 1970s, and achieved virtually full enrolment in secondary education in the 1990s. Ghana did not increase its coverage. In the 1980s, Ghana invested less than two per cent of its gross domestic product (GDP) in education. South Korea invested around four per cent. Education was linked to broader strategies to stimulate the economy, and formed much of the basis for sustained economic growth.[6] South Korea's per capita income in 2010 was 46 times as high as Ghana's.[7]

Every additional year of schooling that the population receives is estimated to increase the gross domestic product of a low-income country by 0.37 per cent. Every girl's future income increases by 10-20 per cent. Every krone invested in education yields 10-15 kroner in economic growth during a working life of twenty years.[8] If all children in low-income countries could read when they left school, 171 million more people would have a better basis for working their way out of poverty. This would reduce poverty in the world by twelve per cent.[9] Recent research suggests that 10-15 per cent of economic growth in low- and middle-income countries is attributable to health improvements.[10] Even though health and educational assistance alone cannot create economic growth, it can help to reverse a downward spiral and lay the foundation for growth.

Interactions between health and education. It is estimated that mortality among children in Sub-Saharan Africa in 2008 could be reduced by 1.8 million, or 41 per cent, if their mothers had secondary education.[11] Increased education increases the proportion of mothers who seek skilled health professionals, vaccinate their children, understand the importance of clean water and nutritious food, and send their children to school. Good health helps to improve learning outcomes. Nutrition for the mother during pregnancy and for the child during the first years of life is also vital for the child's learning abilities.

Education is one of the most effective strategies to combat child marriage. Girls with secondary school education are six times less likely to marry as children, compared with girls with little or no education.[12] In Sub-Saharan Africa, women with no education have 6.7 children on average. With primary education, the figure falls to 5.8, and with secondary education it falls to 3.9 children. Girls' education also influences employment. In Brazil, fewer than 37 per cent of women with no education have jobs in the formal sector. With completed primary school, the proportion employed increases to 50 per cent, and 60 per cent if they have attended secondary school. Education and research have formed the basis for India's pharmaceutical industry. This has made the country almost self-sufficient with medicines as well as becoming a major exporter. One result is reduced cost and better access to medicines for many low-income countries.

"I like school because it makes a difference to how my future will be." Jenepher Phiri (13), a student at Ray School in Skarinda, Zambia. The school is run by the Zambian government with support from UNICEF's programme for child-friendly schools.
Watch the video:


Photo: Marte Lid

Education and health for all have a global impact Good levels of education and health in the world have importance beyond individual countries. Greater numbers of highly educated people will enable the development of more knowledge, technology and research results that can be used by decision-makers and service providers across national boundaries. Diseases are transmitted across national borders. Through global cooperation, many challenges in health, education and the development of knowledge can be solved.

Higher education provides a foundation for growth and democracy. In Sub-Saharan Africa, seven per cent of young people have access to university education, while the global average is 30 per cent.[13] The percentage of the population with higher education has a major impact on development in all areas, including the development of democracy, gender equality and better human rights. In the longer term, investment in these areas can contribute to evidence-based policy, which in turn can result in more sustainable development. Investment in higher education is particularly important for health and primary education, which require large numbers of qualified personnel.

6 Building Human Capital in East Asia: What Others Can Learn, Jandhyala B. G. Tilak, 2002
7 Global Monitoring Report, UNESCO, (page 205-207), 2012
8 Hanushek, EA et al. General Education, Vocational Education, and Labor-Market Outcomes over the Life-Cycle, Institute for the Study of Labor, 2 Discussion Paper No. 6083, Bonn, Germany, October 2011
9 Education First, An Initiative of the United Nations Secretary-General (2012)
10 Achieving Dramatic Gains in Global Health by 2035, A New Investment Framework, Draft Report from the Lancet Commission on Investing in Health, 2013
11 UN progress report for the Millennium Development Goals, Global Monitoring Report, 2013:16

12 UNFPA Child Marriage: Giving Girls a Chance: An Agenda for Action, pp 51:52
13 World Bank blog, How to meet Africa's enormous need for higher education, by Rittva Reinikka, 4 June 2013

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Brain drain

The term "brain drain" refers to the loss of educated workers to other countries. Highly qualified people emigrate to countries with more favourable social, economic or political conditions. In addition to university and college graduates, key personnel are involved, such as teachers and nurses with secondary or vocational education.

An example from the health sector, highlights that one billion people have no access to qualified health workers, according to the Global Health Workforce Alliance. An agreement between the member states of the World Health Organization is intended to reduce the problem of the brain drain from developing countries. The Code of Practice, which is not legally binding, was unanimously adopted in 2010. The code specifies, among other things, that high-income countries should not actively recruit health workers from low-income countries. Although this is not enough to stop the brain drain, it may contribute to change in the longer term. The code specifies the critical measures needed for better distribution of health workers, both between countries and between urban and rural areas. Health workers cannot be forbidden to seek work where they want to, but incentives to stay in their own country will regulate migration without restricting their rights. Incentives may be financial or non-financial, such as housing, further education, school opportunities for health workers' children, working conditions and good leadership.

Because international labour market forces affect the brain drain, initiatives in sending countries of origin must be reinforced by initiatives in the recipient countries. As well as the non-legally binding agreement in the World Health Organization, there are special bilateral agreements between many countries that govern health worker migration. Some countries, such as the Philippines, train heath workers for jobs abroad. Workers abroad who send money home to their families and communities represent an important source of income. Bilateral agreements have proven useful as a way to provide some regulation of the extent and conditions of such work.

GLOBAL CHANGES HAVE IMPLICATIONS FOR DEVELOPMENT COOPERATION

Environment and climate

Climate changes impact poor people hardest, and will have major health consequences in the future. Food and water crises, pollution and extreme weather pose threats to life and health. Fuel for use in open stoves is inefficient and leads to deforestation. The use of charcoal is not only bad for the climate, but it contributes to the deaths of around two million people per year due to the smoke inhaled from indoor fires.[14] These are global challenges that require large investments far beyond the health and education sectors. Investment in new technology, higher education, and research on the environment and climate are important to find effective solutions. In development cooperation, interdisciplinary and intersectoral work with sectors such as agriculture, water and energy is therefore even more important than before.

Demographic changes

Of the world's poor people, 70 per cent live in middle-income countries, where 64 per cent of child mortality occurs. Of children who do not attend school, 23 per cent live in India and China. It is a great challenge to find forms of cooperation for reaching these children without reducing efforts in countries with weaker resource bases at the same time. Unequal economic distribution internally in a country is often an obstacle to development. Financial support is not the only way to achieve a more equitable distribution. Political dialogue combined with professional and technical cooperation can yield good results.

Today, there are 7.2 billion people on earth. The United Nations Population Fund estimates that in 2050 the world population will reach 9.6 billion. After that, growth is expected to level off. Most of the population growth will take place in the poorest countries, where 60 per cent of the population is under 25. The need for education and health services is growing. Development cooperation must help to build the capacity needed for the health and education systems of these countries to deal with changing demographic trends.

Today, more than half of the world's population lives in cities. Urbanization is increasing, and growing numbers of poor people live in cities. This provides both opportunities and challenges. Distances to clinics and schools are shorter. At the same time, pollution, poor water supplies and sanitation, and changing social safety nets for families mean that authorities often have to deliver services in different ways, and to different groups than they did in the past.

"It would have been difficult without the help we get here. We might have died from diseases or had many children – without adequate spacing between them." Chikondi Nansala (23), father of one child, Malawi. Norway has supported the civil society organization Banja la Mtsogolo (BLM) with almost NOK 50 million since 2001. BLM provides information and free contraception to young people. In 2011, BLM had more than 46,000 youth consultations.

Watch the video:

14 World Health Organization

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New stakeholders and forms of cooperation

Today, nations such as China, South Korea, Brazil and Saudi Arabia are donor countries. Philanthropic organizations such as the Bill & Melinda Gates Foundation, various forms of cooperation between public and private sectors, as well as a number of global initiatives, funds and alliances have been established. This applies especially to health, but also to the education sector. This is the result of efforts targeting specific diseases and goals, and recognition that the challenges must be solved through cooperation. Cooperation with new stakeholders challenges traditional development assistance, but can also create opportunities for new approaches.

Fragmentation of international development cooperation is a risk. The principles for coordination of aid in the Paris Declaration of 2005, which was signed by 91 countries including Norway, provide a good guideline. The partners in the field of basic education have created a number of best practices for coordination. In the health sector, there are many stakeholders, different diseases, and a great deal of equipment and medicine. This is challenging to coordinate. The best results emerge where different stakeholders have joined forces and pooled their resources for a targeted effort in specific areas. Another prerequisite is a clear division of responsibilities and honouring of commitments among both donors and the countries' own government agencies.

New technology for low-income countries too

The Internet, mobile phones, ICT solutions and social media have changed the world. Rwanda, Kenya and several other countries have adopted new technology on a large scale to improve the organization and delivery of health and education services. In the health sector, biotechnological innovations have contributed to new or improved vaccines, medicines and other health products. Investments in higher education, research and innovation in developing countries may increase the amount of technological development conducted there, which may yield more relevant and user-centred solutions.

New technology presents challenges and opportunities. Private-sector players utilised in development drawn into cooperation to a greater extent. This has taken place in areas where they have special advantages, such as in the development of new and simple birth aids. In some countries, mobile phone-based banking is used increasingly in the health and education sectors for the transfer of salaries, grants and incentive-based funding. Together with others, Norway has led a UN-appointed working group for the use of mobile technology in the health sector. This contributes to the scale-up of programmes. Through its contribution to the fund supporting the reconstruction of Afghanistan, Norway supports new ICT solutions. In development cooperation for education in Afghanistan, complaint mechanisms have been established at the schools to detect fraud, including with the use of mobile phones. Cash support to girls at school is being tested to encourage them to complete their studies. The Norwegian Refugee Council offers repairs to mobile phones as part of a vocational training programme. Data on the number of students and teachers, the condition of the schools and other information is digitized and collected in a central public database on the Internet.

Transparency and accountability against corruption

Corruption has been placed on the international agenda to a greater extent than in the past, due to national democratization processes and a sharper focus on the use of development assistance. Health and education are no less susceptible to corruption than other sectors. Some of the risk lies in construction projects and procurement of equipment. Payment "under the table" for teaching and health services is also a major problem. Medicines are at risk of theft, and up to half of the medicines in developing countries may be counterfeit or in poor quality. This affects each individual's everyday life in the encounters with health and education systems. Norway has zero tolerance to corruption, and relies on close cooperation with countries and other donors to prevent the practise.

"It's fantastic that my son is HIV negative. When I was pregnant I got free medicines so that he would not be infected by me." Kanyisiwe Oreen Mwaba (26) from Zambia's capital, Lusaka. She and her son Musonda (1) have received treatment through an international initiative to prevent HIV transmission from mother to child.

Watch the video:

NORWAY'S CONTRIBUTION TO HEALTH AND EDUCATION

Norway's contribution to education and health has increased since the Millennium Development Goals were introduced. Health and education aid has partly been channelled through multilateral schemes. In addition, Norway has supported these sectors in several countries. The combination of financial and technical assistance, political leadership and social mobilization is common to both, but the approaches have been different and have varied over time.

Norway combines financial aid with other means. The combination of political engagement, alliance building, funding and technical initiatives has had great impact. Consistent policy and conscious choice of mechanisms and partners has been vital for successful mobilization of a vigorous joint effort with specific goals. Emphasis has been placed on leadership to strengthen the international efforts, especially for child and maternal health as well as girls' education and basic education in humanitarian crises and conflict.

Norway provides a clear voice for rights and equal opportunities in international negotiations at the UN, in dialogue with partner countries, and through support to civil society organizations.

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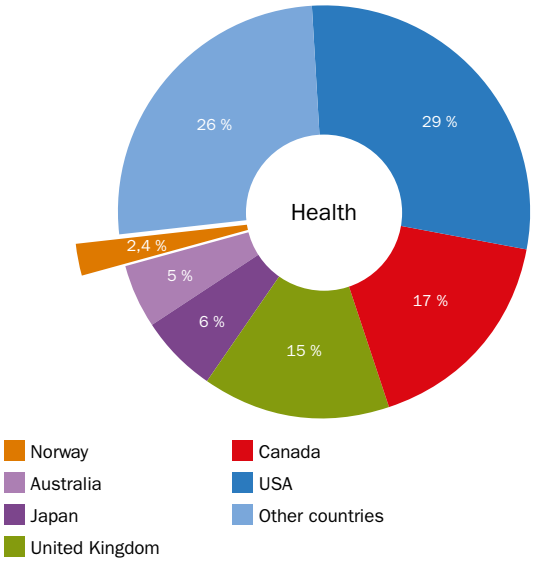
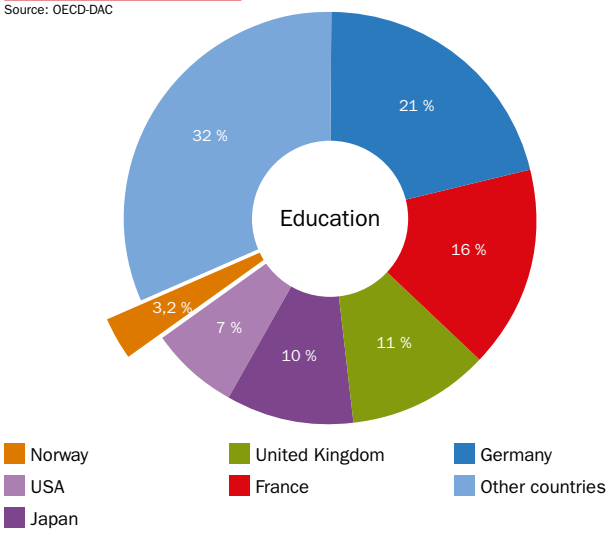
FIGURE 1.1. BILATERAL AID TO HEALTH DISTRIBUTED BY DONOR COUNTRY



Source: OECD-DAC

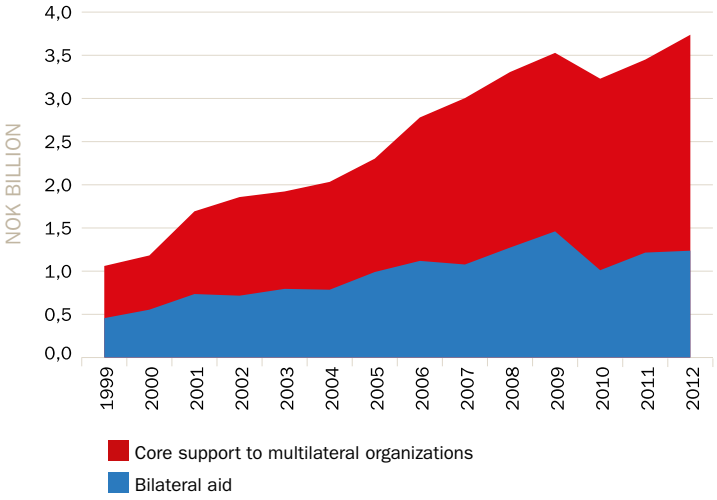
FIGURE 1.2. BILATERAL AID TO EDUCATION DISTRIBUTED BY DONOR COUNTRY

Source: OECD-DAC



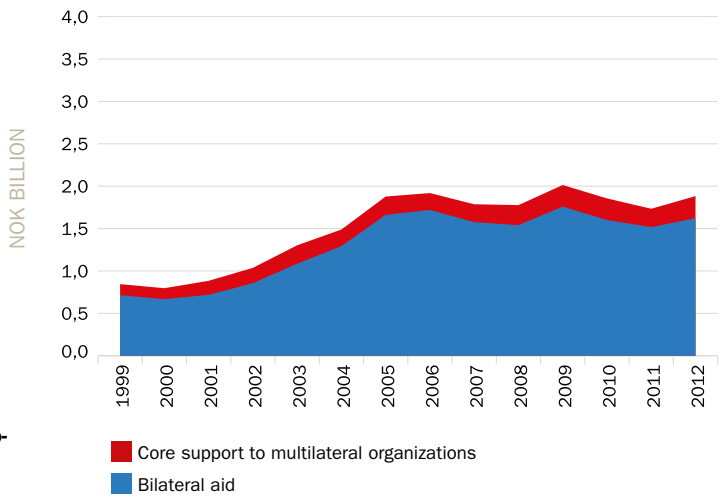
In 2012, the Norwegian share of development assistance for global health and education amounted to 2.4 and 3.2 per cent respectively. Health and education have played a key role in Norwegian development policy for many years, and together they have accounted for about 20 per cent of Norwegian aid.[15] Greater emphasis was placed on education and HIV/AIDS from 2001 to 2005, while there has been more emphasis on health from 2006 to the present. In the introductory pages to chapters 2 and 3, the commitment to education and health is described in more detail. In recent years, the Norwegian bilateral contribution has been somewhat higher for education than for health. In addition to government-to-government aid, this includes support to civil society organizations and earmarked funds channelled through multilateral organizations.[16] Core support to multilateral organizations has been significantly higher for health than for education.

FIGURE 1.3. HIGHEST PROPORTION OF HEALTH AID THROUGH MULTILATERAL ORGANIZATIONS



Total Norwegian development assistance to health has more than tripled since 1999 and exceeded NOK 3.7 billion in 2012. In 2012, NOK 1.2 billion of the total health aid was bilateral aid, while NOK 2.5 billion constituted the proportion of the core contributions to multilateral organizations estimated to be directed at the health sector. This was equivalent to about 14 per cent of total Norwegian aid, compared with ten per cent in 1999. Today, maternal and child health accounts for most of this commitment. Prevention and treatment of infectious diseases, especially HIV/AIDS, has also long been a priority. Together, these represent the health-related Millennium Development Goals. Malawi was the country that received the most health aid in 2012.
Source: Norad

FIGURE 1.4. EDUCATION AID HAS LEVELLED OFF SINCE 2006



Total Norwegian aid to education more than doubled between 1999 and 2006, but has since remained unchanged at NOK 1.9 billion. This includes more than NOK 1.6 billion in bilateral education aid, as well as the proportion of the Norwegian core contributions to multilateral organizations that is estimated to go to education, about NOK 250 million. Education aid amounted to eight per cent of total Norwegian aid in 1999 and seven per cent in 2012.[17] Nepal, Uganda and Madagascar were the most important recipient countries in 2012.
Source: Norad

In 2012, Norwegian and international civil society organizations managed NOK 410 million of the Norwegian bilateral health initiatives (33 per cent) and NOK 355 million of the education initiatives (22 per cent). They also managed a large proportion of the humanitarian development cooperation. Private-sector players are engaged in the development of vaccines and trials in the use of mobile technology in health sector, as well as in vocational education. While research on education has been relatively modest, Norwegian invest-

15 2012: Health 3.5bn, Education 1.6bn + multi. Total: about 5.5 – 6 billion of 27 billion, i.e. 20 per cent
16 This is often called multi-bilateral aid, but is regarded as bilateral aid

17 Applies to bilateral aid. This includes government-to-government aid, aid through civil society organizations and earmarked funds through multilateral organizations.

TIL INNHOLD

ments in global health research through the Research Council of Norway and international institutions have increased to more than NOK 350 million and represent approximately ten per cent of Norwegian development assistance for health.

Humanitarian aid. Norway provides important contributions to health and education in crisis and conflict. It is not possible to isolate the proportion spent on health and education. Of the support to the UN-coordinated disaster relief appeals in 2012, health represented 4.2 per cent and education 1.3 per cent.[18] Around 50 per cent of the total humanitarian effort was managed by multilateral organizations. The rest were managed by civil society organizations, such as the International Red Cross, the Norwegian Refugee Council, Norwegian People's Aid, Norwegian Church Aid, and Médecins Sans Frontières (MSF). This is described in a separate annual report: Norwegian humanitarian policy, published by the Ministry of Foreign Affairs.

Box 1.1. The important role of civil society organizations as service providers

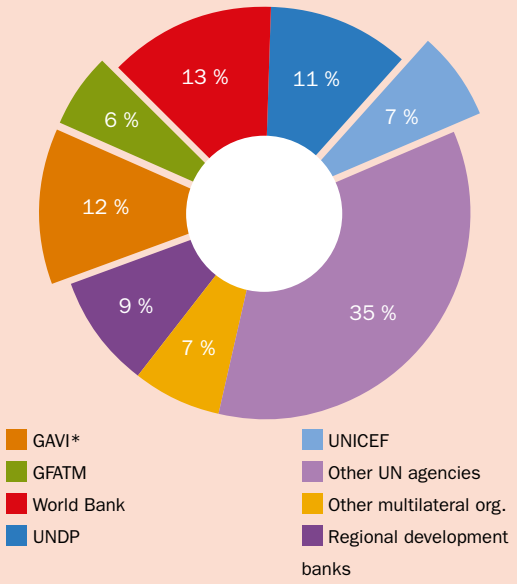
Norad's civil society panel (March 2012) reported after investigations in four countries that civil society organizations play an important role as service providers, especially in rural areas. Estimates from Ethiopia show that non-governmental organizations account for as much as 25 per cent of the total service delivery in the country. In Malawi, civil society accounts for almost 40 per cent of the country's health services, while in Nepal it accounts for between 10 and 15 per cent of all teaching. The figures are significantly higher in hard-to-reach areas and countries with intense political unrest or armed conflict, where the government cannot or does not want to offer these services to the population. In addition to this work, civil society organizations have become increasingly involved as driving forces for political changes.

Source: Tracking Impact: An exploratory study of the wider effects of Norwegian civil society support to countries in the South, Norad (March 2012)

THE NORWEGIAN SHARE OF RESULTS THROUGH MULTILATERAL ORGANIZATIONS

More than two thirds of the health aid and half of the education aid is channelled through multilateral organizations. Norway is often only one of several donors that contribute to pooled funding. A typical example is core support to multilateral organizations, which is not earmarked for a specific thematic or geographical area.

FIGURE 1.5 UN AGENCIES RECEIVE MOST OF THE MULTILATERAL AID



The figure shows the distribution of Norwegian core funding to multilateral organizations in 2012. Norway's core support amounted to NOK seven billion in 2012. Over half of this went to UN organizations. GPE, which is discussed below, is not core support and is therefore not included in this figure.
*GAVI includes IFFIm and AMC
Source: Norad

In 2012, Norway contributed more than NOK 13 billion, almost half of the Norwegian development budget, to multilateral organizations and global funds. Of this, 52 per cent represented core contributions.

Core support gives the organizations greater financial flexibility and makes it easier to plan for the long term. When several donors contribute to a common pool, it is challenging to say which results are attributable to which donors. One method to describe Norwegian results of this support is to compare the Norwegian share of the contribution to an organization with the results that it achieves. As an illustration, this indicates that Norway's share of the results is equal to the Norwegian share of the support.

The method only provides an estimate. For example, UNICEF interventions receive funding from various donors, as well as a mix of core funding and earmarked funds. This makes it complicated to determine which results were achieved for which funds. It is not sufficient to count outputs either, such as the number of teachers trained or schools built. The deciding factor is the outcomes of the outputs, such as an increase in pupils' literacy. Such outcomes will typically be the result of many different interventions and donor inputs (see box on page 23 about measuring results). Another challenge is to determine the time of the results. For example, when the vaccine alliance GAVI reports a number of lives saved in 2012, this is the result of many years' work.

Efforts to calculate the Norwegian share of results through multilateral organizations are limited to results where such calculations are possible, and do not provide a complete picture of Norway's commitment. The method is controversial because exact calculations are not possible. All reservations taken into account, the calculations still provide an idea of the scale of the Norwegian results. The uncertainty does not necessarily mean that the Norwegian results are overstated. On the contrary, Norway chooses to provide aid through multilateral organizations because pooling resources can have a greater impact than Norway could have achieved alone.

18 OCHA Financial Tracking Service

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UNICEF

Norway is the third largest donor to UNICEF, and supported the organization with a total of almost NOK 1.4 billion in 2012. Core support amounted to one-third (NOK 450 million), while earmarked funds accounted for two thirds (NOK 916 million). In 2012, UNICEF's budget totalled NOK 23 billion. Whether we look at core support or UNICEF's total budget, Norway's share is six per cent. Six per cent of UNICEF's results can thus be attributed to Norwegian support.

UNICEF and its partners have ensured that 79,000 children, who otherwise would probably have dropped out of school because of the conflict in Syria, have been able to continue their education without interruption. In total, 47,000 children have received psychosocial support. Because Norway contributed six per cent of the funds, it can be claimed that nearly 5,000 Syrian children were able to continue their education and nearly 3,000 received psychosocial follow-up because of the Norwegian contribution. In Somalia, UNICEF and government agencies enabled nearly 90,000 more girls to attend school in 2012 compared with the previous year. Because this result was mainly achieved through UNICEF funds, six per cent – that is, schooling for 5400 of these girls – can be attributed to Norway's contribution. UNICEF maintains that 19 million people in humanitarian disasters received access to safe drinking water in 2012; of these, one million were helped through Norwegian support.

Sources:
UNICEF Annual Report 2012
UNICEF Thematic Report 2012: Basic Education and Gender Equality The Global Partnership for Education (GPE)
The GAVI Alliance for global immunization
The Global Fund to Fight AIDS, Tuberculosis and Malaria www.theglobalfund.org
www.norad.no

THE GLOBAL PARTNERSHIP FOR EDUCATION, GPE

As shown in the result example for the Global Partnership for Education, GPE (see page 32) 413,000 additional teachers have been appointed, 37,000 classrooms have been built and 220 million textbooks distributed since the partnership was launched in 2002. GPE estimates that through its efforts, 22 million more children have gained the opportunity to go to primary school. Norway has contributed NOK 1.4 billion of GPE's budget totalling NOK 17 billion since its inception in 2002. This represents about eight per cent. The Norwegian support to GPE can thus be said to have provided access to primary education for almost two million more children during this period.

THE GAVI ALLIANCE FOR GLOBAL IMMUNIZATION

The result example of GAVI (see page 70) shows vaccination against common diseases helped prevent 5.1 million deaths from 2000 to 2012.[19] All Norwegian support to GAVI is core support. Norway's contribution to GAVI during this period amounted to about ten per cent. It is thus fair to say that Norway's support contributed to preventing more than half a million deaths during these twelve years.

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

Since the establishment in 2001, Norway has covered two percent of the budget of the Global Fund to Fight Aids, Tuberculosis and Malaria (see p. 72). The entire Norwegian contribution is core support. According to the Fund, this had contributed to saving 8,7 million lives by the end of 2011. This was an increase of one million lives from the previous year. Norway's share equals two percent for the period, hence 174,000 saved lives. Further, some 106,000 people were treated for HIV, while 220,00 cases of tuberculosis were diagnosed and treated. Norway's contribution also helped treat 6,6 million malaria cases.

Box 1.2. Measuring results

To measure the results of an initiative, one needs to know the starting point, that is, the situation to be changed. From this baseline, a clear goal is formulated for what is to be achieved within which time frame. Each of the 27 examples in this report provide the following information:

- The point of departure (Why)
- What has been done to achieve the goal (What)
- The amount of the Norwegian support (How much)
- What has the initiative achieved (Results)
- Experience to take with us (Lessons)

The section on results focuses on the effects these initiatives have had for the target group or community. If a partner with Norwegian support builds a health clinic for pregnant women, establishes a school for birth attendants, and holds information seminars for pregnant women, it is the effect of these initiatives that counts. Do the women have better access to health care? Are more babies born with qualified health workers present? Has knowledge about hygiene and nutrition increased?

One challenge in measuring results is to assess the extent to which they are due to a specific initiative. To ascribe a result achieved to one donor or one intervention is called attribution. It is rarely possible to calculate attribution with mathematical precision, but evaluations and research help to show which associations are likely.

Box 1.3. Good statistics are important

Good data that describes realities is a prerequisite for good decisions. The book Poor Numbers argues that decisions about development issues are often based on numbers that might mislead us. The author shows how three indices for per capita Gross Domestic Product produced totally different rankings of the poorest countries in Africa.

Others have pointed out how difficult it is to make reliable statements about school participation in Pakistan, when even the estimates of its population vary by up to 20 million. Measurement of unemployment can be misleading in subsistence economies. Malawi's national statistics indicate that unemployment is around three per cent, while the International Labour Organization (ILO) estimates that 60 per cent of young people are more or less unemployed. Poor statistics may result from lack of capacity and knowledge, unclear or ambiguous definitions, or political pressure for a distortion of the figures. In addition, areas may be hard to reach due to war or other safety concerns. To improve the underlying and to enable better decisions, Norway supports the development of national statistical systems in countries such as Malawi, Kyrgyzstan and South Sudan.

19 The Results Report for 2011 referred to the GAVI Alliance's report that from 2000 to 2010 it had helped to prevent 5.8 million deaths. In the meantime, the calculation methods have changed somewhat, and the number was therefore adjusted downward.

Universitas Gadjah Mada (UGM), with more than 50,000 students and hundreds of professors, is an academic powerhouse in Indonesia. UGM was a key driver in the democratization process that ended Suharto's authoritarian rule in 1998. The photograph was taken at the Faculty of Law in November 2013. Read about the results of support to UGM on pages 52-53.

part 2

TIL INNHOLD ↑

2. RESULTS OF DEVELOPMENT COOPERATION IN EDUCATION

Since the 1990s, Norway has been a driving force for the right of every child to education. Together with partners, we have invested heavily in primary education in general and girls' education in particular. This work has helped to increase school attendance by children in developing countries to 90 per cent, compared with 82 per cent at the turn of the millennium. In higher education, Norway has contributed to capacity building for education and research at higher education institutions in developing countries.

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Photo: Ken Opprann

GIRLS' EDUCATION SOLVES ALMOST EVERYTHING

Photo: Ken Opprann

A break for students at the Stella Matutina school in Burundi's capital, Bujumbura.

Of all the girls in the world, 65 million do not attend primary and lower secondary school. Among young women in developing countries, 116 million have never completed primary school. This is almost a quarter of all girls and young women aged 15-24. Two-thirds of the illiterate people in the world are women. Norwegian development cooperation has a strong focus on gender equality in development initiatives. According to a list from the UN, the impact of girls' education is that:

FEWER WOMEN WILL DIE IN CHILDBIRTH

If all mothers completed primary education, maternal mortality would be reduced by two-thirds

FEWER CHILDREN WILL DIE

If all women had primary education, 15 per cent fewer children would die. If they also completed lower secondary education, 50 per cent fewer children would die.

FEWER UNDERNOURISHED CHILDREN

If women completed primary school, 1.7 million children would be saved from stunted growth due to malnutrition. If women completed secondary education as well, twelve million children would be saved.

FEWER YOUNG MOTHERS

After completing primary school, ten per cent fewer girls would bear children before the age of 17. With the completion of secondary school, nearly 60 per cent fewer girls would become teenage mothers. These estimates are from Sub-Saharan Africa as well as South and West Asia.

LESS POPULATION GROWTH

Girls with an education have fewer children. In Sub-Saharan Africa, women with no education have 6.7 births, on average. With primary education, the figure falls to 5.8, and with secondary education it falls to 3.9.

LATER MARRIAGE

If all girls could attend primary school, there would be 14 per cent fewer child marriages. With a secondary education, the number of young brides would be reduced by two thirds.

GREATER EQUALITY

Education reduces disparities between men and women. In Pakistan, for example, women who have completed primary school earn 51 per cent of what men earn. But with a secondary education they earn 70 per cent of men's income.

MORE WOMEN FIND JOBS

In Brazil, fewer than 37 per cent of women who have not completed primary school are employed. The number of working women increases to 50 per cent if they have a primary education and to 60 per cent if they have attended secondary school.

Sources:
Girls' education – the facts, UNESCO website, October 2013
Bistandsaktuelt, October 2013

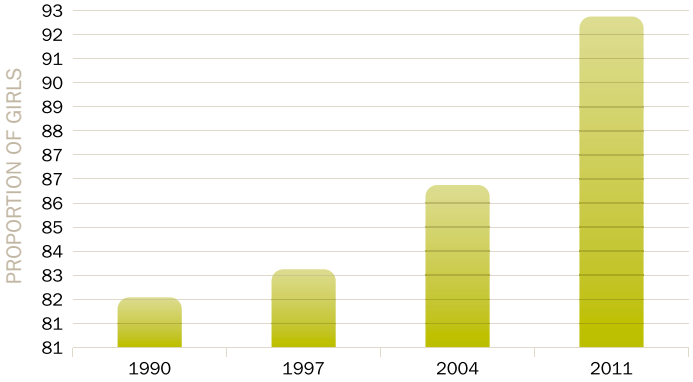
TIL INNHOLD ↑

Each level of education has its special features and benefits. Preschool is essential for early development and prepares the child for school attendance. Preschool is especially important for children with special needs or children from resource-poor environments. All children have the right to attend primary school. The quality of education is essential to ensure that children learn basic skills such as reading, writing and mathematics, enabling them to progress at school. Secondary and higher education are important for the individual through the infusion of knowledge, and for working life, employment and economic growth. By running schools and colleges based on the principles of participation, co-determination and transparency, states build up the democratic skills of the population. Several reports from the World Bank and UNESCO in recent years highlight the importance of higher education in the global knowledge economy, for economic growth and for the country's opportunities to realize their own resources. A knowledge-driven economy requires solid primary education, relevant higher education of good quality, lifelong learning, innovation, technology and ICT.

HOW FAR HAVE WE COME?

Great progress has been achieved towards Millennium Development Goal 2: Achieve universal primary education. For Millennium Development Goal 3: Promote gender equality and empower women, one of the targets is full equality in primary education by 2005 and in all levels of education by 2015. The box on the Millennium Development Goals, page 14, shows all the goals and targets for health and education. The objectives for primary education have almost been achieved globally, although the participation of girls varies between countries. In higher education, girls are still underrepresented, and there are large regional variations. In Latin America, South-Eastern Asia and Northern Africa, more young women than men are taking higher education, but in Sub-Saharan Africa, women are underrepresented. There, the number of women has decreased from 66 women per 100 men in 2000 to 61 in 2011.

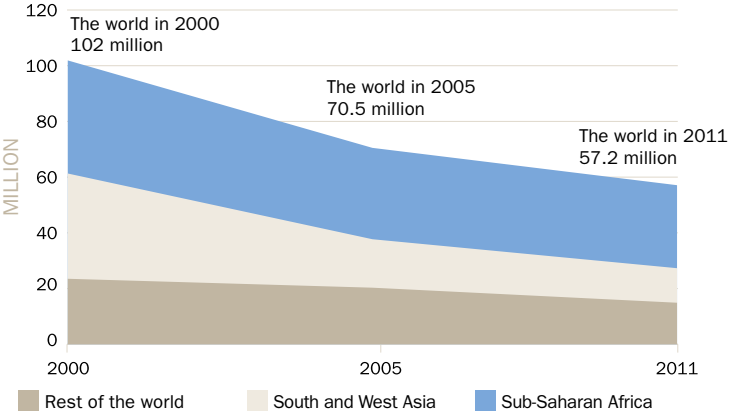
FIGURE 2.1. GIRLS' SCHOOL ATTENDANCE IS ALMOST EQUAL TO THAT OF BOYS. SUB-SAHARAN AFRICA IS STILL LAGGING BEHIND



In 1990, 82 girls attended primary school per 100 boys in Sub-Saharan Africa. In 2011, the proportion of girls had risen to nearly 93 girls per 100 boys.
Source: UNESCO Institute for Statistics.

Since 1999, the number of children in the world who do not attend school has been reduced from 108 million to 57 million in 2011.[20] Today, 90 per cent of all children in developing countries start school. Progress was considerable until 2008, but has stagnated since then. Several countries will not achieve the goals by 2015. In Sub-Saharan Africa, the challenge is particularly great. More than half (52 per cent) of the out-of-school children in the world (see Figure 2.2.) live in this region, many of them in fragile states. The trend is inconsistent between regions and between countries, and between different populations in the same country. There is also a tendency towards increasing disparities.

FIGURE 2.2. THE NUMBER OF CHILDREN OUT OF SCHOOL HAS BEEN REDUCED



Kilde: UNESCO Institute for Statistics

A survey of households in 63 developing countries between 2005 and 2011 showed that children from poor families are much less likely to be enrolled in school than others.[21] Where children live also has significant implications. Children in rural areas are only half as likely to go to school as those living in urban areas. Children with disabilities represent a discriminated group. It is estimated that 24 million of the 57 million children who do not attend primary school are in this group. About 50 per cent of the children who do not attend school live in countries with war and conflict.[22] More and more of the children who start school are girls, but still there are differences between the sexes. There is a tendency for fewer girls than boys to start at secondary levels in low-income countries. In middle-income countries, however, fewer boys than girls start at secondary school level. Girls are still clearly in the minority for admission to tertiary education. They face multiple barriers to completing their education. Among other factors, girls and young women are more vulnerable to sexual harassment and abuse. For many of them, school and student life also represents a risk.

Literacy among young people and adults shows a slight positive trend during the last two decades. The proportion of young people aged 15-24 who can read and write rose by six per cent between 1990 and 2011. This is a small increase in relation to the number of children who have gained access to education during the same period. The quality of teaching and learning outcomes must improve: Some 250 million children can neither read nor write when they start fourth grade. Part of the explanation for this may be that the large increase in the number of children who have started school has not been followed up with a corresponding increase in the number of teachers, classrooms and teaching materials. There is currently a great shortage of teachers in general and qualified teachers in particular. Teacher density is somewhat higher in urban than in rural areas. Schoolbooks, which are often in very short supply, provide another important means of improving quality. ICT equipment and Internet access are also scarce.

20 Out-of-school children, UNESCO Institute for Statistics, home page

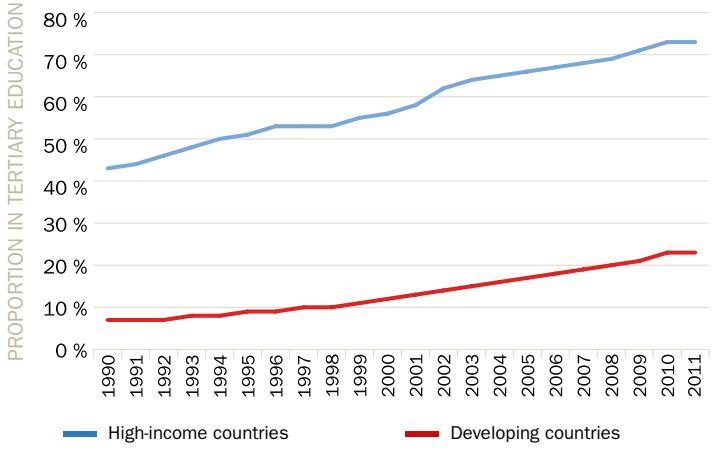
21 The UN Millennium Development Goals Report 2013
22 UNESCO Education for All Global Monitoring Report Policy Paper 10, July 2013

TIL INNHOLD ↑

Today's youth cohort is the largest in the world's history. The talent, energy and ideas of these young people should be used to benefit the community. Today, 69 million young people of secondary school age do not go to school.[23] Even though a growing number of young people in developing countries complete secondary school, the number is still very low compared with that in Western countries. According to UNESCO, the proportion attending secondary school in Sub-Saharan Africa increased from 25 to 40 per cent between 1999 and 2010. In comparison, "everyone" now gets a secondary school education in the United States and in Western Europe.[24] For the education system to contribute to producing a workforce with relevant skills which in turn contributes to economic growth, increased investment in secondary and tertiary education, including vocational education, is required.

Admission to tertiary education is increasing worldwide. More extensive completion of secondary school increases the demand for tertiary education. The number of students admitted to tertiary education in Sub-Saharan Africa increased by ten per cent per year from 2000 to 2005. However, the proportion was still only six per cent of the relevant age group in 2007, which is lower than in regions such as South and West Asia (eleven per cent) and far below the United States and Western Europe (70 per cent). The figure below shows the difference in admission to tertiary education between high-income countries and developing countries.

FIGURE 2.3. TERTIARY EDUCATION ENROLMENT IN DEVELOPING COUNTRIES AND HIGH-INCOME COUNTRIES



The percentage is calculated based on the number in the population in the age group after secondary school and five years into the future.
Source: World Bank

Due to the limited availability of places in programmes of study in tertiary education in developing countries, a number of young people who want to study, travel abroad. This may enable good education for the individual, but is no solution to meeting the growing need. Schemes based on international scholarships are relatively expensive and the risk of brain drain – because graduates do not return home – is great. Forecasts indicate that the number of people who want to study will double by 2025, and that most of the increase will occur in developing countries. Increased capacity is needed to educate more and better candidates. In parallel with providing higher education to more students, institutions and authorities must ensure that the education is both relevant and of good quality for the individual and useful to society.

It is positive that developing countries are increasingly funding their own education budgets. Self-financing in low-income countries has increased by 7.2 per cent per year on average since 1999.[25] Given the considerable educational challenges that developing countries face, great needs for education aid remain, especially in fragile states.

EFFORTS TOWARDS THE MILLENNIUM

I am Malala

Malala Yousafzai (16) from Pakistan has played a very important role in the campaign for education for all. She has had a great impact on many people by blogging about girls' right to education since she was eleven years old. In 2012, she was shot in the head and neck by members of the Taliban as she was going home from school, but she survived. The episode resulted in large demonstrations and a campaign, "I am Malala", which contributed to Pakistan's first law on the right to education. In April 2013, Malala appeared on the front cover of Time magazine as one of the world's 100 most influential people.

In Pakistan, more than five million children do not attend school. Over nine years (2003–2011), Norway has supported the Basic Education Improvement Project in the province of Khyber Pakhtunkhwa (KPK) in the north-west part of Pakistan with a total of NOK 102.3 million. The goals included increasing the number of children who attend school and girls' access to education, and raising the quality of education. Through the project, school principals have received training in leadership and financial matters; guides for teachers have been devel--oped, and mentor support teachers have received training. Re-establishment of parent-teacher associations and dialogue with Koranic schools for improving language and social studies have been important for local recognition of the changes. In this way, education at the Koranic schools could be made relevant for a wider range of further studies and jobs. Construction of secondary schools for girls and installation of water supplies and sanitation are measures that can increase girls' access to education. When disastrous flooding struck the province in 2010, the rehabilitation of girls' schools was included in the project. Norway also supports projects in tertiary education in Northern Pakistan, via NORHED. A brief description of the programme appears on page 31.

In July 2013, Malala Yousafzai held a speech at the UN about the importance of education for all.

23 UIS (UNESCO Institute of Statistics)
24 According to the Global Monitoring Report for 2012, the gross enrolment ratio for secondary education in North America and Western Europe amounted to 102 per cent in 2010.
25 Education for All Global Monitoring Report 2012

TIL INNHOLD

DEVELOPMENT GOALS

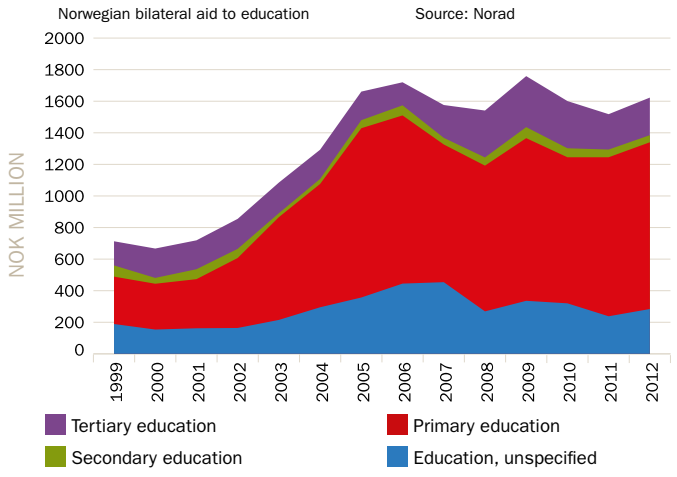
The main objective of Norwegian development cooperation in education has been to contribute to achieving Millennium Development Goals 2 and 3 and the goals of Education for All. This means that universal primary education and gender parity in schools have been priority areas for Norwegian aid. Access to education for girls, marginalized groups and children in countries ravaged by war and conflict have been particularly important areas of focus. Improving the quality of schools has also been an objective. Increasing the number of teachers, improving curricula, introducing more and better teaching materials and using relevant teaching languages have been important targets for achieving quality improvements.

The goal for Norwegian support to higher education in recent years has been to strengthen institutions in developing countries and their ability to educate more graduates who can contribute to the development of society and industry. In line with Millennium Development Goal 3 on equal access to education at all levels for women and men, an important target has been to increase the proportion of women who complete higher education.

NORWAY'S DEVELOPMENT PARTNERS AND HOW WE WORK TOGETHER

The main strategy for achieving education goals has been to support the countries' own plans, by enhancing their capacity and implementation capability. In recent years, with reduced international aid, Norwegian support for primary education has remained stable.[26] More than half (53 per cent) of the Norwegian bilateral aid for education is channelled through multilateral organizations such as UNICEF, the Global Partnership for Education (GPE), the World Bank and UNESCO. These organizations have played a key role in efforts to meet the Millennium Development Goals for education so far. Norway is an active participant in the professional development and management of these organizations. Seven per cent of total Norwegian aid, including the proportion of core funding to multilateral organizations, went to education in 2012.

FIGURE 2.4. THE LARGEST PART OF NORWAY'S EDUCATIONAL SUPPORT GOES TO PRIMARY EDUCATION



"I am very happy that both girls and boys go to school today and that parents want to send their children to school." Ghanamati Chaudhari, a teacher at Srijana School, Mohamadpur VDC, outside Nepalgunj. Of the children who start school in Nepal, more boys than girls complete their schooling.


Photo: Marit Hverven

Watch the video:

If bilateral aid to education is seen in isolation, there has been a clear increase during the past decade, from NOK 856 million in 2002 to 1.623 billion in 2012. This year, 65 per cent went to primary education, three per cent to secondary education and 15 per cent to higher education.

About 20 per cent of aid for education is managed by Norwegian civil society organizations. These play an important role in influencing the policy development and as a supplement to the state in service delivery.

Through bilateral cooperation, Norway supports the education field directly in countries such as Burundi, Madagascar, Palestine, Nepal, Pakistan and Afghanistan. This support contributes to better planning, operation and follow-up of education programmes in these countries. The examples of results from these countries in this report and in Norad's results portal on the Internet describe how Norway works in specific terms.

Norway supports capacity development in higher education and research both through embassies and through the programmes NOMA, NUFU, EnPe and NORHED (see box page 31). Norad manages these programmes. The evaluation of NOMA and NUFU from 2009 concluded that the programmes have had great impact at the individual level, but less visible effect at the institutional level. Based on this evaluation, a new programme —the Norwegian Programme for Capacity Development in Higher Education and Research for Development (NORHED) — was established in 2011. NORHED combines the objectives of NUFU and NOMA, so that capacity development becomes more integrated and more sustainable. The new programme supports Millennium Development Goal 3 by carrying forward objectives including the goal of enabling more women to gain access to and complete higher education.

NUFU and NOMA had specific targets for the ratio of women: 40 and 50 per cent respectively. The objectives were largely achieved, partly through financial awards to those projects that succeeded in recruiting the desired proportion of women. Arrangements were also made for women who gave birth during the study period, giving them a better opportunity to complete their studies. For NORHED, equality is a key objective, with a focus on recruitment of female students and staff. These initiatives promote implementation and integration of gender as a dimension in education and research.

26 Education for All Global Monitoring Report, Schooling for millions of children jeopardized by reductions in aid, UNESCO, Paris, June 2013

Sources: Education for All Global Monitoring Report, 2012, the Global Partnership for Education UNICEF Annual Report 2012 and Thematic Report 2012: Basic Education and Gender Equality

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Box 2.1. "Education for All" goals

Education for All (EFA) is a global initiative in which states and international organizations work together. The initiative was first adopted at a world conference in Jomtien in 1990 and later at a summit in Dakar in 2000. There, 164 countries, including Norway, agreed on six global educational goals (the EFA goals) to be met by 2015. UNESCO was assigned the task of coordinating the international effort. These are the EFA goals:

Goal 1: Expand and strengthen early childhood care and education (pre-primary school), especially for the most vulnerable children.

Goal 2: Ensure that by 2015 all children, particularly girls, children in difficult circumstances and children belonging to ethnic minorities, have access to, and complete, free and compulsory primary education of good quality (UPE – Universal Primary Education).

Goal 3: Ensure that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programmes.

Goal 4: Achieve 50 per cent improvement in levels of adult literacy by 2015, especially for women, and equitable access to basic and continuing education for all adults.

Goal 5: Eliminate gender disparities in primary and secondary education by 2005, and achieve gender equality in education by 2015, with a focus on ensuring that girls and boys have full and equal access to and equal achievement in basic education of good quality.

Goal 6: Improve all aspects of the quality of education and ensure that recognized and measurable learning outcomes are achieved by all, especially in literacy, numeracy and essential life skills.

The Global Monitoring Report provides annual reports on the six EFA goals.

Box 2.2. UNESCO

UNESCO's main goal for the field of education is to promote the right to quality education for all and lifelong learning. The organization provides professional assistance to UNESCO member states in their capacity building and development of national institutions and policies on education. The Education for All (EFA) programme, with the goal that everyone will have access to basic education by 2015, is UNESCO's main commitment in education. UNESCO is responsible for coordinating the work of government agencies, international organizations and civil society towards this goal. UNESCO also reports on progress towards the Millennium Development Goals in education.

Norway supports UNESCO's work in general, as well as providing earmarked funds for the programme Capacity Development for Education for All (CapEFA) and its annual report, The Education for All Global Monitoring Report (GMR), which was first published ten years ago. The report shows how far the international community has progressed in its efforts to meet the six Education for All goals and describes the greatest barriers to goal achievement. The report also draws attention to a thematic area of special importance to education and EFA. The report for 2012 focused on young people, skills, and work.

Norway supports the following UNESCO institutes: UNESCO Institute for Statistics (UIS), which is the primary source of international comparable statistics on education, science and technology, culture and communication in more than 200 countries and territories; International Institute for Educational Planning (IIEP), whose mission is to strengthen member states' capacity to plan and manage their education systems; UNESCO International Bureau of Education (IBE), which specializes in the content, methods and structure of education. IBE builds networks to share expertise on curriculum development in all regions of the world; and the UNESCO Institute for Lifelong Learning (UIL), the adult education institute that works to combat illiteracy in the world and promotes policy and practice for lifelong learning.

Box 2.3. UNICEF's programme for basic education and gender equality

UNICEF is one of the most important channels for securing Norwegian support to education in international development cooperation. The fund has a strong commitment to the international dialogue on education. At the same time, it is strategically located in countries where it is involved in close dialogue with local and national authorities. At the same time, UNICEF has contacts with civil society and local communities, other donors and UN organizations. It also plays a key role in supporting the education policies of national authorities.

In addition to providing general support to UNICEF, Norway provides direct contributions to UNICEF's global education programme, Basic Education and Gender Equality (BEGE). In 2012, this contribution amounted to NOK 550 million. The programme aims to ensure all children the right to basic education of good quality. The four main areas that will contribute to this goal are the commitments to: 1) Early childhood and development; 2) The right of access to education; 3) Relevant education of good quality, and 4) Education in emergencies and conflict. UNICEF has education programmes in 150 countries.

The UNICEF programme Child-Friendly Schools (CFS) has been developed so that UNICEF, in cooperation with national authorities and other partners, can contribute to better quality teaching through its support. CFS schools have teachers with professional and teaching skills, motivated students, resources and school materials, school infrastructure and support from an active local community. Through direct support to BEGE from Norway and other countries, UNICEF has been able to develop and test this initiative and to ensure skills development for UNICEF staff and partners. With support from UNICEF, 85 countries are now using the model in an adapted form. Of these, 42 countries report that the model has been integrated into national plans and policies. It is thus calculated that as many as 579,000 schools worldwide receive funding through the model.

In addition to financing, Norway contributes to the professional and administrative dialogue with UNICEF. Norway participates in the board, in which UNICEF's impact on education and other programme areas is monitored. UNICEF and Norway also have a bilateral annual meeting in which the agreement is followed up.

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Box 2.4. Norway's support for higher education in developing countries

Norad has supported higher education in developing countries for several decades. The aim is to empower the countries themselves to educate their own workforce. The programmes described here can also help to boost research environments to international standards, so that they can become part of the global research network.

NUFU – the Norwegian Programme for Development, Research and Education, 1991-2012. NUFU was based on partnerships between higher education institutions in developing countries and Norway. The programme included collaboration on research, education, capacity building and institutional development. In the most recent period (2007-2012), 69 projects were conducted in 19 countries in Africa and Asia. The summary at the end of the programme showed 194 completed doctoral degrees and 294 master's degrees. Women accounted for 46 per cent of the PhD candidates. Most candidates worked at higher education institutions in their home countries after completing their education. One effect is increased research capacity at universities in developing countries. This has led to increased publishing of research, and the programme resulted in 2030 publications from 2007 to 2012.

NOMA – Norad's Programme for Master Studies, 2006-2014. NOMA supports the development and operation of master's degree programmes through partnerships between higher education institutions in developing countries and Norway. Through NOMA, more than 1,000 graduates have completed their master's degree in disciplines that strengthen national development, such as agriculture, natural sciences, health and social sciences. Half of the candidates are women, and most candidates work at higher education institutions or in the public sector in their home country or in the region after completing their studies. The throughput of students has been good, but the sustainability of the initiatives has been questioned.

NORHED – The Norwegian Programme for Capacity Development in Higher Education and Research for Development. NORHED, launched in 2012, is a further development of NUFU and NOMA. The aim of the programme is to strengthen the capacity of higher education institutions in low- and middle-income countries. Increased capacity will lead to a larger workforce with better qualifications for the country, increased knowledge relevant to development, evidence-based policymaking, and greater gender equality. Thematic priorities are natural resource management, governance, health and education.

EnPe – The first call for proposals for grants for Norad's programme for master's degree studies in energy and petroleum (EnPe) was completed in 2009, with the start of education in 2010. The programme is managed by the Norwegian University of Science and Technology (NTNU). The aim is to contribute to capacity building in the energy and petroleum sector in selected partner countries.

Since 2005, NUFU, NOMA, EnPe and NORHED have had a volume totalling NOK 150-200 million per year.

Quota system

Through the quota system, students from developing countries can apply for support from the Norwegian State Educational Loan Fund to study at a Norwegian educational institution. Every year, 1,100 master's and PhD students study in Norway with funding from this programme.

Box 2.5. To Africa with the Bible

About 230 years before the Storting (Norwegian parliament) created Norad's predecessor, the "India Fund", in 1952, development assistance was associated with missionary work. A driving force for schooling and health in Africa was the first missionary in the Missionary Society, Hans Schreuder. He completed a theological degree at the University of Christiania (now Oslo) and studied medicine in parallel. In 1844, he settled in Port Natal (now Durban) in South Africa. King Mpande reigned over Zululand, which was in danger of being colonized by Europeans. After treating Mpande's gout, Schreuder became the king's trusted doctor. He was also the king's peace mediator during civil wars and an advisor in disputes about succession. It was said that Schreuder was as fluent in Zulu as a white person could be.

In 1850, Schreuder published the first grammar book for the Zulu language. In addition, he wrote a Norwegian-Zulu and Zulu-Norwegian dictionary and translated large parts of the Bible into Zulu. Hymns that he wrote in Zulu are still sung today. It took 14 years before the king gave Schreuder permission to perform baptisms, and in total there were only about 350 Christians in the church. The financial contributors at home in Norway had been hoping for greater success in the mission field, but Schreuder and three Norwegian colleagues were allowed to continue their work. During a visit to Norway in 1866, Schreuder was celebrated as a hero everywhere he went. He was invited to a gala banquet with the government, and during a mission conference in Haugesund, the population quintupled because so many people wanted to see the pioneer from Zululand.

Source: "Himmelfolket En norsk høvding i Zululand [The people of heaven: A Norwegian chieftain in Zululand]" by Øystein Rakkenes, published by Cappelen forlag in 2003 Illustration: Halfdan E. Sommerfelt

The missionary Hans Paludan Smith Schreuder (1817-82) from Sogndal was called "the apostle to the people of Zululand". He was a pioneer for Norwegian development assistance in the fields of health and education. He worked in Zululand in Southern Africa for 38 years.

EXAMPLES OF RESULTS IN EDUCATION

EXAMPLE 1 GLOBAL PARTNERSHIP FOR EDUCATION HELPS MORE CHILDREN TO GO TO SCHOOL

Ten years of the Global Partnership for Education has helped more children in developing countries to attend school than ever before. More schools, more teachers and more school materials improve the children's learning environment. But marginalized children are still left out and learning outcomes in schools are unsatisfactory.

WHY: MILLIONS OF CHILDREN WITHOUT ACCESS TO EDUCATION

In 2002, UNESCO estimated that about 95 million children had no access to primary education. Fewer girls than boys gained access to, and completed, primary school. In developing countries that joined the GPE later, it was estimated in 2002 that only 56 per cent of students completed primary school. Reports on the quality of schools and learning outcomes for students gradually appeared from the mid-2000s, and showed alarmingly poor results, especially in Sub-Saharan Africa, but the problem was global. Both access to and the quality of schools is worst in countries affected by fragility and conflict. Funding for education, both in terms of development assistance and national budgets for education, was far below what was required to achieve the Millennium Development Goals and the Education for All goals by 2015.

WHAT: GLOBAL PARTNERSHIP FOR EDUCATION

The Global Partnership for Education was established in 2002 as a partnership between developing countries, donors, multilateral organizations, the private sector, philanthropists and civil society organizations to contribute to meeting the Millennium Development Goals for education. Until September 2011, the partnership was called Education for All – Fast Track Initiative. The partnership supports developing countries in developing and implementing education plans that can ensure all girls and boys a good basic education. An important prerequisite for GPE cooperation is that developing countries have the primary responsibility for planning and implementing reforms such that Millennium Development Goal 2 on education for all is met in each country. The reforms must ensure more children have access to schooling, greater numbers of trained teachers, relevant content, improved learning materials and improved student assessments and tests, as well as generally improving access to and use of data on education. GPE contributes with funding of the programmes, advice and innovative education solutions. Between 2003-2013, GPE distributed about USD 3.8 billion in aid to education in 55 countries. In 2013, 59 developing countries are GPE members. Of these, 38 are in Sub-Saharan Africa and 28 are fragile states.

How much: GPE is one of Norway's main areas of focus in development cooperation for education. Norway is the fourth largest donor, and has contributed NOK 1.4 billion from 2002 to 2012. This represents 8.8 per cent of the total NOK 16.5 billion that GPE has managed during the period.

RESULTS: 21.8 MILLION MORE CHILDREN HAVE GAINED ACCESS TO PRIMARY SCHOOL

The GPE estimates that since it was launched in 2002, 21.8 million more children have gained the opportunity to go to primary school because of the added capacity to which the GPE has contributed in member countries. Of these children, 10.1 million are girls. From 2002 to 2013, 413,000 more teachers have been hired, 37,000 classrooms have been built and 220 million textbooks have been distributed. A survey in 2010 showed that countries that received support from GPE had twice the enrolment of children who were outside primary school compared to countries that did not receive support.

Of the children in fragile GPE states, 71 per cent completed primary school in 2011, compared with 56 per cent in 2002. Both in access to and in completion of primary education, the disparity between girls and boys has narrowed. For every 100 boys who completed primary school in 2002, 83 girls did the same. In 2011 this ratio had increased to 93 girls, on average. The disparities between girls and boys are still highest in fragile GPE states. Progress towards the Millennium Development Goals can be attributed both to the support itself and to the political will of the countries that have applied for funding to implement the plans for which they have applied for support. GPE has helped to sustain the international focus on education. Nevertheless, international aid to education has declined in recent years.

Burkina Faso joined GPE in 2003 and has made great progress since then. Over ten years, the proportion of children attending school has increased from 51.1 per cent to 79.6 per cent. In 2012, 55 per cent of children completed primary school, compared with 39 per cent in 2008. Between 2008 and 2012, the number of teachers increased from 32,000 to 43,000, and more than 12,000 classrooms were built. Despite this positive trend, higher quality is a major challenge that must be given priority. There are also large geographical disparities in school coverage in the country.

After a decade-long civil war that ended in 2002, Sierra Leone is getting back on its feet. Sierra Leone became a member of GPE in 2007 and has received professional assistance to develop a sector plan for education for 2007-2015. With the sector plan in place, Sierra Leone has received NOK 85.3 million from GPE. This was used for building schools and toilets as well as drilling wells to provide drinking water for students. Scholarships have been granted to 75,000 girls, 1.7 million textbooks have been produced and intestinal worms have been removed in 1.8 million children. Better health and sanitation improve school attendance and increase the prospects for learning. The scholarships have been granted to girls whose families otherwise could not afford to send them to school. In 2002, only 55 per cent of children completed primary school. Now the figure is 76 per cent. Of these children, 77 per cent continue in secondary school.

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LESSONS LEARNED: NEED FOR INCREASED FOCUS ON QUALITY AND INCLUSION OF VULNERABLE GROUPS

Although concerted international efforts have had positive results, about 57 million children are still out of school. The poorest children, children in conflict-affected states, children with disabilities, ethnic minorities and nomads constitute such excluded groups. These children also start school later and more frequently leave school before they complete primary education. GPE has contributed to knowledge about precisely where the challenges lie, and this improves the basis for adapting the initiatives. Marginalized groups must be included in order to achieve the goal of education for all. Interventions are also needed to reach the high proportion who start school but do not complete, and those who repeat grades because of excessive absence or unsatisfactory learning outcomes.

Partners among developing countries and donors recognize that children's access to school is not sufficient, and that more attention must be paid to what they actually learn. In 2012, UNESCO estimated that of the 180 million children who attended school in the GPE developing countries, only 80 million would achieve the minimum requirements for expected learning outcomes when they start fourth grade. The aim of GPE's strategy for 2012-2013 is to contribute to education for all and learning for all, with a focus on marginalized children and fragile states.

Sources:
The Global Partnership for Education: Ten key results since 2002, home page, 2013 GPE Results for Learning Report 2012, home page
Evaluation of "Education for All – Fast Track initiative", February 2010

Photo: Ken Opprann

Norwegian support for education often includes building separate latrines for girls and boys. Of school-age girls in Burundi, 95 per cent attend school. The picture is from the Jabe 1 school in Burundi's capital, Bujumbura.

EXAMPLE 2 NEPAL IS ON THE WAY TO EDUCATION FOR ALL

More than 95 per cent of children in Nepal started primary school in 2013. The five per cent who are still out of school are the poorest and most marginalized children, and they are the hardest to reach.

WHY: THE POOREST CHILDREN DO NOT GET EDUCATION

Previous results reports have described the progress of education in Nepal up to 2007. This report shows the development from 2008 to 2011. In 2008, about 89 per cent of children in Nepal started primary school. Most of those who do not start school live in rural areas, are very poor, are of low caste dalit, have disabilities, or have to work instead of going to school. Many of the children who attend school must repeat grades or drop out in primary school.

WHAT: SUPPORT FOR EDUCATION FOR ALL

Norway has supported the Education for All programme to Nepal since 1998. The goal is to offer education to all children of primary school age. In 2009, two additional school years were introduced in primary school, extending the target group that is offered free primary school to include grades 1 to 8. All girls have the right to scholarships through the programme. More teachers have been recruited and new classrooms have been built. Schools can adapt the use of resources to their own needs. The programme includes preschool, primary and secondary school.

How much: Norway has contributed NOK 219 million in 2009-2013. The total budget for the sector plan is USD 2.6 billion. During the period, Nepal covered 75-80 per cent of this, and spends over NOK 300 billion annually. Norway's share of the donors' contributions has averaged about five per cent.

RESULTS: 95 PER CENT OF ALL CHILDREN IN NEPAL START SCHOOL, BUT ONLY 83 PER CENT FINISH

More than 95 per cent of children now start primary school, compared with 89 per cent in 2008. A growing number are also starting school at the right age. The percentage of five-year olds who began first grade increased from 83 per cent in 2008 to 91 per cent in 2011. For girls, the increase was from 81 to 90 per cent. The percentage of first graders who had to repeat the year was 21 per cent in 2011, down from 28 per cent in 2008. The proportion who completed the five-year primary school programme increased from 76 per cent in 2008 to 83 per cent in 2011. The improvements are the result of increased investment from both donors and the Nepalese authorities in all parts of the education sector. Civil society organizations and local associations have made important contributions by motivating parents to give priority to education for their children, and by adapting school life to the reality in which children live.

The goal of just as many girls as boys starting school has been met. The national average hides great geographical disparities. In 2011, several districts had up to 97 per cent participation of girls in school, while other districts had 72 per cent. In particular, several districts in the Terai, the poor lowlands bordering India, still have low participation of girls.

Major advances have also taken place in preschool and secondary school. From 2008 to 2011, the proportion of first graders who had attended preschool increased from 33 to 54 per cent. In the same period, secondary school enrolment increased from 21 to 31 per cent. Equal numbers of girls and boys now start lower secondary school. In upper secondary school, there are still great disparities between girls and boys, especially among children from low castes.

The official statistics show considerable progress in the inclusion of low-caste children in primary school, while some ethnic groups have declining participation. For some ethnic minorities, a major hindrance to learning outcomes is that the language of instruction is not their native language or other familiar language.

An evaluation in 2011 found improvements in school quality. All permanently employed primary school teachers now have basic teacher training. Minimum standards such as adequate teaching materials and trained teachers are a requirement for all public schools. There are plans to identify the schools that do not meet these standards and provide special support to these.

The scope of the sector plan from preschool to secondary school is highlighted as positive in the evaluation. It shows that the government has increased the capacity to plan for the whole sector. The report also highlights that local communities' participation in the control of school plans, budgets and reports is a sign of the government's increased willingness to be open about planning and budgeting processes.

LESSONS LEARNED: HARDEST TO REACH THE LAST FIVE PER CENT WHO ARE NOT ATTENDING SCHOOL TODAY

It is challenging to reach the last 2.1 million children who do not attend school. There are still great differences between geographical areas, different castes, ethnic groups and children with disabilities. To gain a better understanding of the reasons for exclusion and to ensure the inclusion of these groups, a study is now being conducted to shed light on the challenges and propose solutions.

TIL INNHOLD ↑

In the time ahead, it will be important to improve the quality of schooling so that students learn what they are supposed to learn. Important changes in the law relating to education reforms are not in place because Nepal had no elected parliament after November 2012. Many schools have a disproportionate number of students per teacher, often more than 50. One lesson from the evaluation is that the sector programme should launch overarching initiatives that will benefit the entire system, such as better data collection and data analysis. Capacity development is also needed in each school and municipality responsible for important tasks such as teacher recruitment and budget planning.

Sources:
Mid-term evaluation of the School Sector Reform Plan, 2011
School level educational statistics of Nepal, Consolidated report, Ministry of Education, 2011 Nepal National Living Standards Survey II, Nepal Bureau of Statistics, 2004
Nepal National Living Standards Survey III, Nepal Bureau of Statistics, 2011
Draft School Sector Review Plan Extension document, Ministry of Education, 2013

Photo: Ken Opprann

More than 95 per cent of children in Nepal started primary school in 2013. The five per cent who are still out of school are the poorest and most marginalized children, and they are the hardest to reach.

EXAMPLE 3 EIGHT MILLION MORE CHILDREN AT SCHOOL IN AFGHANISTAN

Norad's results report in 2011 showed that Afghanistan had made great progress in getting more children, including girls, to school. Since then, the number has increased further. At the same time, more women have started at teacher training colleges, and more young people are receiving vocational training.

WHY: LACK OF SCHOOL OPPORTUNITIES

Afghanistan is one of the countries with the most children out of school in the world. Before 2001, only one million school-age children were enrolled in primary school. At the same time, according to UNICEF, the country had 7.3 million children aged 5-18. Girls had little or no access to school, and almost no teachers were women. Afghanistan is a fragile state with weak institutions and lack of its own income. Donors funded about 65 per cent of Afghanistan's national budget in 2012. Shortcomings were noted alongside the progress reported in 2011, such as the low level of education among teachers, poor quality of school buildings and low-quality data on school participation.

WHAT: SUPPORT FOR BASIC EDUCATION

The multi-donor Afghanistan Reconstruction Trust Fund (ARTF) with its Education Quality Improvement Program (EQUIP) plays a key role. The fund is managed by the World Bank and it supports the priorities of the Afghan government. The aim is to strengthen the nation's ability to solve the tasks it faces, even though in economic terms the country will not be able to run its own education sector for many years yet. Support for basic education, especially girls' education, has been substantial. Norway has also supported the Global Partnership for Education, as well as programmes run by UNICEF, UNESCO and civil society organizations.

How much: Norway is the seventh largest contributor to the ARTF. Since the fund was established in 2002, Norway has contributed NOK 2.1 billion altogether, about seven per cent of the total fund. In 2012, the funding amounted to NOK 330 million. In recent years, just over half a billion USD per year has gone to educational measures, which is about one quarter of the total ARTF. The figures vary from year to year. Norway also supports UNICEF, UNESCO and civil society organizations. In addition, Norway is responsible for about eight per cent of the contributions to the Global Partnership for Education (GPE), which has signed an agreement with Afghanistan amounting to USD 55 million. The results described below are achieved through joint efforts, but the ARTF is the largest player.

RESULTS: MORE CHILDREN IN SCHOOL, MORE WITH VOCATIONAL TRAINING, AND MORE FEMALE STUDENT TEACHERS

The Afghan government and donors, including Norway, have jointly contributed to a substantial increase in the number of children in school: from fewer than one million children in school in 2001, mainly boys, to 9.2 million in 2013, of whom 3.6 million are girls. This is an increase of 8.2 million children in school since 2001. During that year there were 20,000 teachers; in 2011 the number had risen to about 170,000, of whom 30 per cent were women. The data on children in school have been characterized by uncertainty, partly because enrolled children are included in the statistics for two years even if they leave school during that period. A digitized reporting system is being introduced to make school participation data collected in rural areas available to the government and the public on a website. Spot checks at the schools provide quality assurance of the data.

The number of students in vocational training and higher education has also increased significantly. The number receiving vocational training increases by 38 per cent per year. Here, increasing the proportion of girls presents major challenges. Girls make up only 13 per cent of the students. However, the situation is unclear because the figures concern public vocational training. Private players such as non-governmental organizations run 77 per cent of vocational training.

Educating more female teachers has been one of the initiatives aimed at getting more girls into school. In the 2013 cohorts in teacher education programmes, 71 per cent are women. This is the result of a decentralized structure with many local teacher training colleges, additional support for colleges that take steps to improve the proportion of women, as well as a scholarship programme for girls who want to go to a teacher training college. An example of this progress is the Laghman province, where the number of female students at teacher training colleges has increased from 28 in 2009 to 328 in 2012. The female students do not necessarily get jobs as teachers. A study has now been commissioned to assess the increase in the number of female teachers, and to identify obstacles that prevent women from getting jobs in schools.

In 2008-2013, EQUIP has supported the construction of 442 schools. Standards have been developed for upgrading schools, including separate latrines for boys and girls and protective walls around the schools. These two measures are important for girls' participation. In total, 2619 schools have been selected for upgrade in 2013.

TIL INNHOLD ↑

LESSONS LEARNED: AFGHANISTAN IS DEPENDENT ON AID TO CONTINUE PROGRESS

Afghanistan's education problems have not been solved. Nearly half of school-age children are still not in school and there are large regional disparities, for example in the opportunities for girls. Afghan authorities are aware that the quality of schooling is a challenge and have started a survey of learning outcomes to inform the education sector in the future. Experience shows that it will take time to achieve a satisfactory level. The education system will be dependent on international support if the positive trend is to be sustained.

Sources:
Education Joint Sector Review 1391, the Islamic Republic of Afghanistan, 2012 Norad statistics portal on its home page
Evaluation of Norwegian Development Cooperation with Afghanistan 2001-2011, Norad 2012 World Bank Implementation Supervision Mission EQUIP II – Aide Memoire, October 2013 EQUIP Semi-Annual Report January-June 2013
State of the World's Children Report 2003, UNICEF

Educating more female teachers has been one of the initiatives aimed at getting more girls into school in Afghanistan. In the 2013 cohorts in teacher education programmes, 71 per cent are women.

EXAMPLE 4 BUILDING CLASSROOMS IMPROVES THE QUALITY OF EDUCATION IN MADAGASCAR

Long-term Norwegian support to ILO initiatives in Madagascar has led to improved quality in education and skills development in the construction industry.

WHY: HIGH ATTRITION OF STUDENTS IN SCHOOL

In Madagascar, about 4.3 million children attended school in 2010. Over a quarter of school-age children did not attend school. A significant number of students leave before they have completed primary school. Reasons for the dropout rate include overcrowded classrooms and lack of sanitation facitlities. This has a strong impact on girls' participation.

Madagascar has a long tradition of contributions from the community to the construction and operation of school buildings. The number of public classrooms is close to 74,800. About 90 per cent are in adequate condition, while ten per cent must be renovated. The State's contribution to school construction is extremely limited, and the education plan specified the construction of only 827 classrooms in 2005-2010.

WHAT: NORWAY SUPPORTS THE INTERNATIONAL LABOUR ORGANIZATION (ILO) SCHOOL BUILDING PROGRAMME HIMO BÂTIMENT

HIMO involves local contractors and parents' associations in nearly 40 educational districts in Madagascar. HIMO's vision is to ensure that local firms gain the necessary knowledge, practical experience and skills to construct classrooms, latrines and water pumps as well as procuring furniture for new and refurbished schools. At the same time, ILO is responsible for providing training to parents' associations in maintenance procedures for school buildings. In addition to assisting the authorities with building classrooms, HIMO-Bâtiment aims to provide jobs for local people and a sustainable construction industry in the community.

How much: In the period 2001-2012, Norway has contributed NOK 101.7 million to HIMO-Bâtiment. Of this, NOK 78 million represented support for the 2005-2012 programme, which was fully funded by Norway.

RESULTS: BETTER LEARNING CONDITIONS FOR STUDENTS AND TEACHERS AND STRONGER SOLIDARITY IN THE COMMUNITY

In 2005-2010, 21,000 classrooms were built, mainly by using local resources. A study among 12,000 students and 240 teachers showed that the number of students per classroom decreased from 63 to 44 due to the HIMO programme. The national average is 47 students per classroom. Due to population growth in a period of political turmoil, it was not possible to reduce the number of out-of-school students, and UNICEF estimated that 1.5 million children were still out of school in 2012. However, the students who were already attending school benefited from better learning conditions because the number of students in each class was reduced. The study shows a ten per cent increase in the number of students who passed the final examination in primary school. In 2005-2010, more than 1200 members of parents' associations received training in maintenance and governance. Parents have contributed 32,300 working days in voluntary work. The active participation by parents has encouraged strong local ownership, and helped ensure the project's sustainability.

In the early 2000s, Norway financed the construction and running of a training centre in technical construction disciplines in the city of Antsirabe. The centre still provides training for participants in the HIMO programme. Most of its income is now from consultancy services and professional assistance to construction firms. Orders come from home and abroad, and the centre is now financially independent of aid.

The programme has strengthened the technical skills of 114 small and medium enterprises. The building projects have followed the ILO standards for decent work.

TIL INNHOLD ↑

LESSONS LEARNED: LOCAL GOVERNMENT PARTICIPATION YIELDS BETTER RESULTS

HIMO-Bâtiment's contribution to improving the quality of education took place in a period of political turmoil in Madagascar. Under normal circumstances, coordination of the ILO programme with the education authorities would have been stronger. The freeze in government-to-government aid from 2009 made it more important than ever to prevent dropout of students who are entitled to basic education. Education authorities now want closer harmonization with other educational initiatives that are taking place through external providers. This will be achieved through the government's new education plan.

HIMO-Bâtiment operates with two approaches for building projects: a delegated approach where the work is outsourced to firms or municipalities, and an approach in which local authorities are responsible for the building projects. A check of progress midway through the programme concluded that both approaches yield results, but the approach aimed at local authorities provides better developmental benefits for the local community. This is where transfer of skills and technology should preferably take place.

Sources:
Plan Interimaire pour l'education 2013-2015 HIMO: "Haute intensity de Maître d'Oeuvre»
«Projet HIMOj Bâtiment Mission d'Evaluation à Mi-Parcours Report Final de la Mission" (Ann Schwartz, Jean Louis de Bie, Ridjanirainy Randrianarisoa), 2011
Rapport Final Période: janvier 2009 décembre 2012, Projet HIMO Bâtiments (MAG-07/13)

At the Ambalavato 401 school in Madagascar's third largest city, Antsaribe, the new building with two classrooms was completed in 2011. Principal Jeanne Simée Sahondranirina reports a substantial improvement in everyday life for the 240 students. But an equally large problem is that only three of the eight teachers are paid by the government. The others are paid by the parents of the students. With up to 45 students per class, 10-12 teachers would have been optimal, she says. But there is not enough money for that.

EXAMPLE 5 A BOOST FOR THE WEAKEST SCHOOLS IN BURUNDI

Targeted efforts in the three provinces of Burundi where school results were poorest have helped to increase the proportion of children attending school, and to improve the school environment and examination results. But there is still a long way to education for all.

WHY: SCHOOL SYSTEM UNDER PRESSURE

Burundi experienced a rapid increase in the number of children enrolled in primary school after the government introduced free and compulsory primary education in 2005. The proportion of children in school rose from 60 per cent in 2005 to 96 per cent in 2012. 95 per cent attend Of school-age girls in Burundi school.

Generally, the increase in the number of students has led to greater pressure on the school system, which has limited resources to provide good enough education. Burundi has a great need for more teachers who are qualified, textbooks, and other equipment and teaching materials. More and larger school buildings are also needed. On average, there are 80 students per classroom. Double shifts in teaching have been introduced, which has reduced the teaching time to 3.5 hours per day for each class. In addition, there have been and still are major internal differences between the provinces in Burundi. These relates to the proportion of children attending primary school, the number finishing school, and the results. The three provinces of Ngozi, Muyinga and Kirundo have been far below the national average.

WHAT: DEVELOP TEACHING SKILLS AND IMPROVE THE LEARNING ENVIRONMENT

UNICEF supports the Ministry of Education's national Back to School campaign and the Child-Friendly Schools programme. Together, the measures aim to increase the number of children in school, provide a good learning and teaching environment, and ensure that students continue in school. UNICEF is implementing measures in the three provinces where school results have been particularly poor, and participation has generally been lower than elsewhere in the country. UNICEF has mobilized resources for school participation through local leaders and parents and built 17 new schools with six classrooms each. The schools have running water and separate latrines for girls and boys. UNICEF has also been working for recruitment and in-service training of teachers. A student/child-centred teaching approach contributing to inclusion has been the main objective.

How much: In 2012, UNICEF's contribution to Burundi's education budget totalled USD 2.8 million. The Norwegian contribution amounted to USD 517,924 (about NOK 2.9 million). Norway's support for the programme was channelled through the global support for UNICEF's education programme. From 2010 to 2012, this support is estimated to be just over NOK twelve million for UNICEF Burundi.

RESULTS: MORE CHILDREN COMPLETE SCHOOL AND LEARN MORE IN THE WEAKEST DISTRICTS

The proportion of children who were enrolled in school and continued after the first year increased in Ngozi, Muyinga and Kirundo between 2009 and 2012. In Ngozi, this proportion increased from 46 to 67 per cent, in Muyinga from 44 to 74 per cent, and in Kirundo from 49 to 86 per cent. In 2009, UNICEF funded school materials for 350,000 school-going children in nearly 600 schools in the provinces of Ngozi, Kirundo and Muyinga. In 2011 and 2012, 500,000 children received support. Distribution of school materials has made it possible for disadvantaged families to allow their children to stay in school. The proportion of children who completed primary school in the three provinces therefore increased from 33 per cent in 2009 (28 per cent for girls and 38 per cent for boys) to 48 per cent (43 per cent for girls and 52 per cent for boys) in 2012. In comparison, the completion rate for the country as a whole was 69 per cent in 2012 and 48 per cent in 2009. Despite this progress, it will take time before all the children in these provinces complete their primary education. One reason is that Burundi is in the early reconstruction phase after conflict. Many parents have not had an education themselves and many do not give priority to schooling for their children.

In cooperation with the Ministry of National Education in Burundi, UNICEF has updated teachers' guides and ensured that the teachers in the three provinces have received further education. This has helped to improve examination results. In the final examination in sixth grade, Ngozi Province ranked second in the country in 2012 with a pass rate of 64 per cent, compared with 2009 when the pass rate was only 32 per cent. In Muyinga Province, almost 58 per cent of the students passed in 2012, compared with 31 per cent in 2009. Muyinga, which had ranked as number 15 of 17 provinces after the final examination in 2009, achieved third place after the examinations in 2011 and 2012. In Kirundo, 45 per cent passed in 2012 compared with 32 per cent in 2009.

TIL INNHOLD ↑

LESSONS LEARNED: COMMITMENT TO THE WEAKEST REGIONS HAS BEEN SUCCESSFUL

The example shows that targeted efforts in areas with the poorest performance can boost school attendance and examination results. Further improvement is still needed in these three provinces in particular and in Burundi in general, in terms of both education quality and reaching the many children who are still out of school or do not complete school. UNICEF is now working to include Burundian children who return from refugee camps in Tanzania. To reach more teachers, the teacher education component of the UNICEF programme should be integrated into the official programme of study for teacher training.

One success factor of the programme has been the cooperation with committed governments. Involvement of the local education authorities proved effective in ensuring good monitoring of results. It also gave the government authorities ownership of the programmes and the results that were achieved. Another success factor has been UNICEF's teaching methods, with a student-focused and inclusive approach. UNICEF is planning to develop the programme further to prepare preschool children for primary school. This is especially relevant for children who come from marginalized poor families. To carry out this work, efforts will be made to strengthen cooperation with local civil society organizations and religious communities.

Sources:
Ministry of National Education in Burundi's Statistical Yearbook, 2008-2012.
Internal data from UNICEF: UNICEF Burundi Annual Reports for 2010, 2011 and 2012

Patrik Dusenge (left) and Sumiya Uwimana are in the sixth grade at the Stella Matutina school in Bujumbura, Burundi. Girls and boys attend the same class.

EXAMPLE 6 BETTER TEACHERS PROVIDE BETTER SCHOOLING

Save the Children Norway has helped to increase the quality of education in Ethiopia, Zambia, Zimbabwe and Mozambique. More than a thousand teachers have had the opportunity to strengthen their teaching practice.

WHY: MILLIONS OF CHILDREN GO TO SCHOOL WITHOUT LEARNING BASIC SKILLS

Due to a lack of focus on education quality, many students — mostly from poor countries — lack basic literacy and numeracy skills, even after completing basic education. This crisis in learning was increasingly documented from the early 2000s. The consequence is that many children and young people miss out on skills that are necessary to perform well in life. As well as losing the opportunity to gain literacy and numeracy skills, they do not get the chance to develop their capacity for critical thinking, life skills and communication.

WHAT: TRAINING OF TEACHERS TO REFLECT ON AND DEVELOP THEIR OWN TEACHING PRACTICE

Since 2002, Save the Children Norway has therefore supported efforts to sharpen the focus on education quality, through projects in Ethiopia, Mozambique, Zambia and Zimbabwe among others. The initiative is called the Quality Education Project (QEP). The project is based on studies showing that teachers' relationship with their students is important to the quality of education and learning outcomes for the students. The teachers in the project were trained in conducting action research on their own teaching practice. They worked in focus groups, observed each other and wrote diaries to analyse and improve their own teaching practice. Teachers at teacher training colleges and local education authorities also received training to strengthen the teacher education programme and the efforts of government agencies to boost education quality.

How much: The project received NOK 18.2 million from Norway between 2002 and 2009, distributed to: Ethiopia: 4.63 million, Zambia: seven million, Zimbabwe: 3.7 million and Mozambique: 2.84 million Since 2009, various components have been continued in the other Save the Children Norway's programmes in the four countries. These education programmes also receive Norwegian support.

RESULTS: PROFESSIONAL TEACHERS WHO CARE ABOUT THE CHILDREN

A survey in 2010 showed significant changes in the practices of teachers and school managers, with a better learning environment for their students. The evaluation described the project as an innovation that has strengthened teachers' identity, potential and practice through research on their own education. In all, the project has provided training or further education to more than 1,000 primary school teachers, 108 teachers at teacher training colleges and universities and 39 educational leaders in Southeast Africa.

The evaluation shows that teachers who have participated in the programme use less corporal punishment, provide guidance that is more constructive and show greater capacity to improve their teaching than teachers without the same training. Only teachers who were trained through the project achieved top results in the evaluation's classroom observation. The evaluation researchers highlight this teaching as the best they have seen in Africa for 30 years.

Most schools that participated in the project scored better in mathematics and English than other schools. The evaluation emphasizes that this relationship is not definitive. It took time to develop and launch the project as well as to establish a foundation in teacher training colleges and primary schools in the four pilot countries. The period that the first teachers in the project had worked in the same classes after the training intervention was too short to make it possible to expect conclusive effects on learning outcomes when the evaluation team collected its data in 2009.

From 2010 to 2012, annual surveys of learning outcomes were conducted in a selection of the schools with which Save the Children Norway works. In Zimbabwe, the survey suggests that reading skills are higher in schools where teachers have received training through this project than in other schools. An evaluation is to be conducted in Zimbabwe and Zambia to test and document this relationship. The willingness and ability of government agencies to continue the project will be evaluated at the same time.

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LESSONS LEARNED: NEED FOR ASSESSMENT OF THE EFFECTS OF TEACHING PRACTICE ON LEARNING OUTCOMES

The evaluation from 2010 concluded that enhanced teaching skills could improve the teacher-student relationship and reduce corporal punishment. It also suggests that this helps to improve learning outcomes. The teachers who were evaluated found that focusing on students, observing them and listening to them were among the most important ways to improve teaching that they had learned in the project. Such improvement does not happen overnight. The evaluation notes that changing the teacher's teaching practice takes at least one to two years, because this also involves changing personal attitudes and behaviour.

Although much knowledge is already available about the positive effects of action research, there is a need for better assessment of effects on students' learning outcomes. Save the Children Norway is therefore planning to conduct an impact evaluation of the project.

Sources:
Harber, Clive and Stephens, David, From Shouters to Supporters; Quality Education Project – Final Evaluation Report, Save the Children Norway, 2010
Annual Reports from Save the Children in Zimbabwe in 2010, 2011 and 2012. Save the Children Norway

In the classrooms at the Stella Matutina school in Bujumbura, Burundi, participation is lively. Students are quick to raise their hands and say "please" when the teacher asks questions. The form of address and participation in the lessons are a sign of respect, and the teachers ensure discipline in the classroom.

EXAMPLE 7 LEARNING ENVIRONMENTS ADAPTED TO GIRLS RESULT IN BETTER LEARNING

Girls do better in school when learning environments are gender responsive. The Forum for African Women Educationalists has created a model for achieving gender equality in schools. Authorities in several countries are now adopting the model.

How much: From 2008 to 2012, Norway contributed NOK 3.3 million. This accounted for 21 per cent of the total contribution to FAWE's Centres of Excellence.

WHY: LARGE GENDER DISPARITIES IN SCHOOLS

In 2000, UNESCO stated that gender disparities in schools were largest in Sub-Saharan Africa, the Arab states and South and West Asia. Learning that is better adapted for boys than girls as well as attitudes among students, teachers, school administration and the community in general can contribute to lower school attendance of girls than boys. African girls face problems such as gender-based school regulations, teaching methods and curriculum content, lack of separate toilets for girls and boys, poor safety and inadequate water supply.

WHAT: SUPPORT TO THE FORUM FOR AFRICAN WOMEN IN EDUCATION AND ITS WORK FOR EQUALITY IN SCHOOLS

The Forum for African Women Educationalists (FAWE) has developed a school model for an environment that is academically, socially and physically adapted needs of both boys and girls. The model is specifically directed at schools in areas where there are great challenges in achieving gender equality, such as areas in which few girls go on to secondary school. The programme includes special courses for principals and teachers in how to treat boys and girls on an equal basis, counselling and follow-up of students, and measures to develop students' social skills. The model also emphasizes initiatives to strengthen girls' skills in mathematics and science as well as career guidance. The aim is to help more girls finish school and get better grades.

FAWE's mandate is to use practical measures to demonstrate what can improve schooling for girls in Sub-Saharan Africa. FAWE works to influence authorities to incorporate and use these experiences in national education systems and practices. In the period 2008-2012, FAWE implemented change processes in 14 African countries with support from NORAD. These are Benin, Comoros, Ethiopia, Ghana, Madagascar, Malawi, Mali, Senegal, South Sudan, Swaziland, Togo, Uganda, Zambia and Zanzibar in Tanzania. The model is now being used in 21 countries in Africa.

RESULTS: MORE GIRLS WHO ARE LEARNING MORE IN SCHOOL

School achievement by girls has improved significantly due to FAWE's efforts.

At the Kijini centre in Zanzibar, the proportion of girls who passed the national examination for the second form rose from 30 per cent in 2009 to 52 per cent in 2012. For the fourth form, the proportion rose from 35 per cent in 2010 to 47 per cent in 2011.

At Kamulanga High School in Zambia, the proportion of students who passed final examinations increased from 56 per cent in 2007 to 84 per cent in 2012. The school has a boarding house that offers a safe place to stay for girls who otherwise run the risk of abuse or exploitation because of unsafe living conditions or the long way to school.

The Bukomero Centre of Excellence in Uganda has established an guidance and counselling desk for solving problems related to students' everyday lives. Outcomes have included an improvement in girls' performance in science by about 30 per cent in the 2010/2011 school year.

FAWE can document many such results in several countries over many years. These results have encouraged authorities in several countries to copy the Centre of Excellence model. In 2010, the Kenyan government allocated funds for countrywide continuation of FAWE's work in 72 secondary schools. In cooperation with FAWE, Rwanda's Ministry of Education developed the model further in another school in the east of the country. In 2010, the government of Uganda took the initiative to continue the model in 42 secondary schools and five vocational training institutions across the country.

TIL INNHOLD ↑

LESSONS LEARNED: PROVEN RESULTS MOTIVATE RECURRING EFFORTS

FAWE's work is an example of how local expertise and being close to the challenges can result in practical measures that create results. Narrowing the gender gap in schools is one of the Millennium Development Goals that most governments support, and tested models with evidence of results are good investments. Participation by school management, students and communities has also proved important to enable implementation of the model. The biggest hurdle to girls' education is often culturally determined.

Sources:
FAWE's annual reports 2008-2012 FAWE reports from Zambia and Uganda
Forum for African Women Educationalists (FAWE), home page www.fawe.org

UN Girls' Education Initiative

The United Nations Girls' Education Initiative (UNGEI) was launched in 2000 with the aim of contributing to the Millennium Development Goal for gender equality and women's empowerment. UNGEI has evolved into a recognized partnership that has contributed knowledge, dialogue and advocacy to promote the right of girls to education and gender equality. At the global level, UNGEI's work has included the development of reports and updates on education and gender equality, launched in conjunction with the annual Global Monitoring Reports (GMR) on education. In addition to working globally and regionally, the partnership is established in 33 countries. In these countries, UNGEI often works together with government authorities to ensure that girls' right to education and gender equality are included in national plans and strategies.

UNGEI is managed by UNICEF, but other UN agencies, donors and civil society also participate actively in the partnership. Norway has been a key player in UNGEI. Norad is a member of UNGEI, contributing professional and technical suggestions. Norad has also periodically held management positions in UNGEI's governing bodies. In addition, Norway contributes financially to UNGEI through thematic funding for UNICEF.

Nkurunziza Musalama (13) makes notes diligently as the teacher writes on the board. She is in sixth grade at Stella Matutina school in Bujumbura, Burundi, and hopes she can continue to university to become a doctor.

EXAMPLE 8 CHILDREN AND ADOLESCENTS AFFECTED BY CONFLICT IN COLOMBIA ARE GETTING EDUCATION

Flexible education and psychosocial support managed by the Norwegian Refugee Council yields results for vulnerable groups in Colombia. Due to high numbers both for completion and for participation by girls, the Colombian authorities are taking over the programme and expanding it.

WHY: BECAUSE OF CONFLICT, HALF A MILLION CHILDREN HAVE NO EDUCATION

About 5.3 million people are displaced in Colombia. The country has the highest number of internally displaced people in the world. Of these, 64 per cent are under the age of 24. Although the Colombian authorities maintain that all children and adolescents have the right to education, more than 480,000 internally displaced children and young people were out of school in 2010. Armed attacks on schools, students and teachers contribute to the exclusion of many young people from education in the most vulnerable areas. Because of limited resources and a weak state presence in the regions affected by conflict, government agencies do not manage to ensure education.

WHAT: SMALL CLASSES AND CLOSE MONITORING FOR DISPLACED CHILDREN

Vulnerable groups of children and young people are particularly affected by the conflict in Colombia. The Norwegian Refugee Council has developed flexible education tailored to the needs of these groups. The project was conducted from 2010 to 2012. It is a continuation of the Council's education projects in Colombia, which Norway has supported since 2006.

The initiative is harmonized with the national education system and has been developed in line with international standards for education in situations of crisis; see the next page. The programme takes into account the needs of families for their children to contribute to the household economy, and the fact that they often come from communities affected by violence. The classes are small; educational and psychosocial support is provided with personal follow-up. The Norwegian Refugee Council has also contributed to the capacity of the education authorities to take over the responsibility.

How much: Norway supported the Norwegian Refugee Council's project with about NOK 22.6 million in 2010-2012. The Norwegian Refugee Council has received a total of NOK 55.7 million from Norway for educational purposes in Colombia during the period 2006-2012.

RESULTS: 60 PER CENT OF INTERNALLY DISPLACED PEOPLE IN THE PROJECT AREA ARE GOING TO SCHOOL

From 2010 to 2012, the project made schooling possible for 32,160 children and young people. Between 85 and 95 per cent of the students completed their school education. Of the pupils, 62 per cent were girls. The Norwegian Refugee Council achieved its goal: by the end of the project, 60 per cent of internally displaced young people in the project region were attending school. Primary education has been provided to 2,043 children, adolescents and adults of African-Colombian origin, who have been particularly hard hit by the conflict. Colombian authorities are now continuing most of the education models as part of the education programme offered.

LESSONS LEARNED: COOPERATION WITH AUTHORITIES TO ENSURE SUSTAINABILITY

The choice not to take over the responsibility of government agencies, but to provide guidelines on how school authorities can ensure appropriate schooling for vulnerable children and young people, has been a worthwhile commitment. The initiative has largely succeeded in meeting the educational needs of internally displaced and vulnerable groups. Cooperation with government agencies and educational institutions has been important to ensure sustainable programmes.

Even though the government authorities have had a positive attitude to the flexible educational programme, nothing has happened regarding the state tests, which are not suited to the culture and background of internally displaced people. For this reason, they often do not score well on these tests, and it becomes more difficult to take further education.

Sources
Norwegian Refugee Council Project Report, 2012
Activity Accounts 2012, Norwegian Refugee Council
Evaluation of the NRC Colombia Program 2008 – 2010

TIL INNHOLD ↑

Sharper focus on education in emergencies

In disasters, protracted crises and early reconstruction after conflicts, education contributes to a sense of normality, stability and structure. Formal and non-formal education can contribute training and important information that can save lives. Schooling can impart hope for the future. In long-drawn-out crises in particular, it is important for children and young people to receive an education, to prevent entire generations from missing out on schooling.

Norway is one of six countries in the world that has education as part of its humanitarian policy. Norway has helped to focus attention on education in emergencies and fragile situations through measures including support to the Inter-Agency Network for Education in Emergencies (INEE). INEE was established in 2000, currently has over 8,500 members, and includes national authorities, UN agencies, civil society organizations, donors, professional practitioners in the field and researchers.

One of the most important contributions from INEE is the development of minimum standards for education in crises. INEE has also developed a variety of toolkits and course materials for those who want to use the standards. The standards, which have been translated into 22 languages, are used in over 80 countries by governments, the UN system and other organizations.

For example, the standards have been used by authorities in Vietnam and Lebanon in the development of national plans for emergency response.

These standards and INEE's advocacy efforts also formed the basis for a UN resolution to include education as humanitarian aid and a UN resolution condemning attacks on schools, adopted in 2010 and 2011 respectively.

Norway is one of the largest contributors to INEE and has funded its work with between NOK 400,000 and 800,000 annually since 2004. The Norwegian Refugee Council, Save the Children Norway and Norad participate in INEE's work. Norad has long been a member of the INEE Minimum Standards Working Group, but has now transferred to the Education Cannot Wait Advocacy Working Group. This group works to ensure education for the large proportion of children and young people who do not yet have access to education, because they live in areas affected by crises or conflict.

When there are no school buildings, students and teachers must resort to makeshift premises. Many of the students in the Norwegian Refugee Council's education programme for internally displaced people are young women who participate together with their children.

EXAMPLE 9 FLEXIBLE EDUCATION PROGRAMMES HAVE ENABLED CHILDREN IN NOMADIC COMMUNITIES TO GO TO SCHOOL IN UGANDA

In cooperation with several agencies, Save the Children Norway has helped to give children and young people in the nomad region of Karamoja a flexible and alternative education programme. Teaching adapted to local conditions and lifestyles has enabled 265,000 children to attend school from the start in 1998.

WHY: A LOCAL COMMUNITY OUTSIDE THE EDUCATION SYSTEM

Children in Karamoja have long been left out of the education system. Cattle herding is the livelihood of the Karamajong people in Uganda. The dry climate has led to considerable internal rivalry for resources. Children and young people have had little opportunity to go to school. In 1998, only twelve per cent of the population in the region had basic literacy skills. The local community was sceptical about government schools and a teaching approach that was perceived as having little relevance.

WHAT: ALTERNATIVE TEACHING PROGRAMMES ADAPTED TO NOMADIC LIFE

From 1998, Save the Children Norway worked together with the local community, organizations and Ugandan authorities to develop Alternative Basic Education for Karamoja (ABEK). The initiative has five pillars:

- Relevant curriculum
- Flexible teaching times
- Student-centred teaching methods
- Local teachers
- Schools close to settlement camps

The teaching had to be flexible, mobile and adapted to the working cycle so that the children could take care of cattle, help at home and go to school. Classes were held in the morning and evening, in mobile schools under trees, with a locally anchored curriculum in subjects such as peace and security, rural technology and agricultural production. The local schools were linked to ABEK centres that assisted with educational materials and professional guidance.

How much: Norway supported the ABEK project with about NOK 8.5 million in 2006-2009. After 2009, ABEK was mainly financed by the government of Uganda, with professional and some financial support from Save the Children Norway's national education programme.

RESULTS: THE MOST MARGINALIZED CHILDREN GAIN ACCESS TO SCHOOL

About 265,000 children who previously had no access to education have attended ABEK schools since 1998, and nearly 20,000 students have been transferred to formal schools. This is evidenced in the annual results reporting and two evaluations from 2009 and 2011. Over 55 per cent of the students in the school centres between 2009 and 2011 were girls. To ensure sufficient teachers who wanted to live and work in Karamoja, with its distinctive way of life, 472 local teachers have been trained and teach at ABEK schools. Local teachers also contribute to the local roots and relevance of the education.

The learning outcomes for children in ABEK schools have proved to be above the average in Uganda. Of the students who were tested after completing the third grade level, 49 per cent can read and write in the local language, 83 per cent have mastered basic mathematics, while 33 per cent have some ability to read and write in English. The figures for learning outcomes are higher than what is common in Southern and Eastern Africa, according to SACMEQ, an organization that measures educational quality.

In 2008, Ugandan authorities incorporated the ABEK model in a new Education Act. This allowed for public funding of the school centres, and 87 per cent of the centres currently receive funding from the government. This contributes to the sustainability of the project. According to the Ugandan daily newspaper the New Vision, ABEK in Uganda has been so successful that the government of South Sudan wants to use part of the programme to increase access to and quality of education.

To offer children and young people in Karamoja this educational programme, 16 school centres, 28 temporary schools, 191 mobile schools (under trees) and nine latrines were built, distributed among six districts. The evaluation also shows that the schools have strong local support through village leaders and committees that have worked actively to persuade parents to send their children to school.

While good results can be documented for certain aspects of the initiative, it is a challenge that no census has been carried out in Uganda since 2001. Because the number of children living in the region is uncertain, it is not possible to determine with certainty what proportion of school-age children are still not attending school. In addition, attendance has not been rigorously recorded, so that absence figures are not precise.

TIL INNHOLD ↑

Major challenges remain in efforts to ensure that all children in Uganda have access to basic education. The evaluation from 2009 shows examples of up to 90 per cent are out of school in some areas. In one ethnic group – Ngakaramajong – new UNESCO data show that 78 per cent of children aged between seven and 16 are still not attending school. Learning outcomes also appear to be so weak in many areas that many students never learn basic skills.

LESSONS LEARNED: INNOVATIVE SOLUTIONS, LOCAL COOPERATION AND LONG-TERM EFFORTS ARE NEEDED TO OFFER SCHOOLING TO THE MOST MARGINALIZED CHILDREN

In regions where traditional agriculture provides a livelihood, education demands innovative solutions based on the community's terms and needs. One of the keys to success was to understand the reasons for the opposition to education in this community, and in cooperation to design a programme that offered solutions to the problems.

The evaluations of the programme show that there is a great need to continue the effort. Requirements include more teachers, teaching materials and textbooks, better organization, greater safety and improved health services. There is also a need for better measurement and reporting of education programmes offered in the region, especially in terms of enrolment, attendance, dropout rate and learning outcomes. Better documentation of children's schooling would provide a better basis for government agencies and non-governmental organizations such as Save the Children to improve the programmes offered.

Sources:
Save the Children, Alternative Basic Education for Pastoralist Communities: The Story of the Pen, Save the Children, 2013
Krätli, Saverio, ABEK: Final report to Save the Children in Uganda. Save the Children, 2009
Manyire, Henry, Evaluation of the Mobile Alternative Basic Education for Karamoja (ABEK) Program, Makerere: Save the Children in Uganda, 2011
SACMEQ II and III: South and Eastern Africa Consortium for Monitoring Educational Quality New Vision, South Sudan to embrace K'jong education system, 9 July, 2013
WIDE, Education for All Global Monitoring Report, UNESCO, 2013

Since 1998, 265,000 children of the Karamajong people in Uganda have attended schools adapted to nomadic life and cattle rearing.

The story of Mark Loli

"I was born into a very poor family where education meant nothing. In our community, everything focused on cattle. "

Mark's story is a powerful statement about the importance of education and a young man's dream of a better life. Like many of his relatives in Karamoja, Mark believed that a nomadic existence was his destiny. This would involve constant roaming in search of water and pastures for the cattle. But this life was about to change. At the age of 13, Mark heard about a mobile ABEK school that had been established in the district.

It was not long before the ABEK teachers discovered that Mark had a unique ability to learn, and soon he was offered a place at a public school. For Mark, everyday life was far from simple. At the new school, the teachers beat him and all his free time was devoted to looking after the cattle. But Mark was determined to finish school.

After completing seven years of primary education in just four years, Mark completed lower secondary school with outstanding grades.

Today, the young man has just received his first diploma from Ndejje University. He studied sustainable agriculture, and as soon as he has saved enough money, he intends to study for two more years, again aiming to finish before the standard length of study. Besides his studies, Mark is passionately involved in efforts to improve the lives of the Karamajong people. Among other things, he works for a non-governmental organization that helps people to grow food as a supplement to herding cattle. He has also launched several agricultural projects, which will help increase the income base of the region.

Sources: Article on the website of New Vision
Save the Children story: From the kraal to earn a first-class diploma

EXAMPLE 10 CHILDREN WITH DISABILITIES ARE INCLUDED IN SCHOOL IN VIETNAM

In Vietnam, 60 per cent of children with disabilities have no access to education. Through cooperation between local authorities, schools and the Norwegian Mission Alliance, school coverage for this group has increased to 85 per cent in one province. The province is now being used as a model for inclusive education in the rest of the country.

WHY: CHILDREN WITH DISABILITIES ARE EXCLUDED FROM EDUCATION

Children with disabilities are largely left out of the Vietnamese school system. According to official sources, there are more than 1.2 million children with disabilities in Vietnam and the Ministry of Education estimates that only 40 per cent of them have access to education. Poverty and discrimination deprives this group of the opportunity to realize their right to education on an equal basis with other children. Exclusion increases with the degree of poverty. Education helps to provide practical skills and knowledge that children and families need to escape from poverty.

WHAT: INCLUSIVE EDUCATION PROJECT

The aim of the Norwegian Mission Alliance's project for Inclusive Education is to ensure that children and young people with disabilities have access to relevant education of sound quality. A further aim of the project is to increase awareness about the rights of people with disabilities so that they and their families are included in the community and gain access to social services.

In cooperation with Vietnamese authorities, the Norwegian Mission Alliance transformed the Vinh Long Special School into a resource centre for the whole province. The centre is responsible for communicating knowledge to teachers, parents and the Ministry of Education and Training. In addition, initiatives are offered for children below school age. Interventions in the preschool years are important for children to develop skills in language, movement and interaction. Initiatives for this age group also help to create an inclusive society characterized by awareness of the rights of children with disabilities and their families.

How much: The project began in 2005 and spanned two project periods, ending in 2012. Norwegian support for the project has totalled NOK 7.9 million. From 2008 to 2012, Norway spent NOK 4.3 million on the project. Since then, the Vietnamese authorities have covered all ordinary operating expenses associated with running the centre.

RESULTS: 85 PER CENT OF CHILDREN WITH DISABILITIES WERE INCLUDED IN THE SCHOOL IN THE PILOT PROVINCE

In 2012, 145 preschool children with disabilities participated in activities organized by the resource centre. This was an increase from 20 children in 2007. Here, children acquire knowledge that will benefit them when they later start at a mainstream school. For example, blind children have received instruction in Braille and children with autism have learned a variety of social skills that enable them to participate in everyday school life. The children have shown marked improvement in skills involving communication, movement and the ability to interact with others.

In 2012, 1,309 children with disabilities were included in mainstream schools in the province of Vinh Long, representing 85 per cent of all enrolled school-age children who have disabilities. This was an increase from 198 in 2007. This group of children has been included in mainstream schools in the province, gaining new classmates and friends. The teachers have built up knowledge and experience in adapting learning methods and curricula to the individual child, so that everyone can take part in the lessons and achieve learning outcomes. During field visits, observers have noticed that children with disabilities have the opportunity to participate in class and learn to read, write, solve math problems and acquire social skills on an equal basis with other children. The development in the children's self-esteem and confidence has also been significant. The change in attitude among the local population has provided children with disabilities access to health services and social activities.

The project was phased out in 2012, and inclusive education in the province is now being sustained by the government. Eight years after the project began, Vinh Long has become the first province in Vietnam to implement inclusive education throughout the region, and now leads the way for the rest of the country.

LESSONS LEARNED: INTERACTION BETWEEN GOVERNMENT AUTHORITIES, SCHOOLS AND PARENTS IS IMPORTANT

Changes in attitudes and greater knowledge about children with disabilities have convinced government agencies, teachers and parents that it is possible to provide education for this group in mainstream schools. Such changes have also contributed to a more inclusive environment at home, at school and in the community in general. Adaptation by local government agencies, school management, teachers, parents and local communities has been crucial to provide children with disabilities with access to school and education. In all these processes, the resource centre has played a central and vital role.

Sources:
Evaluation of the Norwegian Mission Alliance project, authors: Nguyen Nguyen Nhu Trang, Tu Ngoc Chau and Kate Halvorsen, March 2011
Final evaluation report of the project "Developing a comprehensive support system for inclusive education for children with disabilities in Vinh Long Province", May 2012
Stigma and restriction on the social life of families of children with intellectual disabilities in Vietnam, Hong Ngo et al., Singapore Medical Journal, 53 (7): 451-457, 2012

TIL INNHOLD ↑

Education for children with disabilities

Children with disabilities are among the most vulnerable in the world, and they are often excluded from society from birth. Because of stigma, children with disabilities are often hidden away, denied their rights and shut out from the community. Children with disabilities are often not registered at birth, which means that they miss out on public services and schooling because they cannot prove their identity. As a result, children with disabilities simply become invisible. Girls with disabilities often experience double discrimination: first because of traditional gender roles, and then because of their disability.

The data on the number of children with disabilities are weak, but GPE has estimated that 24 million of the 57 million children who have no education are living with disabilities. UNESCO estimates that 90 per cent of children with disabilities in developing countries do not attend school. In practice, many children in this group are often excluded from lessons because of inaccessible infrastructure and challenges with transport to and from school. Inadequate teaching materials are also a significant factor, especially for children with hearing or visual impairments or with intellectual disabilities.

Education is a basic human right, and over the past two years Norway has renewed its focus on inclusion of children with disabilities together with partners such as the Atlas Alliance in the Norwegian aid community, and in the global context, the World Health Organization, the World Bank, UNICEF and UNESCO. Between 2000 and 2010, Norway provided funding totalling NOK 70 million to support targeted educational interventions for children with disabilities.

Photo: Ken Opprann

Nguyen, a schoolboy from Vietnam

Nguyen was diagnosed with severe cerebral palsy when he was three months old. For many years, he was dependent on his parents' assistance in all daily activities. In 2006, the family was visited by teachers who were involved in the Norwegian Mission Alliance's inclusive education project. They encouraged the family to send Nguyen to the local school so he could participate in lessons with other children of the same age. "At first we did not want to let Nguyen go to school. We were afraid that the other children would laugh at him and bully him. He can barely walk or talk, so how would he be able to participate in the class?" says Sau, Nguyen's father. After many discussions with the teachers, Sau finally chose to carry his son to school in an attempt to give him the opportunity for a better life. Every day, he carried his son more than one kilometre each way to and from school. Today, Nguyen is twelve years old and is in the 7th grade. He gets good grades and walks to and from school every day by himself. "I am proud of my son. He has many friends both at home and at school. He gets good grades," concludes a visibly proud father.


Photo: Misjonsalliansen

Nguyen (12) and his family participate in the Norwegian Mission Alliance's inclusive education project in Vietnam.

EXAMPLE 11 UNIVERSITY COOPERATION CONTRIBUTES TO KNOWLEDGE AND DEBATE ABOUT DEMOCRACY IN INDONESIA

Cooperation between Universitas Gadjah Mada (UGM) and Norwegian universities has contributed to the development of democracy in Indonesia.

WHY: NEED FOR KNOWLEDGE AND DEBATE ABOUT DEMOCRACY AND SOCIAL REFORMS

In Indonesia, there have been reforms towards democratization since 1998. In the world's third most populous country, people are waiting impatiently for the effect of the reforms. Trust in democracy is being put to the test. Stories of corruption in government systems and lack of transparency in decision-making processes reinforce scepticism.

Universitas Gadjah Mada, with more than 50,000 students and hundreds of professors, is an academic powerhouse in Indonesia. The university was a key driver in the democratization process that ended Suharto's authoritarian rule in 1998. The university's role at that time gives it credibility today, making UGM an institution to which the financial and political elite listen.

UGM wants to strengthen research and education in human rights and democracy, especially in the context of natural resource and climate. This will contribute to relevant skills and knowledge in public debate and social development in Indonesia.

WHAT: COOPERATION WITH NORWEGIAN UNIVERSITIES

Norway wants to contribute to the further development of relevant and high-quality academic environments at UGM. The goal is new and better knowledge of how the democracy reforms are working and how social systems can be developed and improved towards more democracy and well-being for all. Projects should inform government authorities at all levels and in several different sectors. The programme includes continuing education of activists in the democracy movement.

The University of Agder (UiA) and the University of Oslo (UiO) are working together with the UGM in this pledge. The partnership with the University of Agder started in 1992 and has received funding through Norwegian development assistance since 1999. The partnership between UGM and UiO has continued since 2003, with support from Norad's NUFU and NOMA programmes (see page 31) from 2006 to 2010. The aim has been to establish master's degree programmes in democracy, human rights and conflict management at UGM, and to conduct research into democracy, power and conflict in Indonesia and Sri Lanka. Over the years, students and staff from UGM and the Norwegian universities have studied, conducted research and lectured at each other's institutions.

How much: From 1999 to 2012, the partnership between UGM and UiA was supported with a total of about NOK 6.3 million of Norwegian aid funds. The partnership between UGM and UiO received about NOK 17 million in the period 2006-2013 through the NOMA and NUFU projects. The new agreement for 2012-2017 has a budget of NOK 31 million.

RESULTS: KNOWLEDGE AND DEMOCRACY DEBATE CONTRIBUTE TO SOCIAL REFORMS

The partnership has made it possible to extend the range of programmes offered at UGM. Two new master's degree programmes have been established – one on human rights and democracy, and one focused on management of natural resources and climate. Three PhD courses have also been implemented through the NUFU project. So far, 17 candidates have taken a master's degree through NOMA and NUFU, and five are completing PhDs in 2013. A group of 18 candidates has taken the master's degree with an academic focus on forestry management and REDD+, an initiative to reduce greenhouse gas emissions from deforestation and forest degradation in developing countries. A further twelve students and three PhD candidates have completed their degrees at UiA. All of them have now returned as lecturers and researchers at UGM.

Through cooperation with Norway, research on democracy, human rights, power and conflict in these areas has also increased in scope and quality. Among other achievements, the NUFU project between UiO and UGM has resulted in 51 publications in total since 2006, of which 23 were published in international journals. The research results have prompted a wide variety of newspaper articles and contributions to debates in Indonesia. Such contributions have fuelled wide-ranging debate on governance and corruption in the country and have provided inspiration for the democracy movement. Norway has also contributed to the establishment of an online journal for the publication of research on power, conflict and democracy in South-East Asia. However, UGM still has generally low ranking in research publishing internationally, and the university has introduced various schemes to increase the number of publications. The projects have had difficulty in recruiting female students at the PhD level, where only one in three are women. According to UGM, the reason is a lack of qualified applicants. A large majority of the publications are written by male researchers. This imbalance has been corrected to some extent through recruitment of more women as research assistants. In the master's degree programme, the number of female students has increased for each year of study.

TIL INNHOLD ↑

Research cooperation between UGM and UiA has helped to develop policy, legislation and public administration systems in Indonesia. An example is the law on local governance, where UGM researchers are leading efforts to revise the legislation. Another example is the proposal to publish records of the debates in provincial and district parliaments, so that voters can check to see whether the politicians are actually working towards keeping their promises. This proposal has been followed up in practice. The research has contributed to adaptation of Indonesia's decentralization reforms in education and health care. It is likely that the contributions to debates and the specific changes in political and administrative processes will in turn contribute to more transparent and democratic state institutions.

According to the leadership of the institution, international university cooperation has been and remains an important driving force for development. The importance of working together with Norway for increasing international publication, strengthening cooperation with institutions abroad and increasing the number of international students was highlighted by the Director of the Department of Education in Jakarta, Agus Sartono, in an interview with Forskerforum (the monthly journal of the Norwegian Association of Researchers) in 2009.

LESSONS LEARNED: GOOD RESULTS REQUIRE TIME AND TRUST

A challenge in this type of programme has been to open the university environments to the society around them, so that the knowledge developed becomes relevant, disseminated, and used by government authorities both nationally and locally. This may sometimes challenge the university's traditional role and thus meet resistance both within the university and in society. Commitment, determination and time are needed in order to build trust between various players in this development. In this respect, the partnership has succeeded.

Sources:
The fruits of cooperation, article in Forskerforum [Researchers' Forum], pages 12-17, December 2009 Universitas Gadjah Mada, Home page
Project reports, 2006-2012 (NOMA), 2007-2012 (NUFU), 1999-2012 (UGM/UiA)

Universitas Gadjah Mada (UGM) in Yogyakarta started a partnership with the University of Agder in 1992 and the University of Oslo in 2003. The collaboration has been supported by Norad's NUFU and NOMA programmes in the period 2006-2010 (see information on page 29). The photo is from one of several libraries at UGM.

EXAMPLE 12 MAKERERE UNIVERSITY IN UGANDA IS ONE OF AFRICA'S BEST UNIVERSITIES

For more than a decade, Norway has supported Makerere University in educating staff, expanding the portfolio of studies and strengthening research and publication in areas important to the country and the region. The gender perspective has been given priority on the agenda. Makerere is currently ranked as one of the best universities in Africa.

How much: Norway contributed NOK 110 million in funding from 2000 to 2005 and NOK 60 million from 2008 to 2011. In addition, Makerere has received a total of NOK 60 million since 2006 as a main partner in NOMA and NUFU projects. Support from the government of Uganda accounted for 35 per cent of the total funding to the university in 2010/2011. Makerere receives funding from several international donors, where the largest are SIDA, Norad, USAID and the Rockefeller Foundation. In 2000-2009, development assistance to Makerere totalled 700 million, of which Sweden and Norway accounted for 400 million.

WHY: THE UNIVERSITY WAS NOT MANAGING TO EDUCATE THE WORKFORCE NEEDED BY THE COUNTRY

Makerere University started as a technical school in 1922. It soon became an important academic institution in the region. Its graduates included Uganda's first Prime Minister Milton Obote, the father of the Tanzanian nation Julius Nyerere, and the Kenyan writer and professor of literature Micere Githae Mugo. Political setbacks in Uganda from 1970 had serious negative consequences for the development of academia, as in many other parts of society.

Until 1989, Makerere was the only university in Uganda. Makerere made its mark on the research front early in the 1960s, but declined in the 70s and 80s. Research was largely based on initiatives by individuals, with little involvement by the institution. Meanwhile, growing numbers of young people wanted to continue their education. The university did not have the capacity to meet this demand. Trained teachers, buildings and equipment were all in short supply. Gender equality was needed among both students and staff, along with gender mainstreaming in the academic context. Norway wanted to help. The initiative was linked up with Norwegian research groups, which could contribute their experience and expertise.

WHAT: FINANCIAL SUPPORT AND COOPERATION WITH NORWEGIAN INSTITUTIONS

Norwegian academic cooperation with Makerere University started in the 1960s. At the beginning, the focus was on natural resources, especially forests. The partnership was renewed from 2000. The goal was to link higher education at the university to the need for a qualified workforce in different sectors of society. The university's role in the development of good governance, strengthening the role of women in society and the management of natural resources was given priority in the cooperation. Management of natural resources included climate issues, the petroleum industry, food production, nutrition and value creation in agriculture. The activities have also addressed health, culture, urban development and renewable energy. Norway has given priority to skills development among the university staff, the use of ICT in administration, improvement of the library, and upgrading of laboratories and scientific equipment.

RESULTS: MAKERERE IS AN IMPORTANT CONTRIBUTOR TO DEVELOPMENT IN UGANDA

Today, 586 of Makerere's 777 permanent employees have a doctorate. More than 100 have gained their PhD with funding from Norway. By international standards, the high proportion of staff with doctorates is regarded as robust. However, the proportion of women remains low, accounting for only 28 per cent of the total academic staff. A centre for gender studies, established directly under the university's leadership, has made gender mainstreaming a crosscutting theme in all aspects of the university's work. Initiatives include the development of policies against sexual harassment.

The university has increased its capacity and is managing to meet the demand for higher education in Uganda more effectively than before. This fits in well with Uganda's long-term plans for the eradication of poverty. Through Norwegian funding, the programmes of study offered at Makerere have been extended in various fields such as health, gender issues, poverty, human rights, innovation and industry, renewable energy, food production, nutrition and value creation in agriculture. Norway has also supported the establishment of the Human Rights and Peace Center at the Faculty of Law. The university has increased student admissions and completion rates significantly. In 2000, fewer than 3,000 students graduated from Makerere, while 9,300 graduated in 2012.

The number of master's degrees increased from 3,500 in 2000-2007 to 4,700 in 2008-2012. In 2012, 61 PhD degrees were completed compared with 12 in 2000. Today, 44 per cent of all students are women. The target of a 50 per cent ratio of women has been achieved for the Faculty of Law and the Faculty of Humanities and Social Sciences. The proportion of women among PhD graduates since 2000 is 23 per cent. Recruitment of PhD candidates with Norwegian support has a target proportion of at least 50 percent women. The University of Bergen, which has a long tradition of cooperation with Makerere, points out that all the PhD candidates who have graduated at the University of Bergen have returned to Uganda, largely to Makerere.

TIL INNHOLD ↑

Throughout the 1990s, international donors joined forces to strengthen Makerere as a research institution. Since then, research at Makerere has increased in quantity and quality, in areas that are important for Uganda and Africa. Between 2001 and 2007, the number of published peer-reviewed research articles more than tripled, from 73 in 2001 to 233 in 2007. Priority areas for research at Makerere include: Health and health systems; climate and natural resource management; agriculture, nutrition and food security; governance and human rights. Norway supports education and research cooperation in all these areas. Research also contributes to the public debate. For example, the Human Rights and Peace Center has played an important role in Uganda's human rights debate. Researchers from Makerere contribute in important global issues, such as climate and health. These developments have strengthened the university's reputation. National and international partnerships and networks have been extended. Today, Makerere contributes to the establishment of new universities in Uganda and plays an important role in the region. Among other things, Makerere contributes to strengthening the University of Juba in South Sudan with support from Norway. Partnership with Norwegian universities has also developed into mutual research collaboration.

Makerere University is climbing in international rankings

In international assessments, Makerere University is among the best universities in Africa in terms of research as well as the ability to disseminate research results and to influence development. In the international Webometrics ranking of universities in 2013, Makerere achieved fourth position in Africa. The first three universities are all in South Africa. In 2007, the university was ranked as number 54. In the global survey by SCImago Institutions Rankings (SIR), Makerere is registered with 2,120 published documents in 2007-2011, compared with 1,044 in 2003-2007. In the World University Web Ranking 2013, the university was ranked as number 11 in Africa.

LESSONS LEARNED: THE NEED FOR MORE LOCAL SUSTAINABILITY

According to Makerere itself, support for capacity development from the donor community is an important reason that the university has been able to develop its strong position in international terms. Highlights include innovative models with joint programmes of study to reduce brain drain, a focus on PhD education, and the flexibility to develop expertise in the university's priority research areas.

However, there is a need to ensure more local sustainability in such processes. In 2006, the President of Uganda started a review of public universities. It found that international donors have accounted for a large part of research education in the country, and recommended that the authorities increased their involvement to fund research education critical to the country's further development.

The number of applicants to the university continues to rise faster than Makerere can develop its capacity. Between 2008 and 2011, the proportion of students in the population increased from four to nine per cent in Uganda. At the same time, a large number of applicants do not get places at the university.

An evaluation of Norwegian cooperation from 2009 also recommended a targeted effort to ensure that the research produced is used to solve social problems. There is a general lack of evidence about how strengthening an academic environment and knowledge production generates effects for the development of society.

Sources
Phase II at Makerere University, Report by Karsten Haarberg, Milton Ogeda, Elizabeth Heen and Asbjørn Løvbræk, Scanteam, 2009
Universities and Economic Development in Africa – Case Study of Uganda and Makerere University, by Tracy Bailey, Nico Cloete and Pundy Pillay, CHET and HERANA, 2008
Makerere University Self-Assessment Report, October 2013 SIR SCImago Institutions Ranking
Ranking Web of Universities (Webometrics)

Makerere University in Uganda's capital, Kampala, celebrated its 90th anniversary in 2013. Since the 1960s, academics from Makerere and Norway have worked together to develop effective academic collaboration and networking.

EXAMPLE 13 EXPERTS ON GENDER EQUALITY HAVE IMPROVED LEGISLATION AND POLICE WORK

The University of Zimbabwe has educated 200 experts on women's rights from twelve countries in Eastern and Southern Africa. This has contributed to the introduction of gender equality in all areas of the new constitution in Zimbabwe. From the outset 25 years ago, many of the graduates have contributed to legislative reforms and initiatives for gender equality. One of the first students was Professor Patricia Kameri-Mbote from Kenya, who has helped to create Kenya's constitution and the Rwandan legislation on environmental protection.

WHY: ENSURE EQUALITY BEFORE THE LAW

Since the colonial era ended in the 1960s and 1970s, countries in Africa have worked towards eliminating discrimination based on race, class and gender. Zimbabwe and Kenya introduced reforms but kept constitutions that supported African customary law if it was inconsistent with the equality principle. This led to large disparities between women's rights under national law and under the UN Convention on the Elimination of All Forms of Discrimination against Women. Laws that on paper placed women and men on an equal footing often proved to have little effect in practice. One of the challenges that the countries faced was to develop African expertise in women's rights. The countries needed experts who could analyse the encounter between human rights and local culture and customs.

WHAT: EDUCATION IN WOMEN AND LAW

Norway has funded studies in women and law in Eastern and Southern Africa for 25 years. The first diploma course for African students started at the University of Oslo in 1987. In 1990, the University of Zimbabwe took over the course. Three years later, it launched a regional master's degree programme. In 2000, Norway supported the establishment of the Centre for Women's Law. Expertise in gender equality was much needed throughout the region. The universities in Oslo and Zimbabwe therefore chose to offer places on the programme to the neighbouring countries as well. Focus areas have been the development of women's and human rights perspectives in family law, criminal law, resource management and land and water reform. Universities in South Africa, Uganda, Malawi, Kenya, Zambia and Tanzania have contributed. The centre's goal is to strengthen expertise on gender equality in the police and the judiciary as well as among university lecturers, and to get more women into male-dominated arenas. In January 2013, 38 new students from seven countries started the 1.5-year master's degree programme. In 2009, a doctoral degree programme was launched, and it had seven students in 2013. The funding has been used for student scholarships, teaching staff from co-operating universities, infrastructure and administration.

How much: Norwegian support from 1993 to 2012 totalled NOK 67.4 million. The University of Zimbabwe has covered about 15 per cent of the operating expenses. Various projects have been supported by the former United Nations Development Fund for Women (UNIFEM), Oxfam, UNICEF in the United Kingdom and UNESCO. An ongoing study of safe and inclusive cities is being funded by the International Development Research Centre of Canada (IDRC).

Receptionist Primrose Zikiti at the Centre for Women's Law in Zimbabwe's capital, Harare, is among the 13 employees supervising and teaching 38 master's and doctoral students in the autumn of 2013. Students at the centre are from Kenya, Tanzania, Uganda, Malawi, Lesotho, Zambia and Zimbabwe.

RESULTS: ALUMNI CONTRIBUTE TO LEGISLATIVE CHANGES AND INCREASED OPPORTUNITIES FOR WOMEN

During 1993-2001, 157 participants from nine countries completed diploma courses. From 2003 to 2012, 195 candidates completed the programme. They now have the title Masters in Women's Law. Graduates have established courses in women's law at other institutions, such as Mount Kenya University and a university in Zambia.

Staff and graduates have helped to write Zimbabwe's legislation against violence against women. They have also contributed to a change in the law of inheritance and succession that gives women equal rights. The result is that the principle of gender equality applies without exception to all areas in Zimbabwe's new constitution. In March 2013, Zimbabwe decided that at least 60 of the 210 members of parliament must be women. In the general election in September 2013, 86 women were elected to the Parliament, which increased the proportion of women from 19 to 34 per cent. This increase is attributed to the legislation.

The centre's work has prepared graduates to face the local culture and customs of the police with specific measures against discrimination. Students from Zambia's police force are behind official guidelines for the investigation of violence against women and they have provided training on this subject. The guidelines have been made mandatory. In interviews with researchers who evaluated the centre, the Zambian students said that education at the centre had made them more aware of women's rights in their police work.

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Students with influence

Many former students from the Centre for Women's Law in Zimbabwe have had a strong influence on legislation and legal practice in Sub-Saharan Africa. Some examples:

One of those who directly influenced the law on women's representation in parliament was the first female lawyer from the centre who was elected to the Zimbabwean parliament, the former Deputy Minister of Women's Affairs, Gender and Community Development Jessie Majome. Other alumni campaigned for the ruling that at least one third of the parliamentarians in Kenya must be women. Students from Zambia's police force have drawn up mandatory policies for investigation of violence against women and have provided training on this issue.

LESSONS LEARNED: DIFFICULT TO ENSURE ECONOMIC SUSTAINABILITY

Collaboration that began on a small scale has become a valued opportunity in higher education. The centre has been a resource in the work for gender equality in Eastern and Southern Africa. The model is being followed at other universities. The work has been successful because it has been run in an academically sound way and because Norway has provided stable support and professional development. Evaluations in 2001, 2007, 2010 and 2013 have been positive to the centre's achievements and the way it is managed. A critical question is whether the centre is using its full potential to promote women's legal and social status in the region. The centre has been encouraged to develop a clearer strategy for its work, to publish more research, and to expand its regional cooperation.

The centre has not succeeded in becoming self-funded, and it is still dependent on aid. The University of Zimbabwe has taken over the funding of the tenured positions, but does not have the resources to fund travel, grants and accommodation for students. Nor can the university cover salary and travel expenses for lecturers from other countries in the region. An evaluation from 2013 recommended that the centre should find additional sources of income.

Gender equality as a career pat

In 2012, the Norwegian Institute for Urban and Regional Research charted the centre's impact on women's social and legal status, and its financial sustainability. In a survey in which half of the graduates responded, 90 per cent said they were very satisfied with the programme, and 80 per cent thought it had had a positive influence on their career prospects.

A goal is to inform everyone about women's rights

Professor Julie Stewart, Director of the Southern and Eastern African Centre for Women's Law at the University of Zimbabwe, explains: "One example is that the law gives everyone the right to buy property. But women still face social or cultural obstacles. In inheritance cases, land can be distributed to the deceased's family based on customary practice, even though by law the widow should inherit it." Studies of case law in Harare show that urban women, such as childless women, make use of their rights. The economic and political crisis in Zimbabwe has made it very difficult to inform people outside the cities about their rights. Anne Hellum, Professor of Women's Law at the University of Oslo, says: "It pays to provide further education for lawyers. Legal services providers, officers, judges and employees of the police and prison services have a key role in implementing changes in the law." From the start, Hellum has contributed to the development of the Centre for Women's Law at the University of Zimbabwe.

Most students at the Southern and Eastern African Centre for Women's Law at the University of Zimbabwe are lawyers, and some 20 per cent are men. The centre also conducts training of judges and staff of civil society organizations, and publishes textbooks and teaching materials. The library is used by the entire university.

Sources:
Evaluation of the Southern and Eastern African Regional Centre for Women's Law, conducted by the Norwegian Institute of Urban and Regional Research (NIBR), February 2013
Evaluations from 2001, 2007 and 2010 Norwegian Embassy in Zimbabwe, University of Oslo's website
Southern and Eastern Africa Regional Centre for Women's Law (SEARCWL) at the University of Zimbabwe website

EXAMPLE 14 UNIVERSITY COOPERATION STRENGTHENS FISHERIES MANAGEMENT IN VIETNAM

Higher education and research in fisheries and aquaculture contribute to valuable skills that are important for development in Vietnam. Strengthening the country's institutions prevents the drain of resources from the country.

WHY: POOR CAPACITY IN IMPORTANT SECTOR IN VIETNAM

In the late 1990s, higher education institutions in Vietnam were in poor condition. Most of them suffered from poor infrastructure and outdated curricula influenced by the era of the planned economy. Many academic institutions in Vietnam had a weak teaching staff, partly because many teachers found jobs in other countries or professions.

Fisheries and aquaculture are important for Vietnam's economy, and Nha Trang University (NTU) is the main education and research institution in this field. A study from 2002 revealed a need for improvement and development at the university. The quality of the education and research was not satisfactory, the qualifications of the staff were inadequate, and the university had limited experience in international cooperation.

WHAT: COOPERATION BETWEEN UNIVERSITIES IN VIETNAM AND NORWAY

Norway has supported the fisheries sector in Vietnam since 1976. Since 1996, the importance of fisheries management, research and education has increased. In the 2000s, Norway began cooperation with NTU, the Research Institute for Aquaculture No. 1 (RIA1) and Hanoi University of Agriculture. NTU has also worked together with Norway under the NOMA programme (see the box on page 31). The aim was to strengthen capacity and quality in education and research at the institutions. The Norwegian partners were the Norwegian College of Fishery Science at the University of Tromsø, the University of Bergen, and the Norwegian University of Science and Technology (NTNU).

How much: Norway funded the Nha Trang University with NOK 30.2 million from 2004 to 2012. In addition, support through the NOMA programme totalled NOK 11.7 million. Over the past decade, Norway has also supported RIA1 with NOK 30 million. NOK 2.7 million has also been provided to fund collaboration between RIA1, Hanoi University of Agriculture and NTNU.

RESULTS: HIGHER EDUCATION AND RESEARCH IS STRENGTHENING THE FISHING INDUSTRY IN VIETNAM

The projects have strengthened the specialist communities, so that Vietnam's own institutions are now better able to educate the country's resource people for the sector.

At NTU, 63 master's and 17 PhD graduates have been educated in fisheries economics, aquaculture, biotechnology and fisheries management. Half of them are women. Today, the university has achieved a more democratic model of operation than it had before. At the same time, it is more practical and up to date, with a focus on results combined with education quality. The classrooms at NTU have modern teaching facilities and the library has been upgraded with access to electronic journals. At RIA1 and Hanoi University of Agriculture, 106 students have graduated with master's degrees in fisheries management. This is a direct result of the Norwegian development cooperation.

Research has been conducted with sound scientific results. An example is the identification of immune responses in fish. This is important for developing fish vaccines. NTU is now working together with the Norwegian firm Pharmac in the development of vaccines.

Norwegian development cooperation has also helped to increase the publication of research in international journals. NTU is gaining increasing international recognition. The university receives inquiries from students and educational institutions in a variety of other countries. In the past, the flow of students was away from Vietnam. NTU also receives research funding from the government of Vietnam. This indicates the government's recognition of the university's work.

Graduates from the universities provide advice and participate in the management of fisheries resources at both local and national level in Vietnam. NTU is the university that supplies most graduates to the specialist government department and the regional fisheries authorities. The government agencies now gain graduates with greater insight. Cooperation with Norway has helped to strengthen evidence-based and sustainable fisheries management. Norwegian support for education and research at RIA 1 has contributed to an increase of 40 per cent in aquaculture production in the area since the project started in 1999. This is described in more detail in the news article and video from February 2013, "Forskning gir frisk fisk til de fattige [Research provides healthy fish to the poorest people]" on the Norad website.

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LESSONS LEARNED: EDUCATION AND RESEARCH FOR LOCAL NEEDS ENSURE SUSTAINABILITY

In this project, it has been important to ensure sustainability. This involves maintaining the boost in capacity and quality even after the financial support has ended. Sustainability has been achieved in the project because all the research has been conducted based on practical needs for the development of fisheries and aquaculture in Vietnam. The PhD and master degree's programmes have been linked closely with relevant research projects.

Sources:
Nha Trang University website Hanoi University of Agriculture website
Research Institute for Aquaculture No. 1, website Descriptions, agreements and evaluations of initiatives from 2002 to 2013 Norwegian Ministry of Foreign Affairs, country web pages about Vietnam
Norge lanserer Vietnamstrategi [Norway launches Vietnam strategy], press release from the Ministry of Foreign Affairs, 6 June 2008 Forskning gir frisk fisk til de fattige [Research provides healthy fish to the poor], news story, Norad website, 8 February 2013

Photo: NTU

Dr Pham Quoc Hung heads the Institute of Aquaculture at Nha Trang University in southern Vietnam. The university was established in 1959 and conducts research and education for the fisheries sector.

"The fry grow faster and are healthier than those we had before" Nguyen Ba Tinh, who is breeding the freshwater fish tilapia inland in Vietnam.

Interview with Nguyen Ba Tinh, video:

Photo: Ken Opprann

EXAMPLE 15 EDUCATION AND RESEARCH IN ECONOMICS HAVE INFLUENCED POLICY MAKING IN AFRICA

Expertise and knowledge developed in Africa is being applied by African politicians. The African Economic Research Consortium, AERC, has helped 2,320 African students to take master's and doctoral degrees. The standard and capacity of research and education in economics has been strengthened in 25 African countries, and this expertise is being disseminated to decision-makers.

WHY: NEED TO DEVELOP AFRICAN EXPERTISE IN ECONOMICS

AERC was established in 1988 by a group of African researchers who saw a strong need to develop local expertise in performing economic analyses. Such analysis is needed to formulate policies based on African reality. To enable researchers to give good advice to politicians, analyses based on African realities are needed. The insights gained from such analyses combined with an understanding of economic contexts allow researchers to propose an economic policy that can contribute to economic growth and poverty reduction.

WHAT: RESEARCH AND EDUCATION ABOUT ECONOMICS

The objectives of the support to AERC are to provide education for African researchers in political economy and governance, and to produce knowledge to be used in formulating policies for African countries. The basic idea of AERC's work is that development is more likely to occur where there is sustained, sound management of the economy. Such management is more likely where there exists an active, well-informed group of locally based professional economists to counduct policy-relevant research.

When used by those who govern, expertise in social economics can lead to better utilization of resources and more effective reduction of poverty. In a democratic society, knowledge and knowledge environments can influence the way that society is governed.

One of AERC's contributions is to develop master's and doctoral programmes in economics that meet international standards. The programmes must be relevant to African needs and viable based on African resources. AERC supports research by announcing research grants, and provides researchers with access to courses and literature. AERC also establishes forums for knowledge sharing and debate for researchers and policymakers. A network of 900 politicians has been established.

Every year, AERC organizes a regional seminar on economic policy, where African politicians in key positions meet African academics. This year's seminar in the Rwandan capital, Kigali, on the theme of youth and unemployment, gathered 113 participants from 24 African countries.

How much: Norad has provided NOK 134 million in funding to AERC since 1999. In 2012, Norad supported AERC with NOK 8.7 million, which accounted for eight per cent of the AERC's budget for that year.

RESULTS: KNOWLEDGE DEVELOPED AND APPLIED IN AFRICA

In total, 120 students have taken doctorates through programmes developed by the AERC at African universities. A further 200 students have received AERC grants to take their PhD. Three quarters of those who have completed their doctorates are now employed at African universities. At 22 universities in 18 countries, 2000 students have taken master's degrees through AERC programmes. A quarter of the graduates are women. A variety of research projects and seminars address issues related to gender equality.

A participatory study conducted in 2011 shows that 80 per cent of master's students in agricultural economics are hired immediately after they graduate. They work at African universities, government administrations, non-governmental organizations and think tanks, among others. Ministers of finance or commerce in seven African countries, as well as eight current and former presidents and vice-presidents of central banks have an AERC background.

Through annual evaluations and the development of common curricula, AERC has established common academic standards for master's and doctoral degrees at African universities. A survey of employers who have hired former AERC master's students indicates that the technical standard of these graduates is as good as or better than that of students with master's degrees from universities outside Africa. Meanwhile, studies conducted in Africa yield benefits by enabling a good understanding of African economics and African politics.

AERC also provides incentives for researchers to stay in Africa by offering financial and professional support to research projects, and by offering academic environments that provide opportunities for development. The number of researchers participating in annual conferences arranged by AERC increased from 40 in 1988 to 160 in 2013. AERC has expanded its geographical base from seven to 38 countries. AERC's website is an easily accessible source of the knowledge that the organization has developed. On its website, AERC has 584 publications. Of those, 258 are research papers.

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The reputation of the AERC makes it possible to reach out to and influence African politicians. The 900 politicians in AERC's network learn how important it is that they govern on the basis of insight into the economic context. Evaluations show that knowledge from AERC is used in African national plans for reducing poverty. AERC produced knowledge is also reflected in the preparations of African countries for international negotiations, through AERC's contribution to the formulation of negotiating positions. This expertise has influenced Africa's position in the World Trade Organization, and Africa's relationship with China. The willingness of African governments to provide funding to AERC also indicates that AERC is considered a useful provider of knowledge.

LESSONS LEARNED: RESEARCH CONDUCTED IN AFRICA ABOUT AFRICAN REALITIES HAS CREDIBILITY

Educating African youth in Africa costs less than educating them in other parts of the world. AERC's work also shows that strengthening the programmes offered by African universities so that students take their education there, combined with a solid academic environment for researchers, contributes to reducing the brain drain. In addition, the education is more relevant to development in Africa because it is based on Africa's needs. Research developed in Africa is closer to African realities, and has greater credibility with African politicians. Research conducted in Africa by African researchers seems to have a greater influence on African policymaking than research conducted elsewhere. More knowledge about this relationship is needed.

The capacity of universities with which AERC cooperates has increased. At the same time, the number of students has increased dramatically, so that the universities are still under pressure. Therefore, there is still a need for support to African universities.

Sources:
Building Capacity for Economic Research: A Success Story from Africa, Twenty Years of Capacity Building in Sub-Saharan Africa (1998-2008), by Ernest Aryeetey
Review of The African Economic Research Consortium Strategic Plan 2005-2010, by Catherine Gwin and John Loxley, October 2009
Tracer Study of Collaborative Masters of Science in Agricultural and Applied Economics (CMAAE) by Willis Oluoch-Kosura, September 2011, AERC's website

Master's and doctoral students listen to a lecture organized by the AERC in Nairobi, Kenya. The AERC wants to increase the proportion of women who graduate, which is now one quarter. One way of achieving this is to increase the proportion of women who receive funding for academic development and research. Courses in methods and in presentation skills are designed especially for women and researchers from the least developed of the African countries.

part 3

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3. RESULTS OF DEVELOPMENT COOPERATION IN HEALTH

Judith Niyomwungere prepares vaccine at the health centre in Rumonge in Burundi. Here, children receive many different vaccines such as Pentavalent 1, 2 and 3, PCV13, polio, BCG and VAR. During the past twelve years, GAVI, together with the World Health Organization and UNICEF, has bought and helped authorities to distribute important vaccines to more than 70 low-income countries.

Health has been one of the priority areas of Norwegian development cooperation in recent years. Results are achieved through a combination of political leadership, diplomacy, social and professional mobilization and financial aid. Efforts for global health emphasize the importance of improved health for the whole world's population, reduced health inequities, and solutions to health problems across national borders.

Pooled efforts have yielded good results in a short time. Both child mortality and maternal mortality rates have almost been halved since 1990, the number of people with new HIV infections has decreased by 33 per cent since 2001, and many people are receiving treatment. Nevertheless, it is unlikely that the health-related Millennium Development Goals will be achieved globally by 2015.

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Photo: Ken Opprann

WHERE WE ARE:MAJOR HEALTH IMPROVEMENTS, BUT A LONG WAY TO GO

Today, the world's population is healthier than ever. During the past 50 years, progress has been faster than ever before. Life expectancy has increased, fewer people die of infectious diseases and morbidity has been reduced. Inequalities in health between countries have been reduced in many areas. Despite these advances, the disparities between groups within countries remain large.

Three of the Millennium Development Goals deal with health directly. These goals focus on reducing child mortality, maternal mortality, as well as HIV/AIDS, malaria and other infectious diseases. There is great progress in all these areas.

In 2010, it was estimated that 287,000 women died during pregnancy and childbirth. This figure was half that of 1990.[27] Much of this has happened in the last ten years. In 1990, twelve million children died before they turned five. Today, 6.6 million die. Such a rapid decline in child mortality has never happened before in history. We have seen good results from the use of vaccines and mosquito nets, which have caused child mortality in Africa to be halved between 1990 and 2013. The number of people newly infected with HIV fell by 33 per cent between 2001 and 2012 – the statistics have shown a downward trend since 1997. In 2005, 2.3 million people died of AIDS; in 2012, the figure was 1.6 million. The trend has been reversed partly because more people have access to AIDS medications. In 2012, 9.7 million people gained access to medications, an increase of 1.6 million over the previous year.

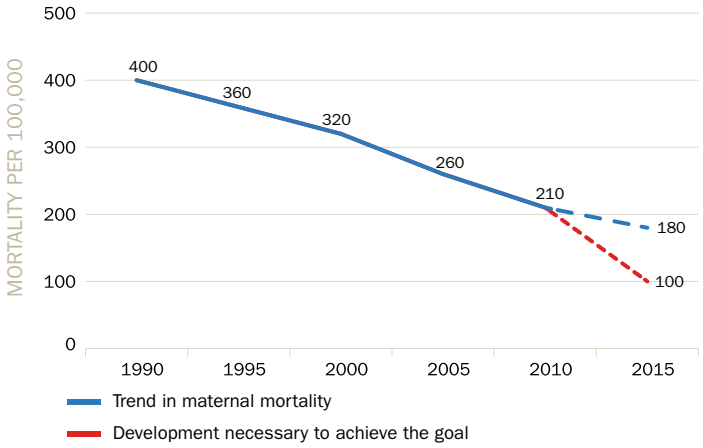
Although many countries have good results and they will achieve several of the health-related Millennium Development Goals, the goals will most likely not be met for the world as a whole by the end of 2015 (Fig. 3.1 and 3.2.). Reduced maternal mortality is the goal that is furthest from being achieved. Maternal mortality, particularly in Sub-Saharan Africa, is still very high. However, over the last ten years the trend has declined dramatically and it is on the right track (Fig. 3.2.). In 2010, maternal mortality in Sub-Saharan Africa was estimated at approximately 500 per 100,000 live births compared with 16 in more developed countries.[28] To a greater degree than for the other goals, prevention of death during pregnancy and childbirth depends on well-functioning health systems with qualified health professionals, equipment and medicines, communication and transport systems, close to where people live.

There are also great disparities in access to health care. About one billion people in the world will not have access to a qualified health worker during their lifetime. Sub-Saharan Africa has 25 per cent of the world's diseases, but only 1.3 per cent of the health workers.[29]

Among the richest fifth of the world population, 85 per cent receive good maternity care, while only 31 per cent of the poorest fifth get qualified hjelp.[30] Establishment of robust national health systems is essential to maintain and build on the progress that has been achieved. Maintaining vaccine coverage and ensuring continued HIV treatment requires systems with the ability to follow up the individual patient. Examples of results in health show how a targeted combination of financial aid, political and social mobilization for increasing resources, use of health diplomacy as well as expertise in health and development cooperation can increase the overall effectiveness of the efforts made by a small country such as Norway. But they also show that interventions sometimes do not produce the results that were planned.

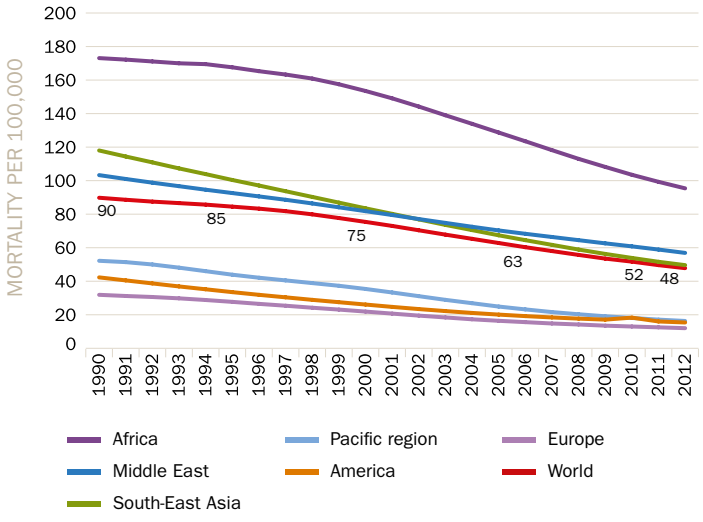
Nutrition is essential for sustaining health, and remains a challenge. About 850 million people are still chronically undernourished. Nutrition interventions early in life will yield particularly large benefits for the individual and society.

FIGURE 3.1. IF THE CURRENT TREND CONTINUES, THE TARGET OF REDUCING MATERNAL MORTALITY WILL NOT BE MET



Maternal mortality worldwide has been reduced from 400 to 210 per 100,000 live births in 2010. WHO has estimated that at the current rate it will reach 180 by 2015, which means it will not reach the target of 100.

FIGURE 3.2. AFRICA STILL HAS THE HIGHEST MORTALITY



Africa is the continent where the decline has been smallest, while Asia has achieved the goal.

Source: WHO data

27 543,000 per year in 1990
28 Trends in maternal mortality: 1990-2010. Estimations developed by WHO, UNICEF, UNFPA and the World Bank. 2012
29 Naicker S, Plange-Rhule J, Tutt RC, Eastwood JB. 2009 30 Gwatkin, Rustein et al. 2000
30 Gwatkin, Rustein et al. 2000

TIL INNHOLD ↑

HEALTH-RELATED MILLENNIUM DEVELOPMENT GOALS CENTRAL IN DEVELOPMENT POLICY AND FOREIGN POLICY

From the early 2000s, Norwegian efforts targeted immunization and initiatives to limit the spread of HIV. In recent years, Norway has contributed to increasing the efforts focused on neonatal and women's health as well as family planning. During the whole period, a key goal has been to combat infectious diseases, including malaria, tuberculosis and polio, and to improve prevention and treatment of HIV/AIDS. This is described in the White Paper on global health in foreign and development policy.[31] The strategy is to agree on common goals, to work for increased resources and coordinated efforts at the global and national levels, and at the same time to strengthen health systems at country level. The goals are to be achieved in cooperation with a large network of international and national organizations and disciplines.[32] Overall this is expected to enable more efficient use of the resources invested and to push the development curve faster in the right direction to improve human health.

COMMON DIRECTION, WISE INVESTMENTS AND FOCUS ON RESULTS

Political leadership to influence global and national priorities
Fragmentation, lack of cooperation between the players and limited ownership of the challenges among national government agencies were among the reasons for the slow progress in the Millennium Development Goals for child and maternal health. Norway therefore took the initiative for political, technical and financial mobilization through international partnerships.

In 2005, Norway appointed one of the world's first AIDS ambassadors. National leaders have received valuable support from AIDS ambassadors, advocacy workers and professionals to develop the international strategy against HIV/AIDS. Another important initiative is the Network of Global Leaders, led by Prime Minister Stoltenberg. In 2012, this network of eight leaders contributed to political mobilization for universal health coverage with a special focus on the health of women and children. In the reports of the Global Campaign for the Health MDGs (illustration below), heads of state and global leaders wrote down their pledges and commitments in a joint document. These are being followed up by dedicated committees to check that these promises are being kept.

31 Report to the Storting [Stortingsmelding] 11, 2011-12
32 Norwegian actors engaged in global health, Norad website, April 2013

Norwegian efforts contributed to the establishment and implementation of the UN Secretary-General's Global Strategy for Women's and Children's Health and the Every Woman, Every Child movement. The strategy has been endorsed by 280 different stakeholders such as developing countries, donor countries, UN agencies and the private sector, civil society organizations and academic institutions.[33] It has led to total funding of over NOK 300 billion, of which NOK 110 billion is a supplement to the amount already planned. Developing countries pledged to contribute nearly half of those funds.

"Every day in Malawi, ten women die during childbirth because they do not have access to skilled help." Brandina Kambala, contraception counsellor and youth coordinator in the organization Banja La Mtsogolo

Photo: Kari Ulveseth

Watch the video:

Another Norwegian initiative led to the Partnership for Maternal, Newborn and Child Health (PMNCH). A global Consensus on Maternal, Newborn and Child Health was launched by the Global Campaign in June 2009, accepted by the G8 summit in July of that year, and included in the UN Secretary General's Global Strategy for Women's and Children's Health in 2010.[34] The initiative brought together countries and organizations in a common understanding of the challenges and the most important measures to meet them.

Investments based on available resources. Aid initiatives developed without securing long-term resources lead to uncertainty and inefficiency. Planning based on available resources increases the predictability of programmes. When the vaccine alliance GAVI was established to support the introduction of new vaccines, the resources available were only sufficient to provide the countries with USD 20 for each additional child vaccinated in relation to the vaccine coverage in the previous year. On average, this covered only a quarter of the costs that each country had incurred to increase the coverage. However, it proved to be essential that the funding was predictable. GAVI thus stimulated increased vaccine coverage and encouraged the countries to take the necessary actions themselves. Since the creation of GAVI in 2000 until 2012, vaccination coverage has increased from 66 to 74 per cent on average in countries where GAVI has programmes.

33 The Global Campaign for the Health MDGs 34 Every Woman Every Child
34 Accelerating Progress in Saving the Lives of Women and Children, Report, Norad home page, 21 Jan 2013

FORMS OF COOPERATION AND PARTNERS

International partnership. Norwegian health aid has shifted from traditional bilateral aid that funded health care in individual countries to participation in initiatives with international partnerships and cooperation with new players. In this work, Norway has focused on results, innovation and flexibility.

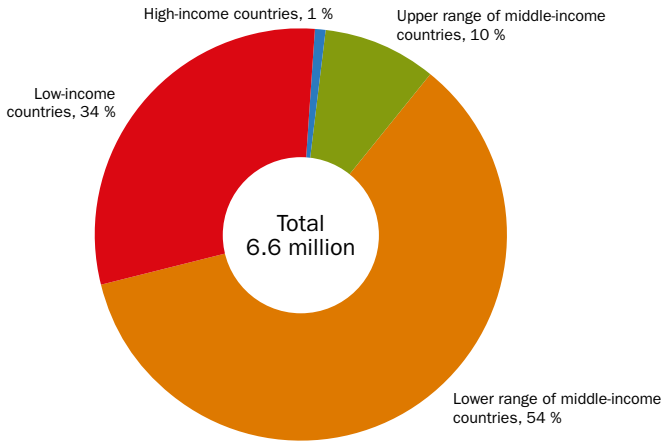
Professional networks and social mobilization In Norway, professional networks have been established between researchers, government agencies and civil society to develop effective measures to limit the HIV epidemic and its consequences. Through the Norwegian National HIV and AIDS Council, cooperation has been established between Norwegian government ministries, research communities and civil society. Civil society organizations are contributing to social mobilization for the health Millennium Development Goals. This applies to work with HIV/AIDS and sexual and reproductive health and rights (SRHR), where these organizations have contributed professionally as well as with political mobilization and advocacy.

Efforts in different areas towards the same goal. Political commitment has made it possible to communicate and mobilize important issues in a broader context. The death of women in childbirth is not only a result of inadequate health care, but also an expression of discrimination and lack of respect for human rights. Norway has promoted this in many forums, such as the UN Human Rights Council.

Ensure that the investments yield better health benefits and are monitored. To gain the most health possible for every krone, investments are made in cost-effective measures, such as vaccines and initiatives that make lifesaving drugs more affordable.

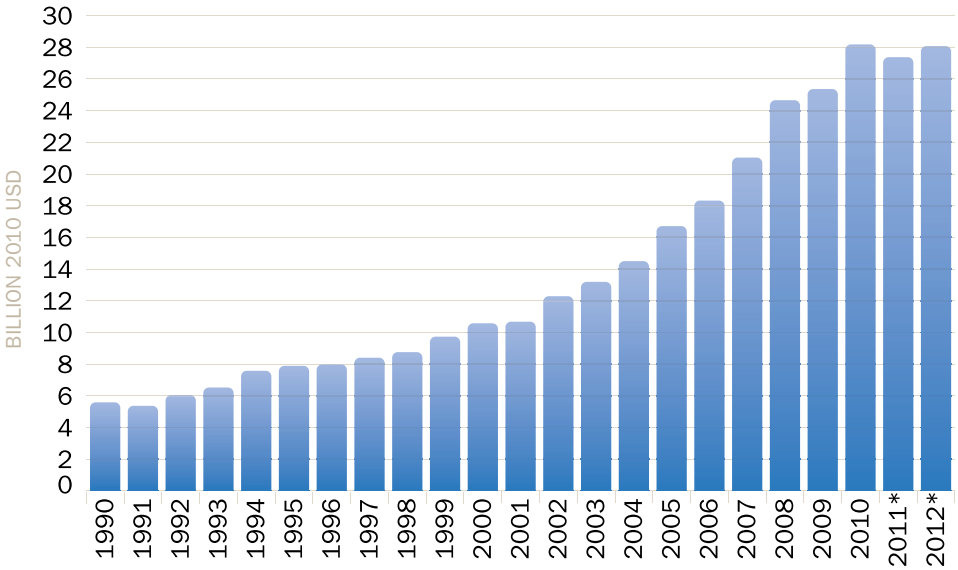
Innovation, research and utilization of new aids and tools contribute to effective efforts. Norway is leading a working group under the UN Secretary General, which is working on innovations for better outcomes in health. Mobile phone banking, patient information, SMS communication and information systems for reporting are examples in which the use of mobile phone technology can enable better services.

FIGURE 3.4. MORE THAN HALF OF CHILD MORTALITY OCCURE IN MIDDLE INCOME COUNTRIES



Source: WHO 2013

FIGURE 3.3. LARGE INCREASE IN THE WORLD'S TOTAL HEALTH AID 1990-2012



*Estimate

Source: IHME database

TIL INNHOLD

In the maternity clinic at Prince Louis Rwagasore Hospital in Bujumbura, Burundi, the days are busy. Up to 15 babies are born here during a typical workday. The maternity ward operates around the clock. The department has three delivery beds and two rooms where caesarean sections can be performed at the same time. As many as seven caesarean sections are performed daily. Concilie Nibaruta started as a midwife two years ago. In a hectic life she learns a great deal from Constance Nuponzima (in the background), who has 30 years' experience in the profession.

Photo: Ken Opprann

TIL INNHOLD ↑

EXAMPLES OF RESULTS IN HEALTH

EXAMPLE 1 INFANT MORTALITY IS FALLING, BUT NOT FAST ENOUGH TO REACH THE MILLENNIUM DEVELOPMENT GOAL

Despite good results in individual countries, infant mortality remains high. Millennium Development Goal 4 on reducing deaths among children under five by two-thirds by 2015 will not be met with the current efforts. This is because of the high infant mortality rate.

WHY: IN 2000, 56 OF 1000 CHILDREN DIED IN THEIR FIRST YEAR OF LIFE

Infant mortality is defined as death in the first year of life. Neonatal mortality refers to deaths in the first four weeks of life. When the Millennium Development Goals were adopted around the year 2000, neonatal deaths in developing countries totalled 31 per 1000 live births and infant mortality was 56 per 1000; among children under five, the mortality rate was 80 per 1000.

WHAT: NORWEGIAN EFFORTS TO COMBAT INFANT MORTALITY

Norway has supported efforts towards the Millennium Development Goals since 2000. Since 2005, the initiatives for global health have given priority to mothers and children through the Global Campaign for Women's and Children's Health. Norwegian development cooperation involves not only money but also advocacy, health diplomacy, and professional collaboration with countries and international agencies. These include the World Health Organization, UNICEF, the World Bank, global initiatives and funds. Therefore, it is fair to say that the overall effect of Norwegian development cooperation is greater than the money alone would suggest.

This example presents global progress towards reducing infant mortality. International aid, including Norwegian aid, has played an important role in achieving these results. Exactly how great this role has been is difficult to calculate, both for aid as a whole and for the specific Norwegian contribution. The example is therefore intended to illustrate the theme, not to specify the results that can be attributed directly to Norwegian support.

How much: Between 2000 and 2005, the Norwegian commitment to maternal and child health totalled about NOK 300 million per year. Since 2005 there has been a significant increase each year and in 2013, the support totals two billion Norwegian kroner.

RESULTS: INFANT MORTALITY HAS BEEN REDUCED, BUT THE TARGET OF A TWO-THIRDS DECLINE IN CHILD MORTALITY WILL NOT BE MET WORLDWIDE

Through the joint efforts of governments in developing countries, donors and various development players, child mortality decreased from 80 per 1000 live births in 2000 to 48 in 2012. Infant mortality has been reduced from 56 to 35 per 1000 live births. Access to qualified birth attendants increased globally from 55 to 65 per cent between 1990 and 2010. However, major challenges remain. When only 1,000 days remained before the end date for the Millennium Development Goals in 2015, it was clear that many countries would not be able to achieve the goal of reducing mortality in children under five by two thirds. The figures are compared with the situation in 1990, which is the base year in relation to which progress towards the Millennium Development Goals is calculated. Bangladesh, Ethiopia, Liberia, Malawi, Nepal, Tanzania and East Timor are examples of countries that had high child mortality in 2000, and that have already achieved the Millennium Development Goal. Infant mortality in these countries fell by between 61 and 67 per cent between 1990 and 2012. The reasons are complex. Important factors included a targeted effort by government authorities to increase immunization coverage and breastfeeding, as well as offering skilled assistance for mother and child at delivery, where the use of life-saving medicines and equipment has played a vital role. International aid has helped to realize these measures.

In Afghanistan, infant mortality decreased from 120 per 1,000 live births in 1990 to 71 in 2012. A large part of this improvement is thanks to international aid, which accounts for 80 per cent of the health budget. A number of national and international civil society organizations have shared the responsibility for providing services. Norwegian contributions to strengthening service delivery through the World Bank and the education of midwives through the Norwegian Afghanistan committee are included in this.

Infant mortality in Tanzania in 1999-2012 decreased by just over 60 per cent from 101 to 38 per 1,000 live births. Norway and other donors have contributed to this reduction through government-to-government aid, support through civil society organizations, multilateral organizations and global funds. Cooperation between state leaders has been an important driving force in accomplishing this, and the commitment of Tanzania's president has been crucial to the country's own investment and development.

While child and infant mortality worldwide has been halved, the neonatal mortality rate has only declined from 31 to 23 per 1,000 live births since 2000. Every year, 2.8 million children still die in the first four weeks of life due to conditions that could be prevented through effective antenatal and neonatal care. Access to essential medicines and equipment also helps to prevent deaths. WHO points out that infants, especially newborns, must be given priority if the goal of combating child mortality is to be achieved.

LESSONS LEARNED: NEED FOR INCREASED AND MORE EFFECTIVE COMMITMENT TO NEONATAL HEALTH

The reduction in mortality was greatest among children aged between two and five. This was mainly due to successful initiatives such as vaccination, supplementation with high-dose vitamin A capsules and prevention of malaria. While pneumonia, diarrhoea and malaria in children can be prevented and treated with simple and cheap means, it is more expensive and takes longer to prevent neonatal deaths. This requires qualified birth attendants

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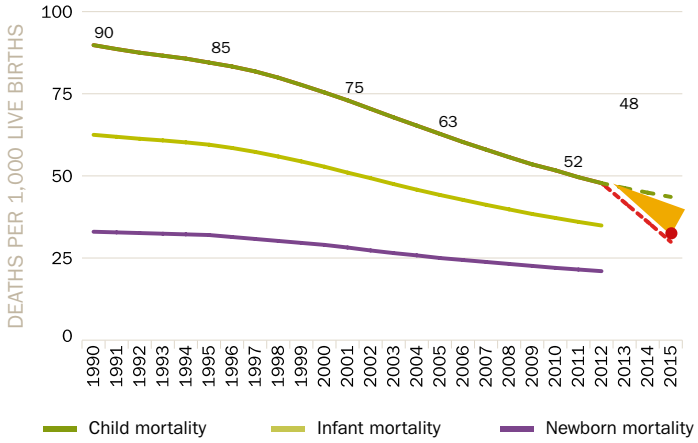
such as a doctor or midwife, equipment and medicines, as well as good access to care for mothers and children. Statistics show that in 2005 only 45 per cent of all pregnant women and newborns in developing countries had access to qualified obstetric care.

The challenge ahead will be to develop and scale up use of effective measures to reduce infant mortality. This must take place in cooperation with global organizations and authorities in partner countries.

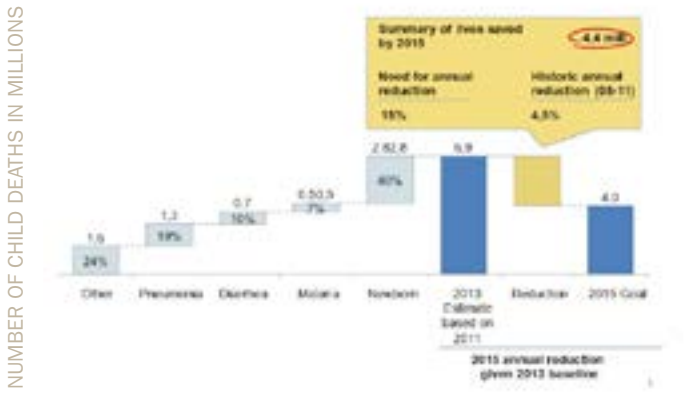
Sources
Committing to Child Survival: A Promise Renewed – Progress Report, UNICEF, 2013
Analyzing Progress on Commitments to the Global Strategy for Women's and Children's Health, PMNCH 2013
WHO, EMRO, Health Systems Profile – Afghanistan
WHO Statistics World Bank UNDP statistics
UNDP-statistics

FIGUR 3.5. NEWBORN MORTALITY MAKES GOALS OF CHILD MORTALITY HARD TO REACH



Proper care at birth not only helps to prevent stillbirths and to save the lives of both mother and child, but also saves society the economic and social costs associated with treatment, disability and loss of income. The dotted red line shows the trend needed to meet the Millennium Development Goal.

FIGURE 3.6. 4.4 MILLION LIVES MUST BE SAVED IN ORDER TO MEET MILLENNIUM DEVELOPMENT GOAL 4 BY 2015



Calculation of the number of lives that must be saved in order to meet Millennium Development Goal 4 and in which areas. The number of deaths among children under the age of five must be reduced from the current 6.9 million to four million per year. In total, 4.4 million more children must be saved by 2015. Of these, 40 per cent or about 2.8 million are newborns. The decline in newborn deaths has been less than for children in general, but by simple means, a large proportion of those could be saved, for example by rapid treatment of birth asphyxia (mucus in the airways).
Note: The 2013 figures are based on the 2011 figures for child health.
It is assumed that the increased birth rate and declining death rate balance each other out.
Source: UNICEF, A Promise Renewed..

Box 3.1. Newborn, child and maternal health and the UN Commission on Life-Saving Commodities for Women and Children

In 2011, a decision was made to boost the Norwegian efforts to improve newborn health by helping to improve the availability and efficient use of life-saving drugs and equipment for mothers and children, especially around birth. The decision is based on studies showing that, for example, in Bangladesh about half of the district hospitals and health centres had no stocks of the recommended drug oxytocin to prevent postpartum haemorrhage.[35] Oxytocin costs from one to four dollars per treatment. A study[36] in Malawi found that district health centres lacked the antibiotics needed to treat pneumonia, which is the disease that kills the most children. The cost per tablet of the antibiotic amoxicillin is less than 10 øre.

Through the UN Commission on Life-Saving Commodities for Women's and Children's Health, Norway is leading efforts to increase access to and use of 13 essential commodities in the form of medicines and equipment. Of these, four are directly focused on newborn health, three on children under five and six on women. The commission aims to save six million lives over the next five years (2013 – 2018), of which 2.4 million are infant lives. The Commission's recommendations include improving the quality of medicines, increasing knowledge about these among health workers and parents, encouraging regional production to reduce costs and strengthening supply chains using mobile technology.

In future, Norway will contribute NOK 300 million per year, or NOK 1.5 billion for the period 2013-2018 for the implementation of the recommendations of the Commission on Life-Saving Commodities. This will cover ten per cent of the total cost of USD 2.6 billion, for 50 of the poorest countries for five years. The funding will mainly come from the partner countries' national budgets, as well as development assistance from Norway, Sweden, the United Kingdom and others.


Photo: Ken Opprann

The health centre in Rumonge in Burundi serves rural families, which communicate via churches to say when they can come. International financing by GAVI and UNICEF, among others, contributes to the purchase of vaccines and to enabling health workers to travel out to the families who do not have the opportunity to visit the centre.

35 Leahy Madsen E, Bergeson-Lockwood J, Bernstein J. Maternal Health Supplies in Bangladesh. Population Action International; 2010.
36 Deficient supplies of drugs for life-threatening diseases in an African community by Norman N Lufesi, Marit Andrew and Ivar Aursnes, BMC Health Services Research, 7:86, doi:10.1186/1472-6963-7-86, 2007

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EKSEMPEL 2 THROUGH IMMUNIZATION, THE GAVI ALLIANCE HAS HELPED PREVENT MORE THAN FIVE MILLION DEATHS

GAVI has saved many lives by contributing to the rapid introduction of new vaccines and increased global vaccine coverage.

WHY: VACCINES THAT COULD SAVE LIVES HAVE BEEN TOO EXPENSIVE FOR POOR COUNTRIES

Immunization is the most effective measure against many infectious diseases. Worldwide, immunization prevents between two and three million deaths each year. Yet in 2003 there were still over 27 million children who did not receive the most basic package of vaccines. Historically, it has taken 10-20 years from the time a new vaccine became available until it was introduced in a developing country. In 2003, 2.5 million children died each year from diseases that could have been prevented with vaccines. Immunization is also regarded as one of the most cost-effective health measures.

WHAT: GAVI IS WORKING TO REDUCE PRICES, DEVELOP NEW VACCINES AND INCREASE ACCESS IN POOR COUNTRIES

Vaccination is an important means in Norwegian development cooperation strategy to reduce child mortality and to meet Millennium Development Goal 4 of reducing child mortality. In 1999, Norway helped establish the global vaccine alliance GAVI, which is a partnership between public and private sectors. The Norwegian medical doctor Tore Godal was GAVI's first director. The GAVI Board includes representatives from governments in donor countries (including Norway) and recipient countries, UN agencies, the World Bank, civil society, research institutions and the vaccine industry.

GAVI's mandate is to save children's lives and protect people's health by increasing access to immunization in poor countries. Support from GAVI is based on applications and it gives priority to the poorest countries. To date, 77 countries have been invited to apply for new vaccines and funding to strengthen immunization programmes and increase vaccine coverage. UNICEF buys vaccines and delivers them to countries on behalf of GAVI. To ensure high vaccine coverage, smoothly functioning delivery systems are needed, including purchasing, distribution, refrigeration of vaccines, and health workers who can provide services. These systems are weak in many countries and alliance partners often provide support for implementation as well. National ownership and development of strategies for long-term, sustainable funding provide the basis for GAVI's activities.

How much: Norway is one of the largest contributors to GAVI. It has contributed approximately ten per cent of GAVI's budget, about NOK five billion in total, from 2000 to 2013. In 2011, the government announced that Norway would increase its funding to GAVI to up to one billion kroner per year until 2015.

RESULTS: INCREASED USE OF NEW VACCINES, BETTER PRICES AND ACCESS TO VACCINES, AND REDUCED MORTALITY

During the past twelve years, GAVI, together with WHO and UNICEF, has bought important vaccines in and helped countries to distribute more than 70 low-income countries. This has enabled poor countries to introduce new vaccines against serious diseases such as yellow fever, meningitis, pneumonia, hepatitis B and rotavirus diarrhoea.

From 2000 to 2012, more than 390 million children were fully vaccinated with support from GAVI. This means that they have been vaccinated against a variety of diseases as part of an immunization programme. In addition, 100 million people were vaccinated against meningitis A and 68 million against yellow fever in immunization campaigns supported by GAVI.

It is estimated that immunization helped to prevent 5.1 million deaths in the same period. Due to immunization against meningitis A in Africa's "meningitis belt", no meningitis cases occurred in 2012. In comparison, there were up to 1000 cases per 100,000 people during previous epidemics.

In 2000, no developing country had introduced vaccines against hepatitis B and Hib (Haemophilus influenzae type b) although these vaccines were available in richer countries. By the end of 2012, all except one of the world's low-income countries had included the vaccines in their immunization programmes with support from GAVI. While it used to take up to 20 years from the time a new vaccine became available in rich countries until it became available in poor countries, GAVI has made the new vaccines against pneumonia and rotavirus diarrhoea available in developing countries in a single year. Since 2010, the pneumococcal vaccine against pneumonia has been introduced in 30 countries, and the rotavirus vaccine in 14 countries.

GAVI has also invested in immunization programmes. The funding has been results-based, which in this context means that funds have been disbursed to the country according to how many additional children it can prove have been vaccinated each year. In GAVI-supported countries, coverage has increased from 61 per cent (2000) to 74 per cent (2012). Global immunization coverage has increased from 73 per cent to 83 per cent from 2000 to 2012. Despite population growth, infant mortality has declined from 12.6 million in 1990 to 6.6 million today. However, 22 million children still do not receive the basic package of vaccines today. Increasing immunization coverage to 90 per cent could save two million more children every year.

Because GAVI pools the demand for vaccines from more than 70 of the world's poorest countries, the alliance has become a force in the market, enabling it to negotiate lower vaccine prices on behalf of the recipient countries. In addition, GAVI ensures long-

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term and predictable funding for the manufacturers. This makes it easier for the vaccine industry to plan long-term production, which helps to make the vaccines available in developing countries more quickly. This also creates interest in this market among new manufacturers. The total cost of full immunization of children with pentavalent, pneumococcal and rotavirus vaccines decreased from USD 35 in 2010 to USD 23 in 2012.

In particular, GAVI's funding mechanisms IFFIm (the International Finance Facility for Immunisation) and AMC (Advance Market Commitments) have contributed to GAVI's potential for market power through its long-term legally binding commitments to purchase vaccines.

LESSONS LEARNED: ALLIANCE FOR IMMUNIZATION IS HIGHLY EFFECTIVE

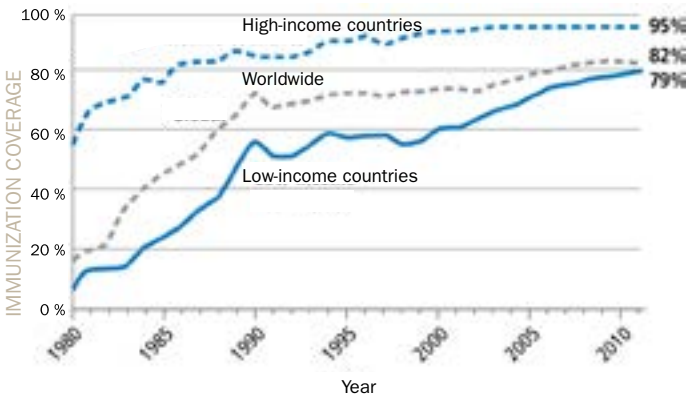
In a British assessment of cost effectiveness in multilateral organizations, GAVI was evaluated as highly effective. What makes GAVI effective compared with many other multilateral organizations is that the interests of many developing countries are aggregated in cooperation with the private sector. In this way, countries that individually have little impact on global markets can influence the price of the vaccines they need. Country-specific solutions are needed to enable effective support to states with particular challenges in governance and health systems. Civil society organizations play an important role where national systems are weak. In many countries, they provide up to 60 per cent of the immunization services.

Evaluations of GAVI's results-based funding have shown that the support has contributed to increased immunization coverage, but have also identified problems with data quality. This has increased the focus and investment in the quality of immunization data. Information, monitoring and logistics systems are areas that need to be further strengthened to ensure sound planning of effective implementation of immunization programmes.

Sources:
GIVS Global Immunization Vision and Strategy 2006-2015. GAVI Mid-Term Review, October 2013 GAVI progress report 2012. GAVI Immunization Services Support (ISS) evaluation
GAVI Advanced Market Commitment (AMC) evaluation. DFID The Multilateral Aid Review 2011

Immunization is the most effective measure against many infectious diseases. Here, a baby is registered for vaccination at the health clinic in Rumonge in Burundi.

FIGURE 3.7. GAVI HAS HELPED TO NARROW THE GAP IN IMMUNIZATION COVERAGE BETWEEN COUNTRIES



The graph shows changes in immunization coverage in low-and high-income countries since 1980. Since the stagnation in immunization coverage in the 1990s, GAVI has contributed to increase the coverage in low-income countries from 61 per cent to 74 per cent in 2012, thus helping to narrow the gap in immunization coverage between high- and low-income countries.

Box 3.2. Facts about immunization

When a person is infected by a disease, this often provides lifelong immunity, so that he or she does not get the same illness several times. There are infections that can cause serious harm and even death of the person infected. The purpose of vaccination is to achieve immunity without the risk involved in being infected by the disease. Vaccination can eradicate infectious diseases. To date, smallpox is the only infectious disease that has been completely eradicated. Efforts are being made to eradicate polio. When the vast majority of the population is immunized against a disease, there will be few people left to whom the infection can spread. Termed community immunity, this makes it possible to stave off the disease, which also protects those who are not immunized. The vaccines used in the childhood immunization programme provide good protection for each individual who is vaccinated. Individual protection after completion of immunization varies from about 85 per cent for pertussis vaccine to nearly 100 per cent for diphtheria, tetanus and polio vaccine. The child immunization programme in Norway today has given us control over many infectious diseases that used to be widespread. Examples of such diseases are polio, measles and diphtheria. To get a disease under control requires immunization coverage of the population of 80-95 per cent, depending on how infectious the disease is. If immunization coverage is too low, the diseases that we now have under control may return. Vaccination must therefore be maintained at a high level every year even if we do not experience epidemics.

EXAMPLE 3 THE GLOBAL FUND HAS HELPED TO SAVE 8.7 MILLION LIVES

In the early 2000s, millions of people died of AIDS, tuberculosis, malaria and other infectious diseases that are both preventable and treatable. The international community therefore joined forces to establish the Global Fund to Fight AIDS, Tuberculosis and Malaria. Millennium Development Goal 6, with targets that include reversing the spread of HIV/AIDS, is well on the way to being met – an achievement to which the fund has contributed.

WHY: PEOPLE WERE DYING OF AIDS, TB, MALARIA AND OTHER INFECTIOUS DISEASES THAT COULD BE BOTH PREVENTED AND TREATED

HIV and AIDS were regarded as a death sentence around the millennium. Only 50,000 people received HIV treatment in Africa and fewer than five per cent of the population had mosquito nets to protect against malaria. Untreated HIV also led to a resurgence of tuberculosis cases. There was a large gap between what we knew had to be done to combat the three diseases and access to professionals and funds. Prevention, treatment, care and support were expected to work together. The focus was therefore on a comprehensive commitment.

WHAT: MOBILIZE RESOURCES TO COMBAT HIV/AIDS, TUBERCULOSIS AND MALARIA

The Global Fund to Fight AIDS, Tuberculosis and Malaria was established by the UN summit on AIDS in 2001, with the G8 countries in the forefront. These countries are Canada, France, Italy, Japan, Russia, Britain, Germany and the United States. The fund finances measures to prevent and treat HIV and AIDS, tuberculosis and malaria, and it is the largest international source of funding in global health. UNAIDS and World Health Organization (WHO) are professional references for national policy. In addition to working specifically with the three diseases, the fund contributes to the involvement of civil society at all levels and to the improvement of health services in general.

The fund is a partnership between the UN, donor countries, recipient countries, civil society organizations, the private sector, and networks for people living with the diseases. Funds are granted by the Board upon application by each country or region, based on results. As of 1 July 2013, USD 20.3 billion has been disbursed for initiatives in more than 140 countries. The fund contributes 82 per cent of international funding for tuberculosis, 50 per cent of the funding for measures against malaria and 21 per cent of the funding for measures against HIV and AIDS.

The fund's vision is a world free of HIV and AIDS, tuberculosis and malaria, and better health for all. In 2012-2016, the goal is to save ten million lives and prevent 140-180 million people being infected by these diseases.

How much: From the start, Norway has contributed about two per cent of the fund's total financing of USD 25.6 billion. In 2013, the Norwegian contribution totalled NOK 450 million.

RESULTS: INCREASED ACCESS TO PREVENTION AND TREATMENT; REDUCED MORTALITY

At the end of 2011, the fund estimated that it had helped to save about 8.7 million lives. This has been achieved through a combination of increased access to treatment and increased efforts to prevent diseases. Measuring the number of lives is based on the calculation of the life-saving effect of three key services: HIV treatment, completed TB treatment and distribution of insecticide-treated mosquito nets, which protect against malaria. See the text box on page 23 for more information.

For more than half of the countries that have received support from the fund, achieving the Millennium Development Goals for HIV and tuberculosis seems feasible. There has also been progress for malaria, but if the targets are to be met by 2015, the efforts must be increased.

HIV: Of those who are eligible for HIV treatment in Sub-Saharan Africa, 56 per cent had access to such drugs in 2012, up from less than five per cent in 2000. As of 1 July 2013, the fund had contributed globally to providing HIV treatment for 5.3 million people, up from 1.4 million in 2007. In the first six months of 2013, the fund also contributed to treatment for 1.1 million people with new HIV infections, up from 900,000 for the whole of 2012.

New HIV infections are still a significant problem, but the number is declining. Since 2001 there has been a decline in new HIV cases of 33 per cent, and of 52 per cent among children. One of the reasons is increased access to services that prevent mother-to-child transmission. The Global Fund currently helps 2.1 million women with such services; an increase from 147,000 women in 2007. The number of deaths due to AIDS peaked in 2005; it has been reduced by 30 per cent since then. Of the 105 countries supported by the Global Fund, 41 per cent are on track to meet the international target of universal access to HIV treatment by 2015. Between 2005 and 2011, seven of the ten countries that have 80 per cent treatment coverage have more than halved AIDS-related deaths. The Millennium Development Goal to halt the spread of HIV is thus within reach.

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Tuberculosis: It is estimated that 67 per cent of the 8.7 million people who become ill with tuberculosis each year are diagnosed, and 85 per cent of these receive effective treatment and survive. This is an increase from 43 per cent detection and 67 per cent treatment ten years ago. The Global Fund has contributed to this increase by contributing to the diagnosis and treatment of eleven million tuberculosis cases as of 1 July 2013. In the first six months of 2013, the fund also contributed to diagnosis and treatment of 1.3 million tuberculosis cases, up from 1.1 million for the whole of 2012. Worldwide, tuberculosis-related deaths among HIV-positive people have declined by 36 per cent since 2004.

Malaria: An estimated 53 per cent of at-risk households in Sub-Saharan Africa in 2012 had at least one mosquito net treated with insecticide, up from three per cent in 2000. As of 1 July 2013, the Global Fund has contributed to the distribution of 340 million malaria nets worldwide to protect families against malaria, an increase from 46 million in 2007. During the first six months of 2013, the fund contributed to the distribution of 30 million mosquito nets. Studies show that about 90 per cent of people who have mosquito nets use them. Global malaria deaths have fallen by more than 25 per cent since 2000.

The results would have been impossible to achieve without a decrease in the unit price of medicines and equipment, through measures including the negotiation of production under licence. Political and social mobilization has led to an increase in countries' own investments. Over the past five years, the countries' own funding of TB, HIV and malaria programmes has more than doubled in the countries that are eligible for support from the fund. This national increase is primarily related to the fight against HIV.

LESSONS LEARNED: EFFORTS MUST BE MAINTAINED EVEN IF ONE BEGINS TO SEE PROGRESS

Ten years of funding for country programmes show how important it is to provide support in accordance with national plans and procedures. The emphasis is on countries strengthening their capacity to make strategic and long-term choices. Efforts target the areas and groups with the greatest challenges in preventing disease and in ensuring equal access to the treatment needed.

It is important that support is maintained even after progress has been achieved, and that it does not stop too suddenly. In several countries, support to malaria programmes declined after the disease was almost eradicated, causing it to flare up again. Interrupted treatment of tuberculosis or HIV leads to resistance, which is much more expensive and more difficult to treat.

The combination of partnerships with governments, civil society, the UN, the private sector and those who are affected by the diseases at both global and national level has proved effective in the fight against the three diseases.

Sources:
Strategic Investments for Impact: Global Fund Results Report 2012
The Global Fund to Fight AIDS, Tuberculosis and Malaria Fourth Replenishment (2014-2016). Update on Results and Impact
The Global Fund Strategy, 2012-2016: Investing for impact UNAIDS Investment Framework
UNAIDS Global AIDS Report, 2013

Box 3.3 Model for estimating the number of lives saved

A model has been developed in collaboration with UNAIDS and WHO to estimate the number of lives saved. The model is based on three selected services (HIV and TB treatment and distributed mosquito nets), multiplied by their proven effect on mortality. Because the estimate is based only on three services, it is likely that this will be an underestimate. In other respects, the Global Fund to Fight AIDS, Tuberculosis and Malaria is based on evaluations in countries in which the greatest amounts have been invested. In the evaluations, other services are also included in the estimates.

The fund's calculation model is now under revision. New figures are expected to be presented in 2014.

Two-month-old Abel reacts with a howl to the BCG shot, while his mom Addis comforts him as well as she can. UNICEF supports a large-scale vaccination programme in Ethiopia.

EXAMPLE 4 RESULTS-BASED FINANCING HELPS TO INCREASE HEALTH SERVICES COVERAGE FOR WOMEN AND CHILDREN

Increased economic benefits through results-based financing can improve coverage, quality and use of maternal and child health services.

WHY: LIMITED ACCESS, USE AND QUALITY OF HEALTH SERVICES

Lack of access to resources, low motivation among health workers and little focus on results has meant that health care is not readily available or is of inadequate quality in many low-income countries. This result is a lack of demand for the services. High mortality and morbidity among pregnant women, newborns and children are partly a result of poor access to and quality of services.

WHAT: RESULTS-BASED FINANCING OF HEALTH SERVICES

Results-based financing (Box 3.4) is one of five focus areas of the UN Secretary General's global campaign for the health-related Millennium Development Goals. A multi-donor trust fund in the World Bank (Health Results Innovation Trust Fund, HRITF), was established by Norway in 2007 and is jointly financed with the United Kingdom. It is one of the largest health funds in the World Bank. Low-and middle-income countries can apply for financial and professional assistance to test various forms of results-based financing in their health services. The aim of the fund is to increase knowledge about how this type of financing can improve results in maternal and child health. A further aim is to expand programmes with good results in their efforts to reduce child and maternal mortality. Pilot programmes have been launched in about 27 countries, and a handful of them have been scaled up to cover the whole country.

How much: Norway has pledged to support the World Bank's multi-donor fund with about NOK 2 billion from 2007 to 2022. The United Kingdom is contributing about NOK 1 billion in 2009-2017. As of 2013, Norway has paid NOK 600 million to the fund.

RESULTS: INCREASED COVERAGE, AVAILABILITY AND USE OF SERVICES

In the pilot countries, results-based financing has led to increased access to and use of health services. In Rwanda, 23 per cent more births have taken place in clinics with results-based financing than in other clinics. There has been a 56 per cent increase in preventive measures for children under two years and a 132 per cent increase for children over five years. No effect has been found on number of children with full immunization coverage or number of antenatal care visits, but the quality of the visits has improved.

In areas where results-based financing was introduced in Zimbabwe, the number of antenatal care visits increased by over 100 per cent after one year. The same happened in Burundi. In Zambia, the number of births in clinics, and not at home, increased at clinics that receive results-based financing (Figure 3.8.).

In Zimbabwe, the efficiency of the health system was increased by bonuses granted for referral to hospital for at-risk births. More deliveries were attended by personnel with higher qualifications and better equipment. Through upscaled programmes, there is reason to believe that results-based financing has an effect on health status. In Burundi, 499 deaths per 100,000 pregnant women were registered in 2010, down from 615 in 2005, after results-based financing was introduced throughout the country. Child mortality was reduced from 175 to 96 per 1,000 live births in the same period. Results-based financing has been proven to contribute to this.

In DR Congo, family planning increased far more in clinics where results-based financing was introduced than in others. An explanation of the difference is that health workers became more active in planning, ordering and using supplies of contraceptives.

The quality and regularity of reported health information have improved in almost all the pilot countries. This is a supplementary effect important to service delivery and monitoring in general.

LESSONS LEARNED: RESULTS-BASED FINANCING LEADS TO BETTER HEALTH COVERAGE

Results-based financing has been shown to improve both coverage and quality of maternal and child health services, at least in the short term. It has also helped to strengthen different aspects of the health system, such as health information, availability of resources, health workers' motivation and absenteeism, problem solving and decentralization. Results-based financing changes ways of thinking. Experiences from Rwanda and Burundi show that this type of financing can also speed up reforms. However, it is also important to be aware that results-based financing can increase the risks of cheating with figures to document good results that lead to increased disbursements. Adequate control mechanisms are therefore important.

To reach the poorest groups, many players combine results-based financing with rewards directed at users, such as transport support to pregnant women or cash transfers for ensuring that children are vaccinated. Increased service use is likely to have an effect on health status. Based on relatively small pilot programmes, however, it is difficult to measure the impact in terms of reducing maternal and child mortality enough to affect the statistics.

Summaries of experience from various countries have shown that it is important to focus on the quality of service delivery, and not only on the quantity of health services. In India, the number of pregnant women increased so dramatically that the clinics did not manage to provide sufficient quality of service. For this reason, quality should be included in new RBF programmes.

Sources:
World Bank, Using Results-Based Financing to Achieve Maternal and Child Health, Progress Report, Health Results Innovation Trust Fund, 2013
Basinga, Gertler et al, The Lancet, Vol. 377, No. 9775 pp 1421-1428, 23 April 2011

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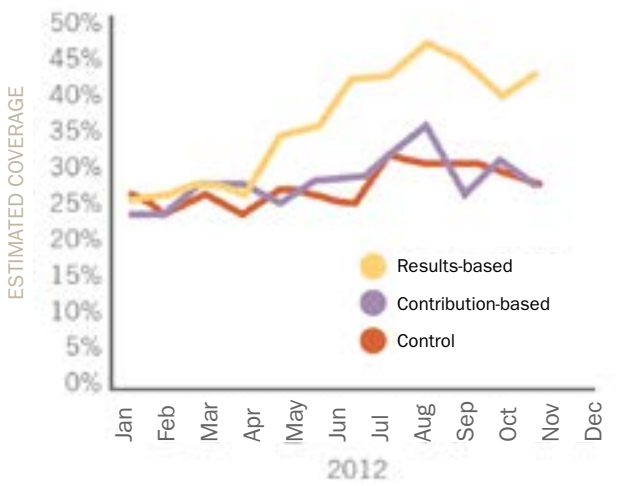
FIGURE 3.8. INCREASE IN DELIVERIES IN CLINICS RECEIVING RESULTS BASED FINANCING, ZAMBIA (2012)



Changes in the proportion of births in clinics after the introduction of results-based financing (yellow) compared with clinics that received the equivalent amount as the usual budget (purple), and clinics that did not receive additional funds (control area, red). In this case, increasing the usual budget had little effect on the number of births.

Box 3.4. Results-based financing

Results-based financing involves paying for results achieved rather than paying for operating expenses in advance. These forms of funding provide motivation to health workers and others who contribute to the achievement of results. An example would be to give a hospital a bonus for the number of births that take place there or if the quality of treatment complies with a given standard. Such incentives can also be used to motivate the users of services. This approach is referred to as *conditional cash transfers* and has been applied with good results, especially in Latin America. The common feature is that disbursements are based on the results achieved or the activities that have been implemented.

At the Kazanchis health centre in Ethiopia's capital, Addis Ababa, attendance is high throughout the week. UNICEF buys vaccines and delivers to countries on behalf of GAVI.

EXAMPLE 5 PARTNERSHIP WITH PAKISTAN AND THE UN ON MATERNAL AND CHILD HEALTH DID NOT DELIVER AS EXPECTED

In 2008, Norway entered into a partnership with Pakistani authorities and the UN to reduce the high rate of maternal and child mortality in the Sindh province. Factors such as flooding, reforms in the health sector and poor coordination internally within the UN led to a lack of progress and inadequate results. Norway has therefore decided to phase out the support.

WHY: SINDH IS THE PROVINCE WITH THE HIGHEST MATERNAL AND CHILD MORTALITY

In Pakistan, child and maternal mortality is particularly high. Areas of the Sindh province (in the south) have the highest mortality rates in the country. According to official health statistics of 2007, an average of 77 per 1000 live-born children died before the age of one, and 84 per 1000 died before the age of five. In Sindh, these figures were 71 and 100 per 1,000. The longest distances between health clinics are in rural Sindh. The situation there is worse than in urban areas. For every 1,000 children, 80 died before reaching the age of one year and 117 before they turned five. Maternal mortality in Pakistan in 2007 was 320 per 100,000 live births, while the corresponding figure for Sindh was 350.

Many challenges make it difficult to work in Pakistan. The project period has been marked by major conflicts in the region and unstable domestic politics. The country has been hit by flooding. Women's everyday lives are restricted by traditional gender roles, and religious and cultural beliefs hinder their access to and use of health services.

WHAT: INCREASE ACCESS TO AND USE OF HEALTH SERVICES FOR MOTHERS AND CHILDREN AMONG POOR AND MARGINALIZED GROUPS IN THE SINDH PROVINCE

The aim of the Norway-Pakistan Partnership Initiative (NPPI) is to reduce the mortality of mothers, newborns and children under five in ten selected districts with the highest mortality rates. The work addresses two result areas:

1. Increased coverage of health services of good quality for mothers and children and services related to family planning

2. Improved knowledge and behaviour among families and communities in connection with health services for mothers and children and family planning

After careful preparation, which included the preparation of a risk assessment and review and improvement of the project's results framework, underlying data and follow-up plan, Norway decided that the aid should go through the UN system to "One UN Pakistan". This is a collaborative programme between UNICEF, the World Health Organization and the United Nations Population Fund. Use of One UN Pakistan was intended to (1) secure disbursements as well as better reporting and accountability for Norwegian funding; (2) minimize the risk of delays, corruption or fraud; and (3) support UN efforts to coordinate the initiative through the reform "Delivering as One", which started in 2007 with Pakistan among the first countries.

How much: Norway's agreed contribution to NPPI was NOK 250 million for 2008-2013. Because of poor progress in the programme, only NOK 105 million had been disbursed as at 2013.

RESULTS: LITTLE PROGRESS, WITH MANY CHALLENGES AND OBSTACLES

Several factors have delayed implementation. Catastrophic floods covered the country in 2010 and 2011. A demanding reform of the health sector removed the national health ministry and transferred responsibility to local authorities, who were poorly prepared for this. Even allowing for these factors, the project has been delayed far more than expected.

There are some good target results, such as improvement of 26 health institutions, two specialized centres with expertise in caring for newborns, training of health workers and mobilization of people in remote areas. Planned follow-up measures to ensure long-term effects and sustainability have not been initiated. Norway's assessment is that the progress as a whole is too weak in relation to the amounts disbursed to the programme. For example, although 26 health institutions have been improved, the result is weak in relation to the original goal of improving 60 health institutions within five years.

An independent review of the programme in 2013 confirmed Norway's suspicions of lack of progress, inadequate project management and coordination, and difficulties in proving achievement of results. The project implementation is so weak, and the likelihood that it can be improved within the existing structure so small, that Norway has decided to withdraw support without completing the programme.

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Norway is phasing out support and has requested One UN and the health authorities in the Sindh province to gradualy phasing out of the most successful interventions in a sustainable way. The partners have also been asked to end non-priority activities, not to start up new activities, to document experiences and lessons learned, and to conduct a final evaluation.

LESSONS LEARNED: CLOSE PROJECT MONITORING BY DONORS IS ESPECIALLY IMPORTANT IN COUNTRIES IN DEMANDING SITUATIONS

One important lesson learnt from working in a country like Pakistan is that it may be better to withdraw from a project that is not performing well than to continue in the hope that it will work out in the long run. Based on a mid-term review of the project, Norway decided to do this. In high-risk projects, such reviews are especially necessary.

The example shows the importance of effective monitoring of project progress, robust risk analyses in advance, and measures to manage risk. As a donor, Norway conducted several analyses and reviews to ensure that good work plans and solid project management were in place before the agreement was signed. Despite these efforts, the challenges proved too large and complex. It is important that partners with responsibility for implementing the project are held accountable, and that the level of ambition and desired results match what can realistically be achieved within the time frame.

The concept of a «One UN», which allign the efforts of the UN agencies, is a new concept. NPPI's experience will be used to prevent similar problems in future cooperation with One UN.

Sources:
Review conducted midway through the Norway-Pakistan Partnership Initiative, May 2013 Health statistics from the government of Pakistan

A woman and her child wait for emergency aid in Sukkur in the province of Sindh after the floods that hit Pakistan in 2010. The area has the highest child and maternal mortality in the country.

EXAMPLE 6 INCREASED ACCESS TO CONTRACEPTIVE IMPLANTS

Cooperation between producers, authorities and health organizations has given girls and women in developing countries greater access to contraception and freedom to choose the contraceptive method that suits them best.

WHY: 200 MILLION WOMEN DO NOT HAVE ACCESS TO CONTRACEPTION

More than 200 million girls and women in developing countries have no access to contraception methods even if they want them. Health clinics in developing countries often offer few methods of contraception, and long-acting methods have long been scarce. Due to problems with logistics and supply combined with low budgets for contraceptives reduce availability. High price is one of the factors that have prevented health authorities in many low-income countries from buying contraceptive rod implants. If the unmet need for modern contraception methods were covered, an estimated 53 million unintended pregnancies would be avoided, about 90,000 women's lives would be saved and 590,000 deaths among newborns would be prevented. When women can use contraceptives to control when to have their children and how many, the risk of dying during childbirth and pregnancy is reduced. Contraception use also reduces abortion rates.

WHAT: AGREEMENTS WITH MANUFACTURERS ON VOLUME GUARANTEES FOR CONTRACEPTIVE ROD IMPLANTS

Increased access to contraception was one of the actions identified by the Norwegian-led UN Commission on Life-Saving Commodities for Women and Children, among 13 simple initiatives and products that could help to save six million lives. The contraceptive rod is a hormone implant inserted under the skin of the woman's upper arm. It works for three to five years, depending on the product type. The implant is in demand among women in developing countries, but it has been relatively expensive and therefore has not been readily available.

BOX 3.5. The contraceptive rod implant Jadelle

The contraceptive rod implant Jadelle was developed by a research and development aid organization called the Population Council in the 1960s. Contraceptive implants are one of the safest and most cost-effective long-acting methods on the market, and their effectiveness can be compared to intrauterine devices. Consisting of one or two hormone rods that are inserted under the skin of the upper arm, the implants provide effective contraception for three to five years, depending on the product that women choose. The implant can be removed by health workers, with no delay in the return of her fertility.

Together with the Bill & Melinda Gates Foundation, the Swedish government and the Children's Investment Fund Foundation (CIFF), Norway has signed an agreement to guarantee the purchase of 40 million contraceptive rod implants from two manufacturers, Bayer and Merck, over seven years. Norway is also supporting the training of health workers, distribution and information through the United Nations Population Fund (UNFPA) and civil society organisations to help ensure access to the products. The aim of the initiative is to improve access to contraception for adolescents and women in developing countries and to offer them the opportunity to choose a method that suits them. Experience shows that the combination of lower price, easier access and better information are likely to support increased use.

How much: Cooperation and planning began in September 2012, in connection with the global Family Planning 2020 initiative, when Norway pledged to double its contribution to family planning. Norway's contribution has several aspects. Norway, with its partners, has entered volume guarantee agreements for the purchase of implants from 2013 to 2019 for a value of more than USD 340 million, of which Norway's share is USD 140 million. The volume guarantees have helped to halve the price of implants. Norway has granted NOK 300 million to contraception initiatives in 2013 through UNFPA and civil society partners. Norway has announced its intention to keep the grant at the same level until and including 2020.

RESULTS: HALVED PRICE AND INCREASED DEMAND

Because of the volume guarantee, the price of two types of contraceptive implants was halved from 2012 to 2013, from USD 18 to 8.50, for developing countries. Aid organizations and health authorities in developing countries increased their total orders of the implants by 50 per cent in 2013 compared with the previous year. The contraceptive rod implants will be available free of charge or at a subsidized price in the countries concerned. Forecasts show that the entire production volume totalling over five million implants, for which Norway is among the guarantors, will be purchased in 2013. UNFPA is the largest buyer of contraceptives worldwide. The price reduction on the Implanon and Jadelle implants saved USD 44 million for UNFPA in 2013.

Based on a survey of needs for training, health workers in public and private health clinics in many countries have received training on the contraceptive implants. Communication efforts have been launched to reach the target groups. This is a new initiative, and the results will become evident only when the products reach the health units and the groups in focus begin to use the products. Based on orders in 2013, the availability of contraceptive implants will be doubled, that is, to about 2.5 million new users.

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LESSONS LEARNED: POLITICAL LEADERSHIP IS IMPORTANT TO REDUCE PRICES AND IMPROVE THE AVAILABILITY OF NEW PRODUCTS

The most important lesson is the relationship between innovation by manufacturers and political leadership. Without global mobilization and the use of volume guarantees to reduce financial risk, the contraceptive implants would not have been an option for women in poor countries for many years to come.

In developing countries and donor countries, the UN Commission on Life-Saving Commodities for Women and Children has ensured legitimacy and attention for the work, as well as willingness to invest in these efforts. The commission is chaired by the President of Nigeria and the Prime Minister of Norway.

Sources
Working paper, Prepared for the United Nations Commission on Life-Saving Commodities for Women's and Children's Health, March 2012
Family Planning in 2020 Progress Report, website, November 2013

Box 3.6. The UN Commission on Life-Saving Commodities for Women and Children

The commission was chaired by Prime Minister Jens Stoltenberg of Norway and President Goodluck Jonathan of Nigeria. The commission presented its recommendations to the UN General Assembly in September 2012. The commission wants to ensure that 13 life-saving commodities that are underused become available by 2015. These commodities could help to save the lives of six million women and children in developing countries.

Photo: Ken Opprann

Hawassa University in Ethiopia was established in 2000. Since then, the university has grown vigorously. Today it offers 60 different programmes of study and 34,000 students are currently registered. More than 38,000 have studied here. This reminder about safe sex is displayed on the campus.

EXAMPLE 7 SYSTEMS FOR HEALTH INFORMATION LEAD TO BETTER HEALTH SERVICES

The Health Information Systems Programme (HISP), led by the University of Oslo, has helped to strengthen health information and data, which has led to better health services in many countries.

WHY: LACK OF HEALTH INFORMATION AND DATA LEAD TO LOW-QUALITY SERVICES

Most developing countries have had weak, incomplete or inadequate systems for health information, and have lacked the capacity to take advantage of new technology. This means that they do not have an adequate overview of their health situation. The result is a poor basis for planning health services and making them more effective, as well as for measuring whether the Millennium Development Goals for health are being met. The University of Oslo started the Health Information Systems Programme (HISP) in the mid-1990s. The goal was to use ICT to integrate fragmented systems, prepare information for analysis and evaluation, and strengthen health authorities' capacity to manage health care. In 2011, the UN Commission on Information and Accountability for Women's and Children's Health recommended that all countries should integrate the use of information and communication technologies in their national health information systems by 2015.

WHAT: SYSTEMATIC DEVELOPMENT OF HEALTH INFORMATION SYSTEMS LOCALLY AND NATIONALLY

The Health Information Systems Programme (HISP) is a global network managed by the University of Oslo. HISP works to strengthen health information systems by improving the collection, analysis and use of health data and indicators. The HISP network has developed and maintains District Health Information Software (DHIS), an open-source and freely accessible computer program. The program is suitable for analysing data at district and national level in developing countries. HISP strengthens information use through training of local technologists and decision makers, and contributes with research and dissemination. The Norwegian funding goes to software development and implementation of computer programs for health information systems in developing countries, as well as education of master/PhD students in health informatics. WHO has rated that HISP a best practise method for developing health information systems. HISP is therefore a key partner for the UN.

HISP started its work in South Africa in 1995. The network operates on request from a number of countries wishing to develop their information systems for health. The aim is to improve the capacity to collect, analyse and use data to make better decisions and to communicate and report results. Close cooperation with and ownership by national authorities, as well as building on existing technology have been important to develop systems that take into account existing knowledge, requirements, procedures, and local capacity for maintenance.

How much: Norway has supported HISP with a total of NOK 130 million since 1995. The University of Oslo has contributed an equivalent amount for its own operations, while a number of other international partners provide support in the various countries covered by the programme.

RESULTS: HEALTH INFORMATION SYSTEMS IN MORE THAN 30 COUNTRIES

HISP has contributed to the education in computer science of more than 100 master's students and 20 PhD students from Ethiopia, Malawi, Mozambique, Sri Lanka and Tanzania, among other countries. Many of these graduates are now working with health information systems in public-sector institutions, the private sector or as academic staff at universities in their home country. See Box 2.4 on page 31 for Norwegian support to higher education that has contributed to the HISP programme.

HISP has had a significant impact on health information systems in low-and middle-income countries. The network of DHIS users includes more than 30 countries in Africa, Asia and Latin America. The services have the potential to include more than 1.3 billion people.

Countries where HISP has been working for a long time can document more systematic use of information to improve health services and administration. In Kenya, the health administration uses electronic data for surveys and planning. In Liberia, the information was used in planning the new national ten-year plan. Agreements on service delivery by civil society organizations are monitored with the help of the software. In Malawi, the availability of data helped to enable the decentralization of decision-making authority to the district level. The district administration uses the system to identify clinics where quality is inadequate, and takes action to improve quality.

In Sierra Leone, WHO has shown that the use of software to analyse, plan, and implement measures for maternal and child health has led to a higher proportion of births in clinics and hospitals than before.

Data for eleven standard indicators for maternal and child health are now available in 75 countries. This makes it easier to measure progress towards the Millennium Development Goals. HISP has helped to raise data quality in the countries in which it works.

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LESSONS LEARNED: NEW HEALTH INFORMATION SYSTEMS BASED ON EXISTING SOLUTIONS

Evaluations of the project show that most countries gain access to relevant information of high quality soon after introducing the District Health Information Software, and that the benefits extend to local levels. These advantages have made the HISP system for health information one of the most widely used in the world. The evaluation also highlighted that local participation in the development of health information systems, and the involvement of local universities in research and development, ensured the necessary sustainability and national ownership of the project. International dissemination and sharing of experiences and solutions is important to spread knowledge in the field across national boundaries.

Experience has also shown how comparing different data sources enables synergies and reduces the number of fragmented systems. The design of the solutions must therefore support sharing of data between systems.

The expansion of the Internet in developing countries, fuelled by the ongoing mobile revolution, creates entirely new possibilities. Internet-based health information systems reduce reporting time, decentralize access to information and enable elastic scalability. These features enable a rapid local response to health challenges.

Sources:
Countdown to 2015, Accountability for Maternal, Newborn & Child Survival, The 2013 Update
Health Metrics Network "Results Report 2010: Building momentum, saving lives" WHO, Geneva 2010

Francine Girukwayo (left) and Bella Nshimirimana record vaccination details at the health centre in Rumonge, Burundi. Worldwide, 22 million children still do not receive the basic package of vaccines.

EXAMPLE 8 REDUCED HIV AND AIDS AMONG VULNERABLE GROUPS IN AFRICA

Cooperation across national borders achieves results in the areas of HIV and AIDS, sexual and reproductive health and rights, and the rights of lesbian, gay, bisexual and transgender people in Africa.

How much: Norway supports the initiative with NOK 35 million annually, while Sweden is contributing SEK 350 million annually from 2012. In total, Norway has contributed NOK 265 million.

WHY: INITIATIVES IN INDIVIDUAL COUNTRIES MAKE EFFORTS AGAINST HIV AND AIDS AND FOR SEXUAL AND REPRODUCTIVE RIGHTS MORE FRAGMENTED THAN NECESSARY

It is estimated that 2.4 million people contracted HIV in Sub-Saharan Africa in 2001 alone. Through illness and death, the HIV epidemic was destroying communities and reversing the development of countries. Different countries in the same region often have similar challenges. High migration contributes to the spread of HIV, and makes both prevention and treatment more difficult. The stigmatization of sex between men is widespread in the region. Increasing rates of HIV infection result from lack of knowledge and marginalization. In the early 2000s, efforts against HIV were increased both in individual countries and globally, but little work was done at the regional level.

WHAT: SUPPORT FOR REGIONAL PARTNERS TO PREVENT HIV INFECTION, BETTER CONDITIONS FOR WOMEN AND GIRLS AND WORK TOWARDS RIGHTS FOR VULNERABLE GROUPS

In 2001, Norway and Sweden established a partnership for work related to HIV and AIDS at the regional level. A team at the Swedish Embassy in Lusaka, Zambia is managing this initiative.

The partnership has now been extended to cover sexual and reproductive health and rights (SRHR), particularly for women and girls, as well as the rights of sexual minorities. The aim is to meet needs that have emerged more clearly over the past decade. The goals are:

- To prevent HIV infection
- To improve living conditions for women and girls affected by the HIV epidemic
- To increase respect for the human rights of lesbian, gay, bisexual and transgender (LGBT) people

The measures include sexuality education, training and seed funding women to start small businesses, increased access to condoms, psychosocial work with children who have lost parents, support for grandparents who take care of orphaned grandchildren, political advocacy and research. The work is carried out by the regional offices of UN agencies, non-governmental organizations, research institutions, and regional economic communities such as the Southern African Development Community (SADC) and the East African Community (EAC).

RESULTS: MORE PREVENTION, IMPROVED LIVING CONDITIONS AND STRENGTHENED EFFORTS FROM INDIVIDUAL COUNTRIES

Migrants are a particularly vulnerable group in the context of SRHR as well as HIV and AIDS. The team's efforts have paved the way for greater collaboration between countries in the region. As a direct result of this work, nearly 50,000 migrants gained access to health care in Southern Africa in 2012. Psychosocial support for children who have lost one or both parents also helps to improve the prospects of a good future for these children. Support for a regional centre of competence contributed to enabling more than five million children in Southern and Eastern Africa to receive such help in 2012.

The team supports projects to strengthen the efforts of countries in the region against HIV and for SRHR. Five countries are receiving funds to strengthen their processes for health budgeting and for learning from each other. Political decisions to increase access to care in the region have resulted in increased access to HIV testing and treatment. Due to efforts to promote human rights, more people dare to be tested. In this way, the partnership has helped to increase the number of people receiving HIV treatment in Sub-Saharan Africa from 50,000 in 2002 to 7.5 million in 2012. At the same time, the number of people who become infected each year declined from 2.4 million in 2001 to 1.8 million in 2011.

LGBT people are highly vulnerable to abuses of human rights. The partnership supports the documentation of violations of LGBT rights, including through the preparation of a report in 2012, which increased the visibility of this issue regionally and globally. Working for the rights of sexual minorities is extremely sensitive in most countries in the region, but it has been shown that this can be discussed at the regional level, particularly if promoting good health is the point of departure. An example of this is the decision of the East African Community in 2012 that working with HIV in the region should also include men who have sex with men.

In recent years, women's rights and SRHR have come under strong pressure. In 2012, the UNAIDS regional office for Eastern and Southern Africa started a dialogue with African countries' negotiators in regional and global forums to strengthen women's rights, including sexual and reproductive rights. One result of the increased efforts has been that several African countries represented at UNAIDS board meetings have now become more active in protecting the rights achieved regarding SRHR and HIV.

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LESSONS LEARNED: REGIONAL WORK CAN YIELD RESULTS THAT CANNOT BE ACHIEVED IN OTHER WAYS

The regional perspective has proven fruitful for sharing experiences and paring the way for common solutions across national borders. Regional forums have also proven more open to discussion of sensitive issues such as HIV, AIDS, and LGBT people's rights, and to establishing normative frameworks for work in individual countries. Small organizations working independently have gained knowledge and support through the regional institutions that are receiving support. Regional economic communities have made political decisions which are to be implemented by all their member states.

Sources
Jones, Peris, Hellevik, Siri B., Aasland, Aadne and Aasen, Berit, Evaluation of the Swedish-Norwegian Regional HIV/AIDS Team for Africa, Sida Evaluation, Stockholm, 2009
UNAIDS, Report on the Global AIDS Epidemic, Geneva, 2012
UNECA, Securing our Future. Report of the Commission on HIV/AIDS and Governance in Africa, Addis Ababa, 2008

HIV prevention

Read on page 9: Education and knowledge – a prerequisite for HIV prevention. Combating HIV is a good example of how initiatives for health and education reinforce each other.

Sokoine University of Agriculture (SUA) in Morogoro, Tanzania was established in 1984 and has about 7,000 students, of whom 30 per cent are women. The university has developed agricultural methods, plant varieties and animal breeds that are more productive and resilient. Norway has been one of SUA's most important partners, especially for the Faculty of Forestry.

EXAMPLE 9 EFFORTS TOWARDS CHANGE IN LOCAL COMMUNITIES HELP TO REDUCE FEMALE GENITAL MUTILATION

Female circumcision or female genital mutilation (FGM) is a practice that has accompanied some cultures for thousands of years. Knowledge about which measures are effective in reducing female genital mutilation has improved in recent years, and in many countries, its extent in relation to the population has decreased sharply. At the same time, population growth means that in many countries the total number at risk is higher than it was ten years ago.

WHY: IN 2003 IT WAS ESTIMATED THAT EVERY YEAR TWO MILLION GIRLS WERE AT RISK OF GENITAL MUTILATION

Female genital mutilation involves cutting or removing parts of women's external genitalia. The negative consequences for women's health, sexuality and later childbearing may be extensive. The data on how many women undergo cutting are uncertain, but when the government launched its action plan against the practice in 2003, the World Health Organization estimated that every year two million girls were at risk of genital mutilation. The practice is tightly woven into culture and tradition, which makes it difficult to end. It is virtually impossible for one family to stop the practice on its own; then the girls in the family will not be accepted as brides for others in the community. Although the practice cannot be justified on religious grounds, many people still believe that religion requires girls to undergo cutting.

WHAT: EFFORTS TO CHANGE PRACTICES AND ATTITUDES LOCALLY

Since the 1980s, Norway has supported several initiatives to combat female genital mutilation, most of them in East Africa. Support was mainly channelled through civil society organizations, and was limited. Although the government launched its action plan in 2003, funds were not earmarked for implementation and so several years passed before funding increased and became more focused. In 2006, Ethiopia was selected as a pilot country for a strengthened initiative, in which Norwegian Church Aid and Save the Children Norway launched a cooperative programme with twelve local partner organizations. In addition, the involvement of Focus, Care and other Norwegian organizations in Ethiopia and other countries in East Africa was increased. The largest increase in Norwegian support took place in 2008 when, on Norway's initiative, the United Nations Population Fund and the Children's Fund, UNFPA and UNICEF, launched a joint programme to combat female genital mutilation in 15 countries: Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Senegal, Somalia and Sudan. Norwegian Church Aid participates in the joint programme of UNFPA and UNICEF in Ethiopia, and it is working to establish dialogue with religious leaders.

How much: Norwegian support to combat female genital mutilation has totalled about NOK 369 million in 2003-2012. Since 2008, NOK 20 million of these funds has gone to the joint programme of UNFPA and UNICEF every year. Norway is one of the largest donors to the programmes within this thematic area, and covers over 60 per cent of the budget for the joint programme. The rest of the Norwegian aid is channelled through Norwegian and international civil society organizations. In addition, Norway provides core support to the World Health Organization (WHO), UNICEF and UNFPA.

RESULTS: DECREASE IN FEMALE GENITAL MUTILATION, BUT MANY WOMEN ARE STILL AFFECTED

A large collection of statistics from 29 countries in Africa and the Middle East was published by UNICEF in 2013. The statistics were collected through household surveys in 2000-2010. The figures show that the practice has become less common in half of the 29 countries since 1984, when the first national health and demographic surveys were conducted. In East Africa, the focus area for Norwegian efforts, the study showed reduced prevalence of genital mutilation among girls aged 15 to 19 compared with 45- to 49-year-old women in Eritrea, Ethiopia, Kenya, and Tanzania. In Somalia, Djibouti and Sudan, however, the proportion remained relatively constant. In West Africa there has been a decline, particularly in Burkina Faso and Guinea.

Many factors have contributed to the reduction, and it is difficult to isolate the effect of aid compared with other factors. Since much of the statistical basis in the collection is older than 2008, these results cannot be attributed to the large joint programme of UNFPA and UNICEF, but rather to the combined efforts of these organizations, WHO and civil society organizations since the 1980s. Some examples of the results of efforts through civil society organizations are:

- The end-term review of the pilot initiative by of the Norwegian Church Aid and Save the Children in Ethiopia in 2010 concluded that the incidence of female genital mutilation had been significantly reduced in the project area. A contributing factor was that the majority of the district authorities in the project area had publicly renounced the practice. A local organization, the Kembatta Women's Self Help Centre, combined information campaigns with providing health care. The result was that 15,000 girls decided not to be cut. The programme is being continued with Norwegian funding.

- The organization Tostan, which Norway supports, has a programme in which 5,000 villages with a total population of three million people in several countries, mainly in West Africa, have publicly declared their abandonment of female genital mutilation.

The decline in female genital mutilation is greater in countries where only certain groups have this tradition than in countries where almost all women are cut in this way. Kenya and Tanzania are examples of countries where the practice has been common among certain groups, but not among all. Here, the practice has virtually disappeared in several ethnic groups. In Kenya and Tanzania, women aged 45-49 are now three times more likely to have been cut than those aged 15-19.

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International changes in social norms

In 2012, the UN committee on social, humanitarian and cultural issues unanimously adopted a resolution to end harmful traditional practices such as female genital mutilation. The proposal came from several African countries. The UN resolution shows that there is a strong political will worldwide as well as among African leaders to end the practice.

Many of the countries where the practice exists in virtually the entire population are densely populated and have high population growth. One example is Egypt, which is a populous nation where 91 per cent of women are cut. Of all the female genital mutilation in the world, 27 per cent takes place in Egypt. This means that although the proportion of women exposed to the practice is falling, the total number in several countries is increasing. Despite the positive trend in several countries, the goal remains a long way away.

LESSONS LEARNED: THE ENTIRE COMMUNITY MUST CHANGE ITS ATTITUDE, NOT JUST INDIVIDUAL FAMILIES

It has taken time to develop effective methods to combat female genital mutilation. Much of the earlier work has turned out to be less successful. One important lesson is that to change attitudes and behaviours in a population, it is necessary to support local organizations, groups and individuals trusted by the community, such as religious leaders and other local leaders who promote change.

Experience shows that results emerge after a long process of local dialogue and training initiatives that last several years and include discussion of the rights and duties of people in the community. This helps to change the underlying norms that perpetuate the practice in communities. The practice must be discussed in the community, to change perceptions of what is good and right in order to be accepted as a woman and bride, and for recognition of the value of girls and of boys on an equal footing. Information campaigns through the media and education in the health and education sector, as well as the adoption of national laws against female genital mutilation, have also been important contributory factors in efforts to change social norms. Laws alone have little meaning if they are not combined with other measures. The UNFPA-UNICEF joint programme is being followed up with evaluation and research that will contribute to further learning.

Working together with religious leaders in Ethiopia

In Ethiopia, Norwegian Church Aid works through the Ethiopian Orthodox Church to draw attention to the problems of female genital mutilation. This is part of Norwegian Church Aid's work with religious leaders. The work is financed both by the UNFPA-UNICEF joint programme and by direct Norwegian funding. Every Sunday during the service in Kara Elu Medhanialem, the issues are raised during the Mass and in meetings afterwards. Various solutions have been discussed and now the congregation has played an active role in changing attitudes. There are great differences in urban and rural areas in the understanding of why it is important to stop this practice. There is more emphasis on cultural values among families from rural areas, but there has been a positive shift in their understanding of why this practice must end, says Pastor Samuel Bevhanu.

Sources:
The Norwegian Government s International Action Plan for Combating Female Genital Mutilation Plan, Ministry of Foreign Affairs, 2007 Norad Report 13/2011 Diskusjon, Kjønnslemlesting Hva skjer, og hva gjør Norge? [Female genital mutilation, what's happening, and what is Norway doing?]
Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change, Annual Report 2012, UNFPA/UNICEF Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change, UNICEF, July 2013
An Update on WHO's Work on Female Genital Mutilation (FGM), WHO 2011
Norwegian Church Aid report: God Looked at Everything He Had Made and He Found It Very Good, The Ethiopian Catholic Church's Stand on Female Genital Mutilation, February 2013
Norwegian Church Aid report: Faith-Based Organizations' Response to the Abandonment of Female Genital Mutilation (FGM) and other Harmful Traditional Practices (HTP) in Ethiopia, The Experience of Norwegian Church Aid's Partners, September 2013

Community contact Asefaseh Tesfaye in the Orthodox local parish is working to combat female genital mutilation.

Pastor Tsedalu Mengau's sermon during the Sunday Mass is part of raising awareness about female genital mutilation.

After the Mass, young people of both sexes gather to discuss the problem of female genital mutilation.

EXAMPLE 10 HEALTH SECTOR COOPERATION IN MALAWI IS CONTRIBUTING TO THE DECLINE IN MORBIDITY AND MORTALITY

Broad-based and long-term cooperation with Malawian health authorities and other stakeholders in the health sector is yielding results. Increased access to health services reduces morbidity and mortality.

WHY: HIGH MORBIDITY AND MORTALITY

According to the UN, Malawi is the world's sixth poorest country, and has a national income per capita that is less than a fiftieth of the Norwegian equivalent. Poverty and illness are closely linked, both for individuals and for society as a whole. In 2004, life expectancy in Malawi was 37 years, and infectious diseases such as HIV, tuberculosis and malaria characterized the disease profile. The health indicators were among the worst in Africa in 2004. Maternal mortality was as high as 984 per 100,000 births, while the child mortality rate was 133 and infant mortality was 76 per 1,000 live births. The adolescent fertility rate (births per 1,000 women aged 15-19) was 162. A third of all girls gave birth before the age of 19.

In 2004, Malawi had very limited health services. In 2002, only nine per cent of the health institutions were able to offer services. This meant, among other consequences, that only 57 per cent of all pregnant women had access to qualified birth attendants, while 43 per cent had no access to health care. Of all women, 45 per cent had an unmet need for family planning. Access to life-saving caesarean sections was available to only three per cent compared with the WHO recommended level of 10 to 15 per cent of all pregnant women. According to GAVI, vaccination coverage in the country in 2002 was 51.5 per cent, while there were only 11,000 patients receiving HIV treatment in 2004.

WHAT: SUPPORT FOR IMPLEMENTATION OF MALAWI'S HEALTH PLAN

Support to the health sector has been a key priority for Norway since the establishment of the Norwegian Embassy in Malawi in 1999. Norway's support to the national health sector programme began in 2004. The starting point for the initiative was based on available data from 2002 to 2004. The support is co-financed by the United Kingdom, Germany and Flanders in Belgium. A new three-year agreement was signed in 2012. Malawi's strategic plan for the health sector offers guiding principles for the health sector programme, and for all health initiatives that Norway supports. The strategic plan covers all the priority areas in the sector, particularly maternal and child health services and infectious diseases such as HIV, tuberculosis and malaria. Capacity strengthening and investment in infrastructure are also important goals.

In 2011, funding from several donors, including Norway, was withheld because of suspected corruption. One result was that a critical lack of medicines arose. This had serious consequences for life and health in the country. Norway, Germany and the United Kingdom then signed an agreement for emergency procurement of medicines through UNICEF. Norway's contribution to this was nearly NOK 60 million, through an agreement that expired in 2013.

How much: Direct Norwegian support to Malawian authorities totalled NOK 424 million in 2004-2010. In addition to the direct support, about NOK 150 million was granted for health initiatives that were managed by multilateral organizations and civil society organizations. Norway also contributes through The Global Fund to Fight AIDS, Tuberculosis and Malaria and the vaccine alliance GAVI.

RESULTS: BETTER HEALTH

Life expectancy in Malawi increased from 37 to 51 years in the period. The low life expectancy was strongly linked to the HIV epidemic. With support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and other donors, Malawi has built up a successful HIV programme. At the end of 2011, 320,000 patients were receiving HIV treatment. The availability of treatment to prevent mother-to-child transmission at birth increased from three to 66 per cent between 2004 and 2010. UNICEF estimates that Malawi has the potential for a younger generation without HIV. Access to HIV medicines has enabled more people to live with HIV, which has reduced the number of orphans.

The evaluation of the first phase of the health sector programme (2004-2010) shows significant strides in a wide range of areas. Of the health institutions in Malawi, 74 per cent were upgraded during the period to enable delivery of the basic package of health services, which should be available to everyone in the country, according to government authorities. Yet there is still much to be done before all the institutions achieve a satisfactory level of quality. These measures have contributed to a reduction in infant mortality in the country to 66 per 1,000 in 2010, while maternal mortality was reduced to 675 per 100,000 births in the same period.

With funding from GAVI and other donors, immunization coverage increased to 81 per cent in 2010. The children's disease that previously took the most lives was measles. In 2010, immunization coverage for measles was 93 per cent, and long periods now elapse between each outbreak.

Many factors have contributed to the results. More resources have been dedicated to health and more health professionals have been educated. The number of doctors increased from 43 in 2004 to 450 in 2012. Annual spending on health has increased from USD 7.6 per capita in 2004 to USD 16.2 in 2010.

Two areas have been particularly challenging: systems for procurement and distribution of medicines, and financial management.

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Several reports, including an investigation by the Office of the Auditor General regarding Norwegian health cooperation with Malawi, confirm these shortcomings. The Auditor General's report highlights significant inefficiencies in the resource flows out to hospitals and health centres. Nevertheless, the report concludes that there has been a positive trend in maternal and child health as well as improved access to health care.

LESSONS LEARNED: LONG-TERM AND COMPREHENSIVE COOPERATION IS STRENGTHENING HEALTH SYSTEMS

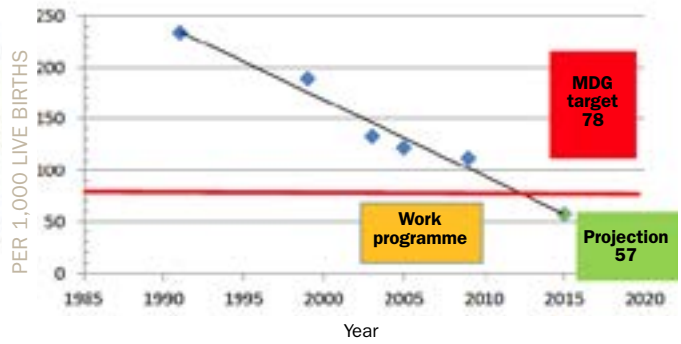
Results are achieved through comprehensive, long-term and coordinated cooperation. At the same time, there are major challenges. In Malawi, as in many other countries, it has proved particularly challenging to develop effective systems for procurement and distribution of medicines. This is partly because procurement and distribution of medicines at the national level requires a high degree of competence combined with good systems and practices in the supply chain. Such expertise takes time to build up and Malawi's generally low level of education has contributed to the difficulties involved. Another problem in the medicine supply chain is wastage and theft of drugs. This is becoming more widespread because of poor control systems. In a poor country like Malawi, health commodities are extremely expensive live, and theft for resale offers great potential for financial gain.

Financial management is another area where there is still a great need for improved systems, procedures and capacity. Long-term efforts that focus both on results – service delivery – and on strengthening of systems are therefore necessary. Here, too, the training of personnel is important.

The health sector programme has contributed to better coordination of all partners in the sector, including those that provide earmarked funding for individual initiatives and programmes. This means that resources are used more effectively and more in line with government priorities. This applies both to the resources channelled through government systems and to those that go directly to projects and programmes led by other actors. This was one of the main conclusions of the evaluation of the health sector programme in 2010. Improved systems and services are still sorely needed, but the overall trend has been positive.

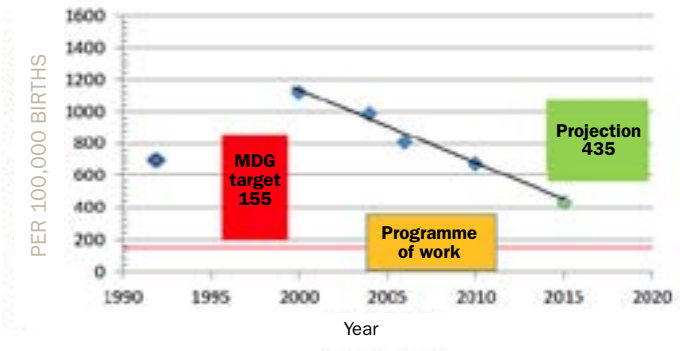
Sources:
Annual reports, Ministry of Health, Malawi DHS 2004
Final Evaluation of the Health Sector Programme of Work (2004-2010), Euro Health Group, September 2010
Malawi Health Sector Strategic Plan 2011-2016, Ministry of Health Malawi
The investigation by the Office of the Auditor General into Norwegian development assistance to the health sector in Malawi. Office of the Auditor General. Document 3:8 (2012–2013)

FIGURE 3.9. MALAWI CAN MEET THE MILLENNIUM DEVELOPMENT GOAL OF REDUCING CHILD MORTALITY



A good childhood immunization programme combined with a number of other measures has helped to reduce child mortality (black line). The goal is shown by a red line.

FIGURE 3.10. MALAWI WILL PROBABLY NOT MEET THE GOAL OF REDUCING MATERNAL MORTALITY



Improved health services for mothers and children have reduced the numbers of women who die in connection with childbirth and pregnancy. Some services have been difficult to develop fast enough and much remains to be done. Healthcare for pregnant women may require high medical competence and effective systems for transferring patients in an emergency. Investment in education of midwives and gynaecologists will therefore be important in the future. The trend in maternal mortality is shown as a black line. The Millennium Development Goal target is the red line.

Source: Malawi Health Sector Strategic Plan 2011-2016, Ministry of Health, Government of Malawi Improved Health Training Education in Malawian Nursing Schools Independent Mid Term Review, 2009

EXAMPLE 11 SUPPORT TO EDUCATION INCREASES THE NUMBER OF HEALTH WORKERS AND IMPROVES HEALTH SERVICES IN MALAWI

Norway has contributed with direct support to the education of physicians and nurses in Malawi. The initiative has had a long-term perspective, and over time, the institutions have been strengthened and built up.

WHY: DIRE SHORTAGE OF HEALTH CARE WORKERS

Malawi is one of the world's poorest countries and the challenges in the health sector are immense. The shortage of health workers is critical and in 2004 the situation was so serious that a national emergency plan was prepared (Emergency Human Resource Programme). In 2004, Malawi had 1.1 doctors per 100,000 people. The proportion of nurses was 25.5 per 100,000. This was very low even compared with other African countries.

WHAT: FINANCIAL SUPPORT AND PROFESSIONAL COOPERATION

Norway has contributed with direct support to the education of physicians and nurses in Malawi. The earmarked investment is in addition to support for the national health sector programme. The initiative started in 2001 and has had a long-term perspective, with several subsequent agreements.

The College of Medicine at the University of Malawi has received Norwegian support since 2001. The support has been used for buildings and infrastructure, and for strengthening the medical school academically and administratively. A number of Norwegian universities and colleges collaborate with the College of Medicine. Support for the nursing colleges has been channelled through Norwegian Church Aid and its local partners since 2005, and is currently in its final period. The project will help Malawi to educate more nurses and strengthen the content of the programmes of study. Academic collaboration between Malawian and Norwegian nursing university colleges plays a key role.

Malawi's emergency plan for health workers has received broad support from donors and other partners. A number of stakeholders and partners have contributed. In particular, the UK Department for International Development (DFID) and the Global Fund to Fight AIDS, Tuberculosis and Malaria have been important.

How much: The College of Medicine at the University of Malawi received a total of NOK 75 million from Norway from 2001 to 2012. Cooperation to strengthen the colleges of nursing was funded with NOK 86 million from 2005 to 2009, while from 2010 to 2012 it was supported with NOK 23 million.

Norway is one of many donors to health staff initiatives in Malawi. In particular, the UK Department for International Development (DFID) and the Global Fund to Fight AIDS, Tuberculosis and Malaria have been important donors.

RESULTS: INCREASE IN THE NUMBER OF HEALTH WORKERS

Together with other donors, Norway has helped to build capacity to train more health workers, including more doctors and nurses. The total capacity for the education of doctors increased from 20 in 2004 to about 60 students a year in 2012. An evaluation report from 2010 shows that the number of doctors in the country increased from 43 in 2004 to 265 in 2009. In the autumn of 2012, the Ministry of Health in Malawi reported that Malawi had 450 doctors. This is the result of several different initiatives, not only those supported by Norway. The figure includes doctors from other countries working in Malawi.

The number of nurses in Malawi increased by 39 per cent from 3,456 in 2004 to 4,812 in 2009. This corresponds to an increase in the number of nurses per 100,000 people from 25.5 to 36.8. Together with other donors, Norway has contributed to the increase. Combined with strengthening other parts of the health system (see result example 10), this contributes to increased access to health care for the population. Some examples are that children with pneumonia who were treated in a health facility increased from about 20 per cent in 2004 to around 70 per cent in 2010, while the proportion of pregnant women receiving qualified obstetric care increased from 56 per cent in 2005 to 71 per cent in 2011. This in turn contributes to the reduction in maternal and infant mortality as described in Example 10

LESSONS LEARNED: DEVELOPMENT OF SUSTAINABLE HEALTH INSTITUTIONS TAKES TIME

Norway has followed two important principles for effective development cooperation that have yielded results with lasting importance in the partnership in Malawi.

A long-term perspective for support is crucial, especially with regard to the education of health professionals. This principle becomes particularly important in efforts to strengthen educational institutions. It takes time to establish sustainable institutions offering high-quality education. It also takes time to see results in terms of more health workers, which in turn provides improved healthcare and better health among the population.

It is also important to support the recipient country's own plans and priorities. This applies to the content of the education as well as the planning and utilization of the overall resources of the staff.

Sources:
Evaluation of Malawi's Emergency Human Resources Programme, Management Sciences for Health, 2010 Final Evaluation of the Health Sector Programme of Work (2004-2010), Euro Health Group, 2010
Norsk bistand til legeutdanning i Malawi [Norwegian development assistance to medical education in Malawi], Johanne Sundby and Robin Broadhead, Journal of the Norwegian Medical Association 21/2011
Norway/Sweden support to University of Malawi, College of Medicine. Review of phase 3 Human Resources Development in the College of Medicine Building on Success by Investing in People, 2009
Improved Health Training Education in Malawian Nursing Schools Independent Mid-Term Review, 2009

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Box 3.7. Increased access to safe abortion in Nepal

UNSAFE ABORTIONS ARE AMONG THE LEADING CAUSES OF MATERNAL MORTALITY WORLDWIDE

Unsafe abortions are a contributing factor to the high maternal mortality rates in many low- and middle-income countries, accounting for 13 per cent of the causes of maternal mortality worldwide. Unsafe abortions cause severe health problems, and women who perform abortions in countries where abortion is prohibited risk imprisonment. Efforts to give women the right and access to safe abortion services is sensitive in many countries since the abortion issue is related to political and religious beliefs, and is governed by law. Funding for combating unsafe abortions in developing countries may be difficult to obtain because many donor countries have laws against abortion.

CIVIL SOCIETY ORGANIZATIONS PUSH FOR CHANGES

Civil society organizations are engaged in advocacy for legislative changes, and document and provide information about the health impact of unsafe abortions. An example is International Pregnancy Advisory Services (IPAS). This is an international organization with experience of working against unsafe abortions in countries such as Vietnam and India. In Nepal, they worked closely with authorities to bring about a change in the law to make abortion legal. The law was passed in 2002.

Since the change in the law, Ipas has worked systematically with government authorities to increase health services including safe abortion as part of women's reproductive rights in Nepal. Today, safe abortion is offered in all 75 districts of Nepal, at 400 public and private clinics. In total, 50,000 health workers have been trained in primary health care and counselling regarding safe abortion.

Since 2002, approximately 500,000 women have undergone safe abortion in Nepal. In relation to abortion services, girls and women have obtained access to contraception. One important factor in information efforts to reach out to women in Nepal was a special logo created to indicate public and private clinics that offered abortion services. The logo has proved to be important in communication with women which cannot read or who have difficulty reading.

REDUCED MATERNAL MORTALITY

Since 200, Nepal's maternal mortality has been reduced from about 400 per 100,000 live births to 170 in 2010. A study shows that unsafe abortion was the leading cause of maternal mortality before the legalization of abortion in 2002. In 1994, about 117 women per 100,000 died because of unsafe abortions. Access to safe abortion is therefore one of the reasons that Nepal seems within reach of achieving Millennium Development Goal 5 of reducing maternal mortality by three quarters between 1990 and 2015.

Collaboration between health authorities and civil society organizations was key to creating change in Nepal. Organizations and health sector worked in partnership to help and treat women with life-threatening complications from unsafe abortions. This created a common understanding of the issues and a desire to end unsafe abortions. This was vital for the authorities in Nepal to change the legislation.

NORWEGIAN SUPPORT

Based on the good results, Norway granted funding to Ipas globally in 2008 in connection with Norway's increased commitment to women's rights. The organization has received annual funding from Norway since then, and support from Norway since 2008 totals NOK 32.5 million. In 2013, Norway signed a new three-year agreement with Ipas and Norwegian support has been substantially increased, from seven to eleven million kroner annually. The Norwegian support has helped to strengthen and extend the range of services available to women in Nepal.

Sources:
A better place for women: Abortion care in Nepal a decade after law reform (Ipas 2012) Maternal Mortality: Paradigm Shift in Nepal, Bhandari TR et al. NJOG/Vol 7/No.2/2012

EXAMPLE 12 NORWEGIAN CONTRIBUTIONS SPARK INDIAN INVESTMENTS FOR WOMEN AND CHILDREN

Cooperation between India and Norway has led to a significant decline in maternal and child mortality in four Indian states. Norwegian funds have triggered six times as much from India for the purpose, and have created positive ripple effects.

WHY: 900,000 NEWBORNS DIE IN INDIA EVERY YEAR

Every fifth child who dies before reaching the age of five is Indian. While child and infant mortality in India has been halved since 1990, the decline is considerably less in the neonatal period. In 2006, newborn mortality for India was 37 per 1,000 live births, and even higher in some states such as Rajasthan (45), Madhya Pradesh (51) and Odisha (52).

WHAT: NEW METHODS AND NEW TECHNOLOGY

In 2006, Norway and India entered a partnership to reduce child mortality, with a special focus on the neonatal period. The Norway India Partnership Initiative (NIPI) aimed to contribute new methods of care that India's own large-scale public health efforts could not provide. The goal was that the initiative would trigger greater and sustainable commitments from the Indian authorities to reduce child mortality. New methods, skills and technology were introduced in 13 selected districts in the three states with the highest infant mortality rates, as well as in the state of Bihar.

How much: The Norwegian contribution in 2006-2012 totalled NOK 330 million. The funding has led to appropriations from India of nearly two billion kroner, six times the size of the Norwegian contribution, to extend several of the measures.

RESULTS: NORWAY'S CONTRIBUTION HAS SAVED LIVES AND TRIGGERED LARGE NATIONAL INVESTMENTS

The independent evaluation from the first six years has concluded that the partnership provides added value to India's public health initiatives for women and children. This cooperation has helped to reduce neonatal mortality in all the states where initiatives are taking place: From an average of 49 deaths per 1,000 live births in 2006 to an average of 42 per 1,000 in 2010. Since it started, the partnership has provided care to more than 1.5 million premature or sick children who previously would not have had access to treatment to receive intensive care in hospital. At least 400,000 women have received extended follow-up during childbirth in hospitals, and about three million mothers and babies have been followed up at home after birth.

It is especially important that NIPI has contributed to put newborn health on the agenda even beyond the four states where the programme has been implemented. The goal that this support would lead to a stronger commitment from India to innovative care for mother and newborn has been achieved. This implies that the changes to which the partnership has contributed will be multiplied.

Intensive care units for newborns are now being established at all public district hospitals throughout the country. Previously, this type of services was only available in state capitals. The expansion means that a further two million sick newborns can receive treatment. Free of charge follow-up in the first six weeks after birth has become part of the duties of all health workers in villages across the country. The government is also establishing treatment centres for children with disabilities in all states based on the model introduced by the partnership. Resource centres for nursing and midwifery education are also being established in eight states based on the NIPI model in Bihar.

LESSONS LEARNED: POLITICAL ENGAGEMENT, FLEXIBILITY AND TIMING

The partnership was initiated at the highest political level, headed by Prime Ministers Stoltenberg and Singh. It was important to gain support for the initiative from the Ministry of Health in India. During the programme period, the emphasis has been responsiveness to the wishes of government authorities and acting quickly when changes were needed. The activities that have yielded the best results have been carried out by a project team that was established specifically for the partnership, managed by the UN. One of the strengths of the team has been that it did not need to take other organizational issues into account. The partnership was also established in the right place at the right time. India had just begun an escalation of public health services for poor women and children, and Norway's contribution created opportunities to try out effective new interventions.

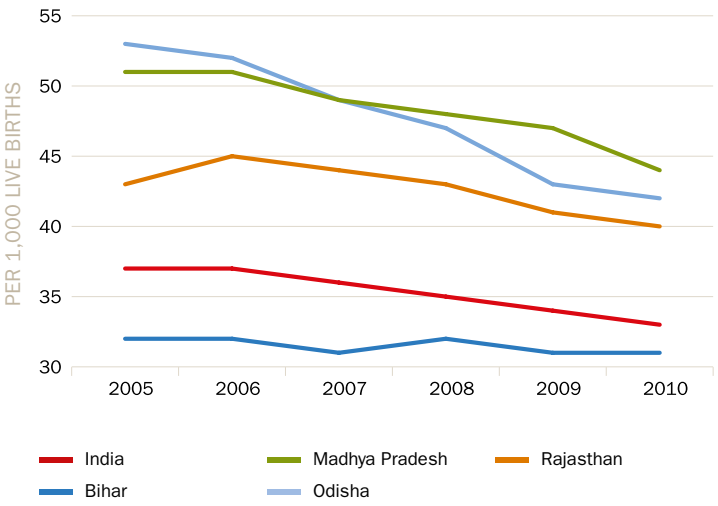
Indian authorities often highlight the cooperative model as an example for other partners to follow. For countries that have financial resources to invest in health care for the poorest people, but require expertise and new technology, the Norwegian-Indian partnership is an example of how small amounts can trigger major efforts to save lives.

Sources:
UN Inter-agency Group for Child Mortality Estimation, report on child mortality, 2013
Evaluation of the Norway-India Partnership Initiative for Maternal and Child Health, Norad, September 2013

TIL INNHOLD ↑

Mothers and children in the town of Alwar in Rajasthan have received health services through the Norwegian-Indian partnership.

FIGURE 3.11. NEONATAL MORTALITY RATE HAS FALLEN IN THE STATES WHERE NIPI WORKS



Source:
Sample Registration System, Office of the Registrar General and Census Commissioner, Government of India-
ple Registration System, Office of the Registrar General & Census Commissioner, Government of India

"To reduce the death toll, we take care of mother and child from the time she becomes pregnant until after the birth." S.P. Yadav, a doctor at the hospital in Alwar, Rajasthan in India. The Norway-India Partnership Initiative (NIPI) started in 2006 to support the Indian government in improving health services in rural areas.

Watch the video:

part 4

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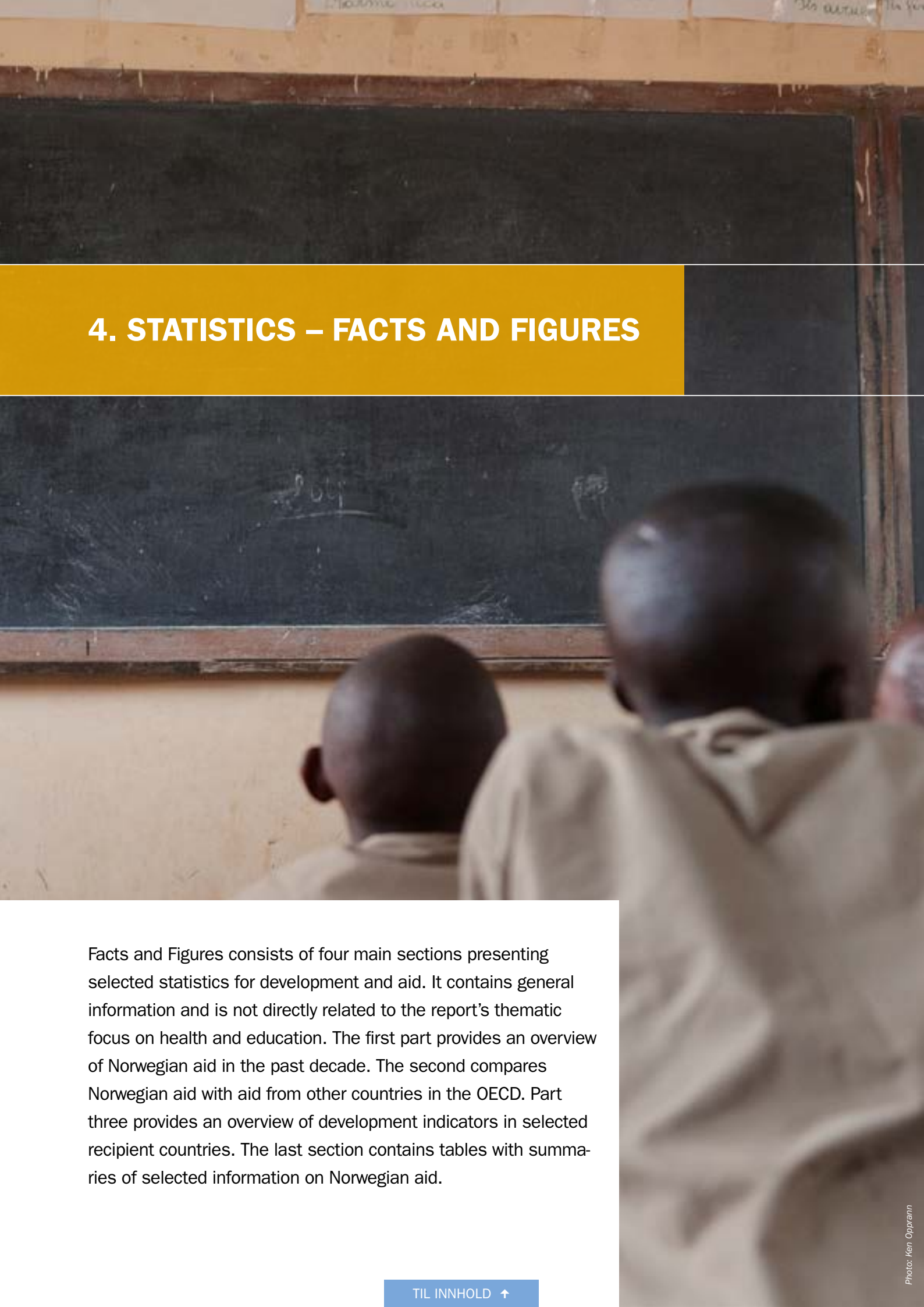
4. STATISTICS – FACTS AND FIGURES



Facts and Figures consists of four main sections presenting selected statistics for development and aid. It contains general information and is not directly related to the report's thematic focus on health and education. The first part provides an overview of Norwegian aid in the past decade. The second compares Norwegian aid with aid from other countries in the OECD. Part three provides an overview of development indicators in selected recipient countries. The last section contains tables with summaries of selected information on Norwegian aid.

Photo: Ken Opprann

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Photo: Ken Opprann

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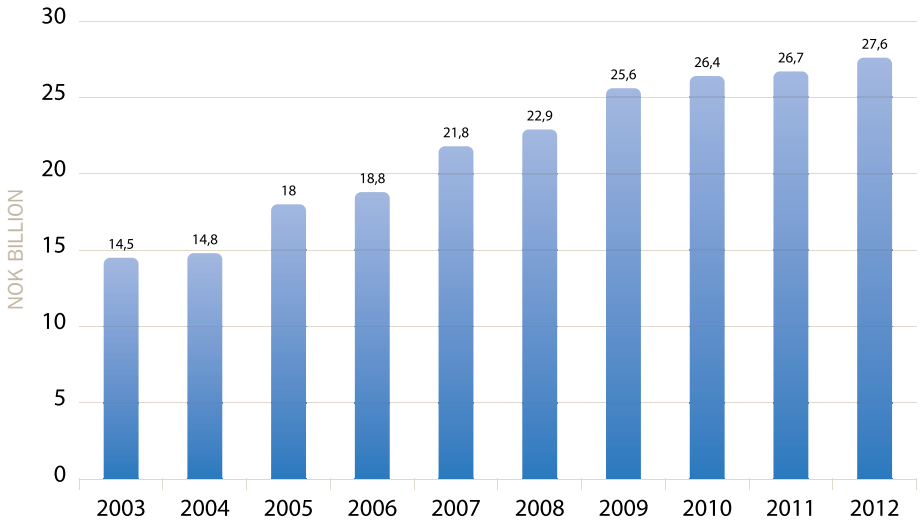
NORWEGIAN DEVELOPMENT ASSISTANCE

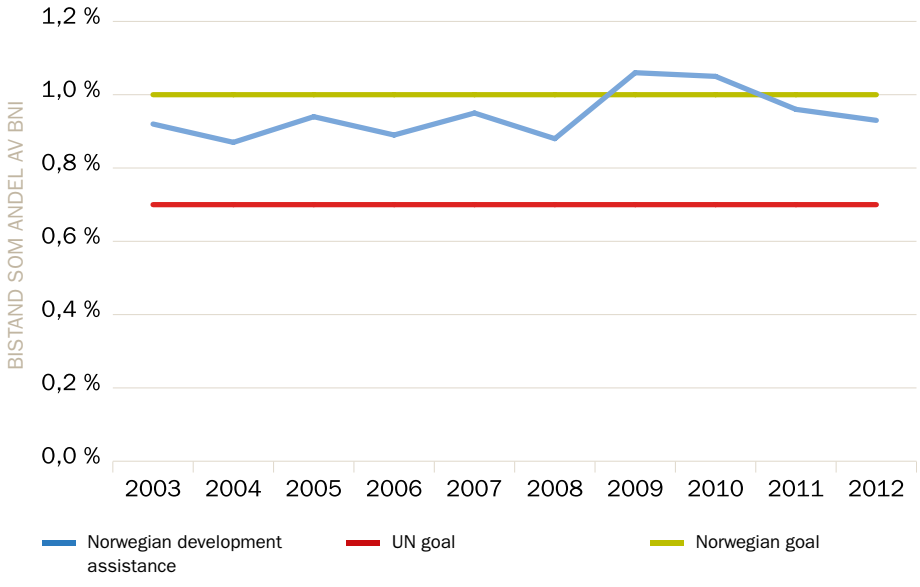
FIGURE 4.1. NORWEGIAN DEVELOPMENT ASSISTANCE HAS INCREASED



Norway's development assistance in 2003-2012

Source: Norad

FIGURE 4.2. NORWEGIAN DEVELOPMENT ASSISTANCE AMOUNTED TO 0.93 PER CENT OF GNI IN 2012



Norwegian development assistance as a percentage of GNI. 2003-2012

Source: Norad

In 2012, Norwegian development assistance totalled NOK 27.6 billion. This was an increase of 4 per cent from 2011. Over the last ten years, total development assistance has increased every year. If we consider development assistance in relation to the population, Norwegians contributed an average of NOK 5500 each in aid in 2012.

A stated political goal in Norway is that development assistance should constitute one per cent of gross national income (GNI). GNI is a measure of a country's total income. The target that one per cent is to be contributed in development assistance therefore ensures that the level of aid increases in line with Norway's development in income. In 2012, Norwegian development assistance amounted to 0.93 per cent of GNI. This is a decrease from 2011, when the level was 0.96 per cent. Norwegian development assistance exceeded one per cent of GNI in 2009 and 2010, and development assistance was over one per cent of GNI in 1982–1994. In addition to the goal that Norway should contribute one per cent of GNI, the UN has set a target that rich countries should provide more than 0.7 per cent of GNI as development assistance. Norway has been above that level every year since 1976.

Adjustment of Norwegian development assistance

In February 2013, Norway's development assistance was adjusted downward for 2010 and 2011. This was due to a change in Norway's reporting practices for funding of financing of the Climate and Forest Initiative in Brazil. The funds will still be regarded as development assistance, but they will be reported later. The consequence of the change was that Norway's development assistance was reduced by NOK 1.3 billion in 2010, and by 1.0 billion in 2011. A further result of this downward adjustment was that development assistance as a percentage of GNI fell from 1.10 to 1.05 per cent in 2010 and from 1.0 to 0.96 per cent in 2011.

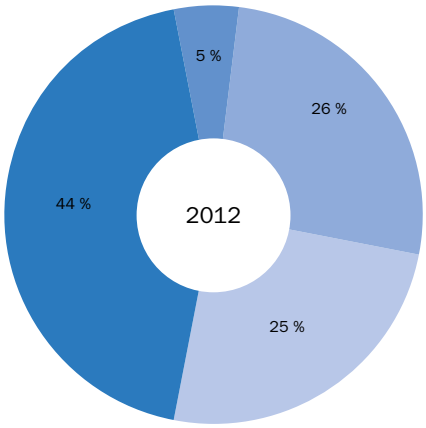
Of the 27.6 billion kroner that Norway contributes in development assistance, 44 per cent is earmarked for a specific geographical area. The development assistance that cannot be distributed by region consists of administrative costs associated with development assistance, core support to multilateral organizations and aid to global programmes.

Administrative expenses consist of costs incurred by Norad, the Ministry of Foreign Affairs, and the Peace Corps for management of development cooperation. In 2012, NOK 1.5 billion was spent on administration, representing 5.6 per cent of the development assistance. Over the past decade, the percentage of development assistance that has been used for administration has ranged from 4.9 to 5.6 per cent.

A multilateral organization is an organization in which states are members. Examples are the UN and the World Bank. In 2012, NOK 6.9 billion was provided as core funding to multilateral organizations. These funds go directly to the organizations without the money being tied to a particular country or type of project. Measured in kroner, core funding to multilateral agencies has been increasing over the last ten years, from NOK 3.9 billion in 2003 to NOK 6.9 billion in 2012. In relation to total development assistance, however, core funding to multilateral agencies has not shown an equivalent increase. Over the past ten years, this proportion has ranged between 24 and 28 per cent.

In 2012, NOK 7.1 billion was provided as development assistance that was not geographically specific. This represented 26 per cent of the development assistance. Examples of this include refugee spending in Norway and development assistance to thematic funds for education, health and the environment. Over the past ten years, this development assistance has increased sharply. In 2003, NOK 1.5 billion of development assistance was global, which amounted to ten per cent of the development assistance that year.

FIGURE 4.3. LESS THAN HALF OF NORWEGIAN DEVELOPMENT ASSISTANCE GOES TO A SPECIFIC COUNTRY OR REGION



Norwegian development assistance in 2012. NOK 27.6 billion.

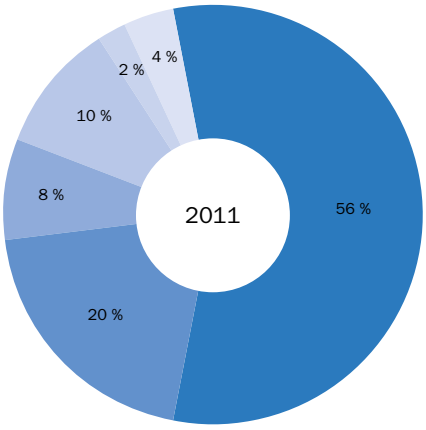
Source: Norad

The proportion of development assistance that was possible to distribute by country or region was 44 per cent in 2012. Since 2003, the proportion of development assistance that has been possible to distribute by region has fallen. Ten years ago, development assistance distributed by region accounted for 58 per cent of the total, 14 percentage points higher than in 2012.

Of the development assistance distributed by region, Africa is the continent that receives most Norwegian aid. Development assistance to Africa accounted for 20 per cent of total aid. This represents almost half of the aid distributed by region. In the past decade, Norwegian development assistance to Africa has increased from NOK 4.1 billion in 2003 to NOK 5.6 billion in 2012. Despite an increase in kroner, aid to Africa during this period has declined as a proportion of total aid, from 28 per cent in 2003 to 20 per cent in 2012.

Aid to Asia and the Americas respectively accounted for 10 and 8 per cent of total Norwegian development assistance in 2012. Asia has traditionally received substantial development assistance from Norway. America has previously received a relatively small proportion of the Norwegian aid, but the region has received a larger proportion since Norway started its climate and forest initiative. From receiving just under four per cent in 2003, the region is now receiving a proportion that is about twice as large.

FIGURE 4.4. AFRICA IS THE REGION THAT RECEIVES MOST DEVELOPMENT ASSISTANCE



Norwegian development assistance in 2012. NOK 27.6 billion.

Source: Norad

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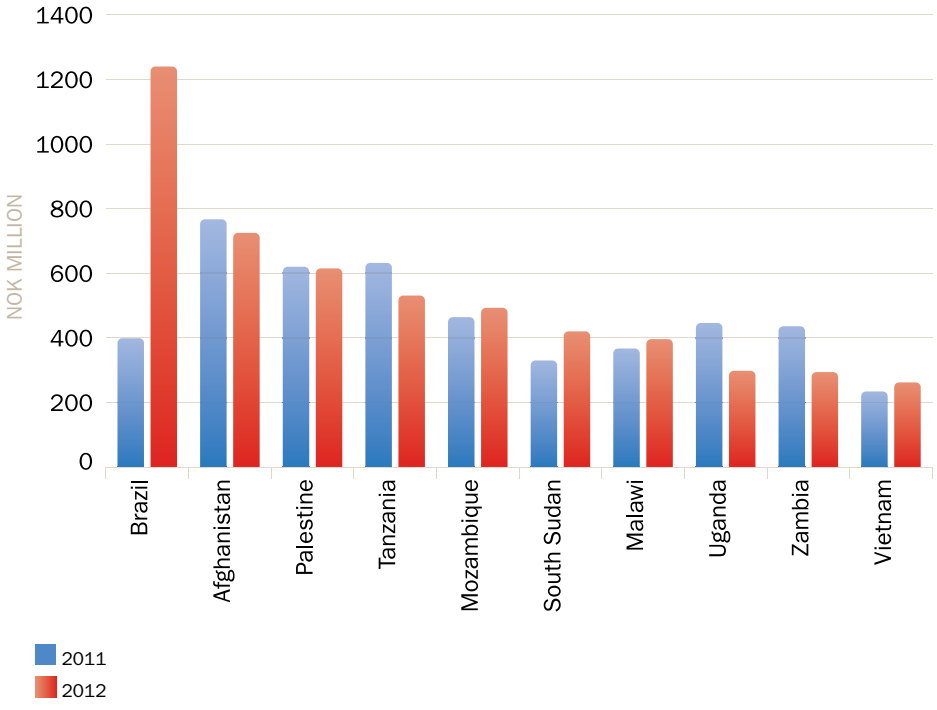
FIGURE 4.5. BRAZIL WAS THE LARGEST RECIPIENT OF NORWEGIAN DEVELOPMENT ASSISTANCE IN 2012



The ten countries that received the most Norwegian development assistance in 2012 compared with the development assistance they received in 2011.

Source: Norad

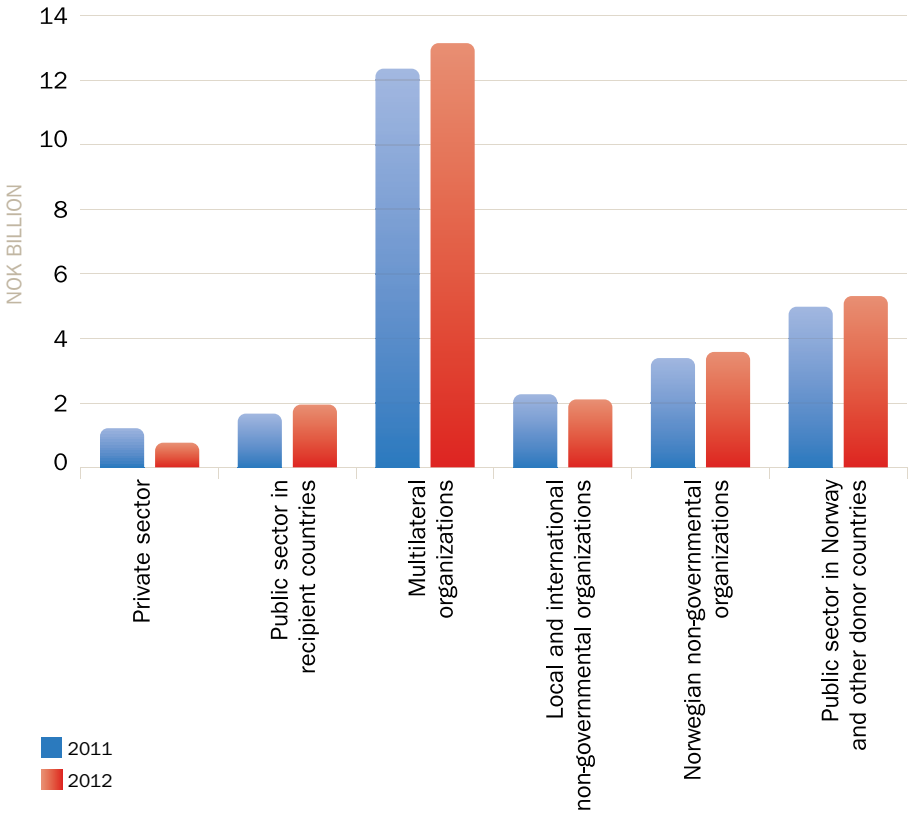
In 2012, Brazil was the country that received the most aid from Norway. Support to Brazil increased from NOK 407 million in 2011 to NOK 1248 million in 2012. Of the increase of NOK 842 million, NOK 460 million was related to Norfund's investments in the energy sector while NOK 363 million was related to the climate and forest initiative. Due to changes in how funding for forests is reported, the figures for 2011 are lower than has been reported previously. (See the text box on page 95).

Tanzania, Uganda and Zambia all had aid reduced by over NOK 100 million compared with 2011. Tanzania had a decrease in aid of NOK 102 million in 2012. Most of this decline can be attributed to reductions in budget support from NOK 260 million in 2011 to NOK 150 million in 2012. Aid to Zambia was NOK 142 million lower in 2011 than in 2012. The decrease is mainly due to reductions in Norfund's investments in the energy and banking sector. Norway's aid to Uganda declined by NOK 148 million from 2011 to 2012. Much of this reduction is associated with aid to the banking sector through Norfund and in Norwegian aid to the Ugandan authorities.

Norfund

Norfund is a state-owned investment fund that aims to foster business activities in developing countries. Norfund's investments are often on a scale that can lead to relatively large fluctuations in aid payments from year to year.

FIGURE 4.6. MULTILATERAL ORGANIZATIONS RECEIVED OVER NOK 13 BILLION IN 2012



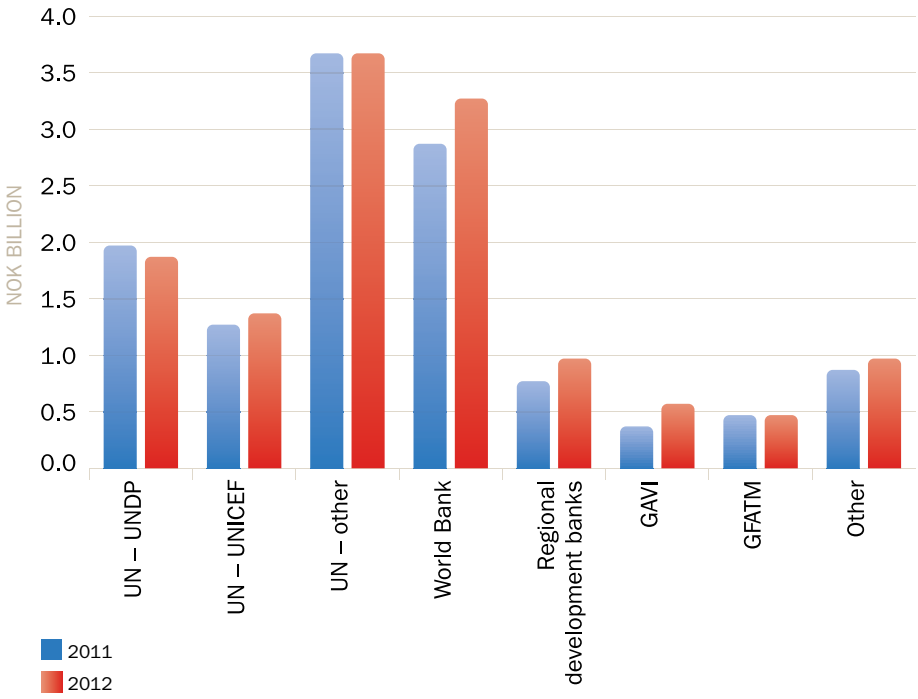
Norwegian development assistance by type of agreement partner in 2011 and 2012

Source: Norad

In 2012, multilateral organizations received NOK 13.3 billion in Norwegian development assistance. This is a combination of core funding and support for earmarked projects. This accounted for almost half of the total Norwegian development assistance in 2012. Norwegian non-governmental organizations received NOK 3.7 billion in aid, an increase of five per cent compared with 2011.

The private sector had the largest decline in both percentage and absolute terms. From 2011 to 2012, this aid was reduced by NOK 451 million, a decrease of 33 per cent. The reason for this decrease was that Norfund channelled significantly higher payments through the private sector in 2011 than in 2012.

FIGURE 4.7. THE UN RECEIVED NOK 7 BILLION IN NORWEGIAN DEVELOPMENT ASSISTANCE



Development assistance to multilateral organizations in 2011 and 2012
The figures for GAVI do not include IFFIm and AMC

Source: Norad

Of the multilateral organizations receiving development assistance from Norway, the UN agencies received the most. In 2012 Norway contributed NOK 7 billion in aid to the UN, which is at the same level as in 2011. Development assistance to the World Bank increased by 15 per cent from NOK 2.9 billion in 2011 to NOK 3.3 billion in 2012. Much of this increase consists of funds paid to the climate and forest initiative Forest Carbon Partnership Facility.

Support to the vaccine Alliance GAVI increased from NOK 429 million to NOK 606 million in 2012. Regional development banks received about 8 per cent of the aid to multilateral organizations in 2012. Compared with 2011, they received an increase of NOK 208 million, most of which went to the African International Bank for Reconstruction and Development. More information about Norwegian aid to multilateral organizations can be found in the appendix with tables on page 120.

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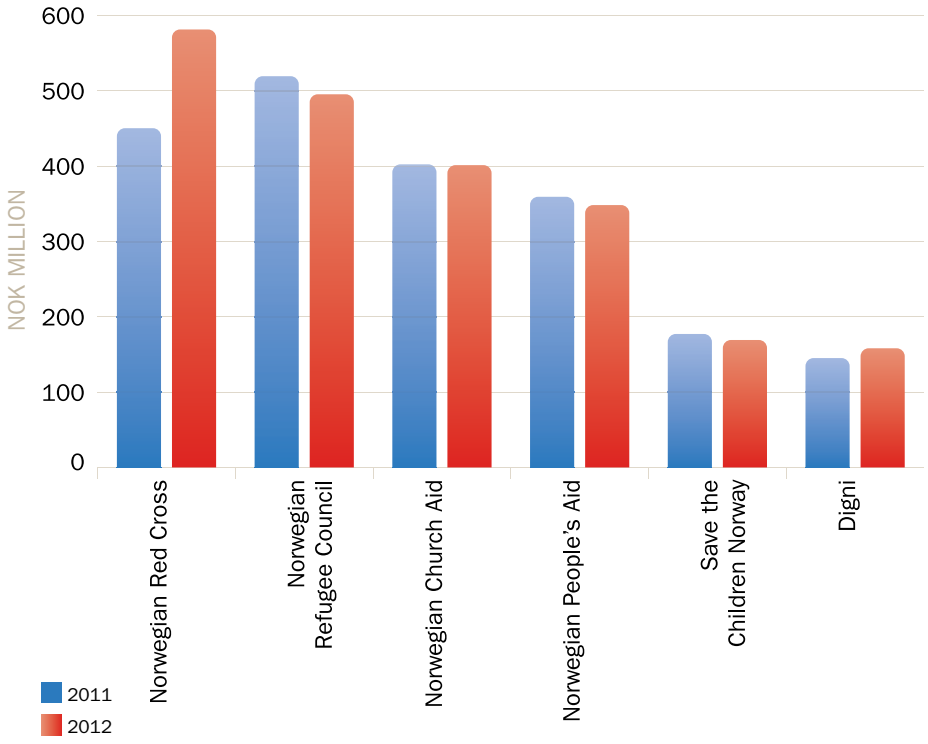
FIGURE 4.8. THE NORWEGIAN RED CROSS RECEIVED NEARLY NOK 600 MILLION IN AID

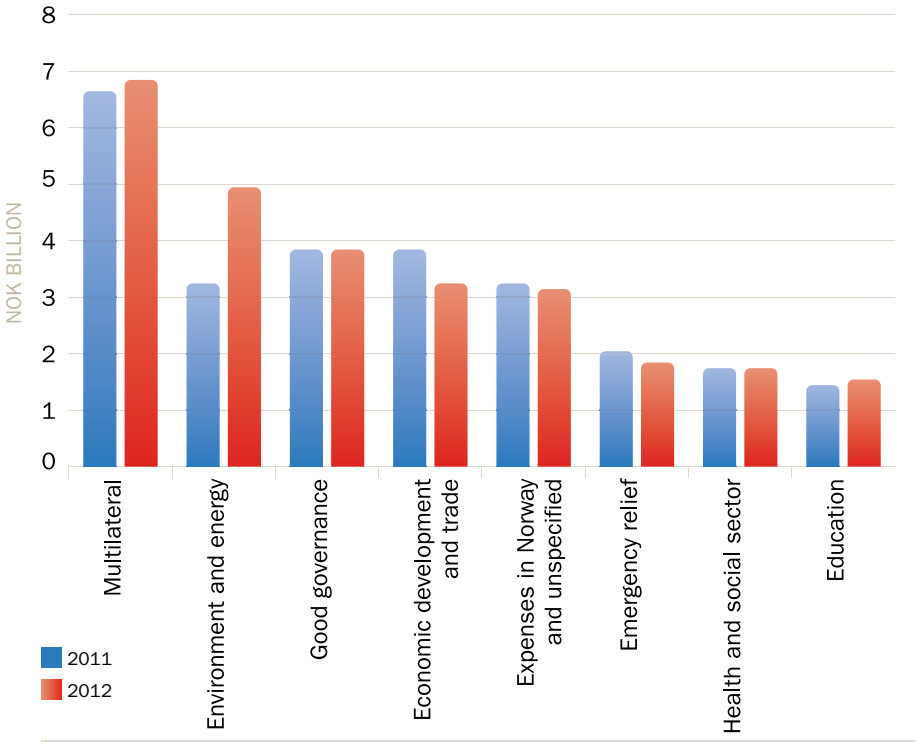


Development assistance to the six largest Norwegian non-governmental aid organizations in 2011 and 2012

Source: Norad

In 2012, Norwegian non-governmental organizations received NOK 3.7 billion. The six largest recipients received 59 per cent of the funds. These organizations have received about the same percentage every year for the last ten years. From 2011 to 2012, the Norwegian Red Cross received the largest increase in assistance among these organizations. The increase from NOK 456 million to NOK 587 million represents an increase of nearly 30 per cent. Much of this increase comprises funds contributed to emergency relief projects that were conducted in cooperation with the Red Cross internationally.

FIGURE 4.9. NOK 6.9 BILLION IS PROVIDED AS CORE SUPPORT TO MULTILATERAL ORGANIZATIONS



Norwegian development assistance by sector. 2011 and 2012.).

Source: Norad

In 2012, NOK 6.9 billion of Norwegian aid was provided as core funding to multilateral organizations. This accounted for 25 per cent of Norway's development assistance. Core support is general support that is not earmarked for a specific sector. NOK 5 billion was spent on environment and energy. This was an increase of 50 per cent from 2011. Norfund's investments in hydropower in Brazil and Chile as well as in the Climate and Forest Initiative represent a large proportion of this increase. Aid for trade and economic development was reduced by 16 per cent from 2011 to 2012. This reduction, amounting to NOK 637 million, can largely be explained by Norfund's lower investments in the banking sector in South Africa, Vietnam and Latin America. The sector Expenses in Norway and Unspecified decreased by 153 million because Norway had lower refugee expenses in 2012 than in the previous year. Refugee expenses declined for the third consecutive year in 2012. From 2009 to 2012, these expenses decreased from 2.5 billion to 1.3 billion.

Photo: Ken Opprann

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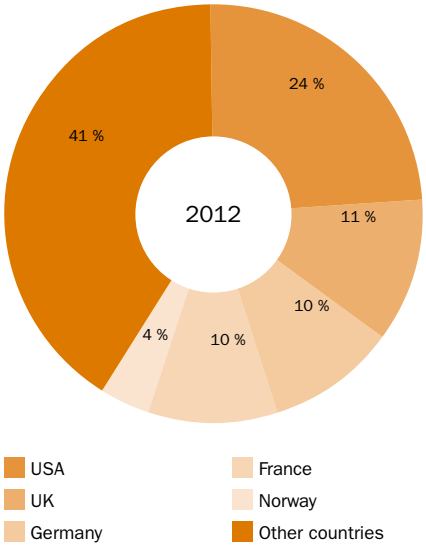
DEVELOPMENT ASSISTANCE FROM NORWAY AND OTHER DONOR COUNTRIES

This section compares Norwegian development assistance with countries that are members of the OECD Development Assistance Committee (DAC). OECD/DAC consists of 26 countries and the EU and is a forum for the major donors of aid to discuss development cooperation policies. These countries have traditionally been the largest donors of development assistance.

FIGURE 4.10. NORWAY CONTRIBUTES 3.8 PER CENT OF THE OECD/DAC COUNTRIES' TOTAL AID

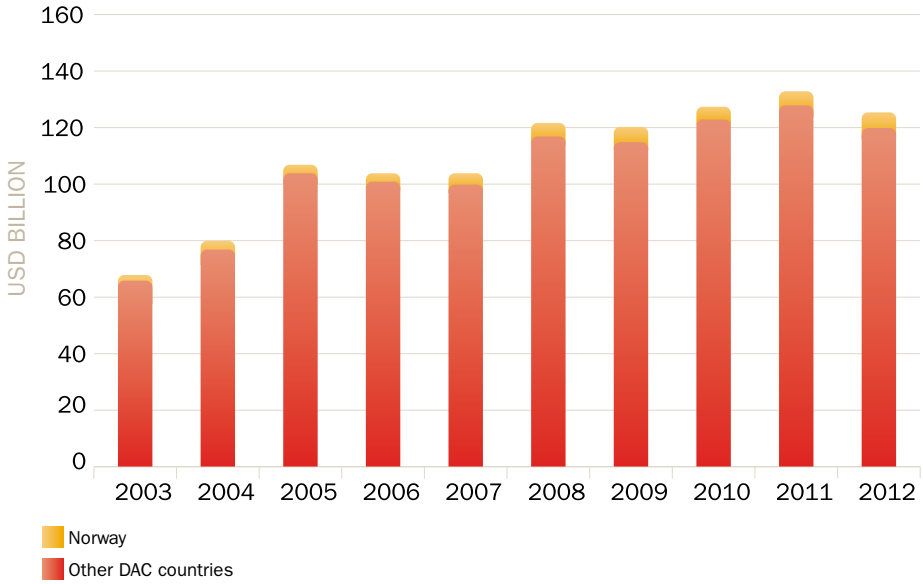


Development assistance contributed by OECD/DAC countries. 2012

Source: OECD/DAC

In 2012, the Member States of the OECD/DAC contributed a total of USD 126 billion in aid (approximately NOK 730 billion). Of this, the Norwegian contribution amounted to 3.8 per cent. In comparison, Norway's population makes up 0.5 percent of the population in the OECD countries. The United States, with a share of 24 per cent, was the country that provided the most development assistance of the OECD/DAC countries. The United Kingdom, Germany and France each contributed about 10 per cent of the aid from the OECD/DAC countries.

FIGURE 4.11. NORWAY'S SHARE OF DEVELOPMENT ASSISTANCE HAS INCREASED, BUT IT IS STILL SMALL



Development assistance contributed by OECD/DAC countries. 2012

Source: OECD/DAC

In 2003-2012, the total development assistance from OECD/DAC countries increased from USD 70 billion to USD 126 billion. During the same period, Norway's share increased from 2.9 per cent to 3.8 per cent.

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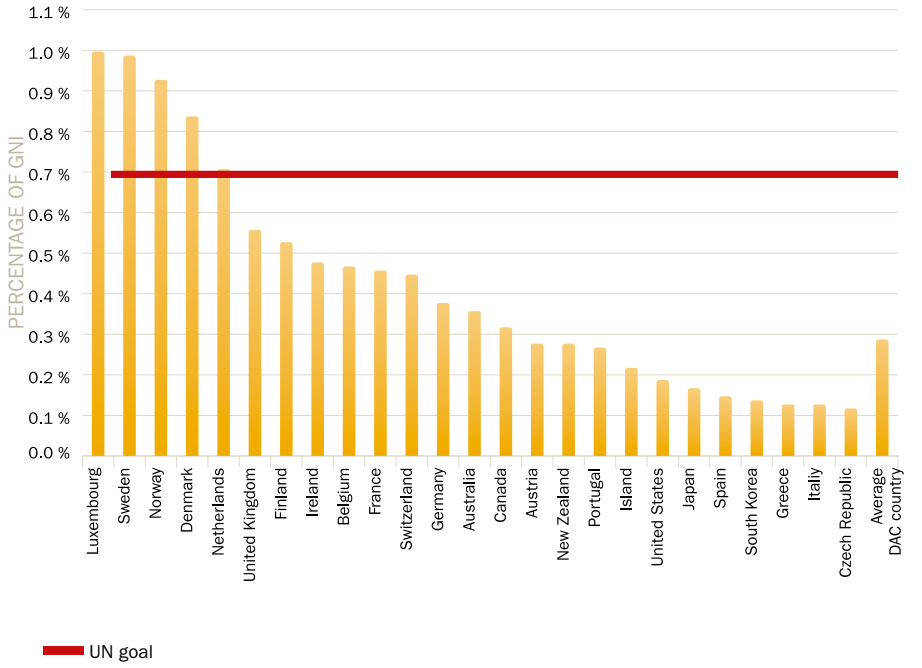
FIGURE 4.12. FIVE COUNTRIES CONTRIBUTE MORE THAN 0.7 PER CENT OF GNI IN DEVELOPMENT ASSISTANCE

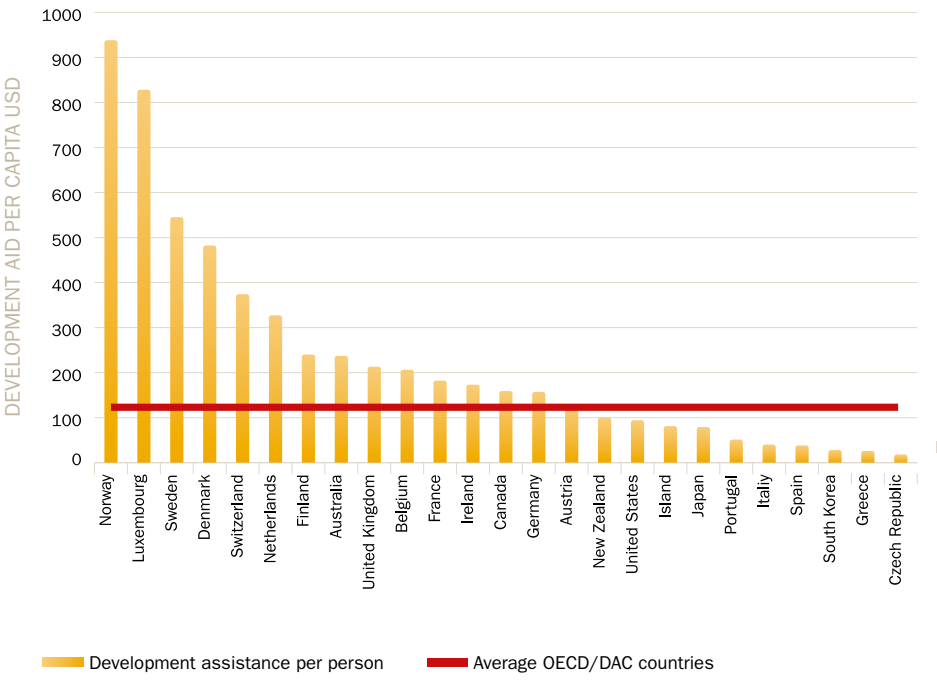


Development assistance as a percentage of GNI in the OECD/DAC countries. 2012

Source: OECD/DAC

There is a great difference in the size of the economies of the various OECD/DAC countries. To get an overview of how much a country contributes to development assistance in relation to the size of the economy, aid can be calculated as a proportion of gross national income (GNI). The UN has set a target that rich countries should contribute 0.7 per cent of their GNI in development assistance. In 2012, Luxembourg, Sweden, Norway, Denmark and the Netherlands were the only countries in the OECD that achieved this goal. Luxemburg contributed one per cent of GNI, which was the highest percentage. Norway contributed 0.93 per cent of GNI in aid. Norway has met the UN target of 0.7 per cent of GNI in aid since 1976. On average, OECD/DAC countries contributed 0.29 per cent of GNI in development assistance.

FIGURE 4.13. NORWAY CONTRIBUTES MOST AID PER CAPITA



Development assistance per capita in the OECD/DAC countries. 2012

Source: OECD/DAC

Another way to look at how much each country contributes is to compare the per capita amount donated in development assistance. On average, the OECD/DAC countries contributed USD 128 per capita in 2012. Norway contributed an average of USD 940 per capita, which is more than seven times the OECD/DAC average. The combination of a strong economy, a relatively large budget for development assistance and a small population means that Norway contributes the highest level of development assistance per capita. Luxembourg and Sweden, with an average contribution of USD 830 and USD 550 per capita respectively, were among the three countries that contributed the most development assistance in relation to their population.

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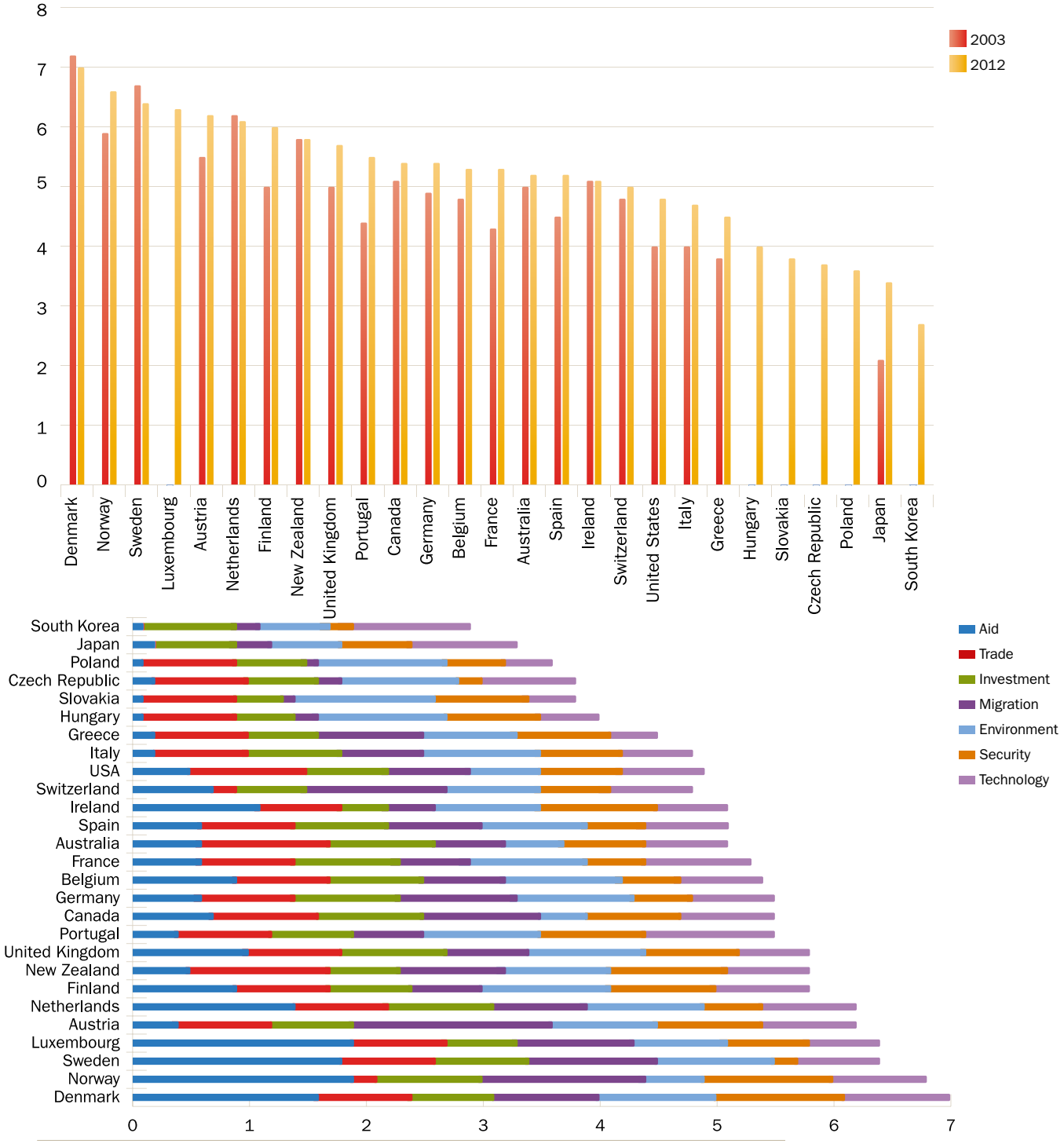
FIGURE 4.14. DENMARK IS AT THE TOP OF THE COMMITMENT TO DEVELOPMENT INDEX



Commitment to Development Index. Comparison 2003 and 2012 (top) and categorized in 2012 (bottom)

Source: Center for Global Development

Development assistance is only one of several factors that affect development. The Center for Global Development has created an index that, in addition to development assistance, accounts for the contributions of different donor countries to development through trade, investment, migration, the environment, security and technology.

The Scandinavian countries set themselves apart with policies that have a strong focus on promoting development. Sweden, Norway and Denmark rank at the top of the list of donor countries' development policies. In 2012, Norway scored high on most indicators except trade. High tariff barriers and agricultural subsidies cause Norway's trade policies to be ranked as one of the worst three of the 27 countries included in the index. Norway has no tariff barriers for the least developed countries, but because this only applies to some developing countries, it is not sufficient to boost Norway on the trade component of the index.

The Commitment to Development Index was first calculated in 2003. Since 2003, Norway has had a steady improvement in its score on the index. From 2011 to 2012, Norway's overall ranking rose from number four to number two.

Photo: Ken Opprann

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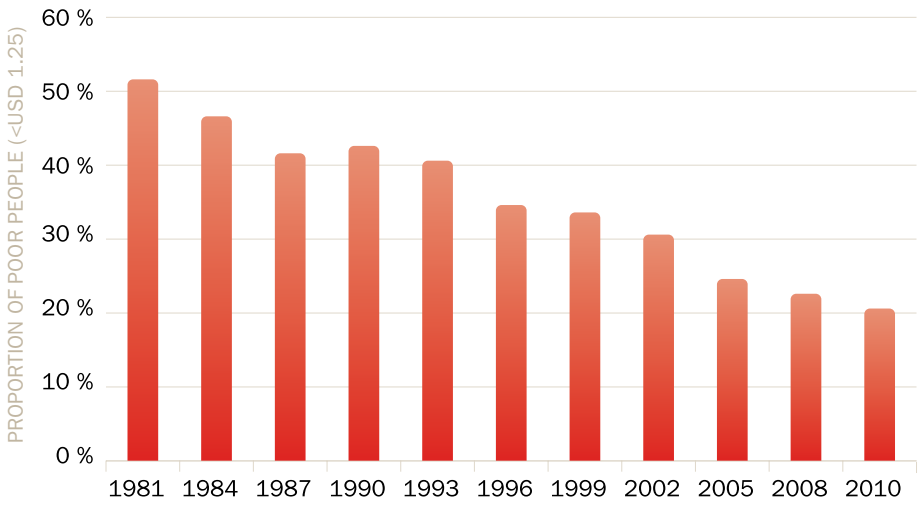
THE DEVELOPMENT SITUATION IN RECIPIENT COUNTRIES

Collection of data is often relatively expensive. In developing countries and regions that are characterized by political instability, collection of data may be too costly or too risky. Many of the statistics are therefore not only based on collected information, but also on calculations. The advantage of calculating statistics is that this provides more complete and up-to-date information on the development situation in a country. However, these calculations still present challenges. The figures are not exact and they may be unstable. Updating of methodology and changes in the basis for calculations may lead to changes in the numbers. Sometimes these changes can be substantial.

This section presents selected statistics for developing countries. The statistics cover the areas of poverty and distribution, health, education and governance. For several indicators, there are no complete statistics for all countries. In some cases, the figures in this section of the report will therefore cover completely different time spans and countries. The graphs focused on individual countries are based on the largest recipients of Norwegian development assistance.

POVERTY AND DISTRIBUTION

FIGURE 4.15. THE PERCENTAGE OF PEOPLE LIVING ON LESS THAN USD 1.25 A DAY IS FALLING

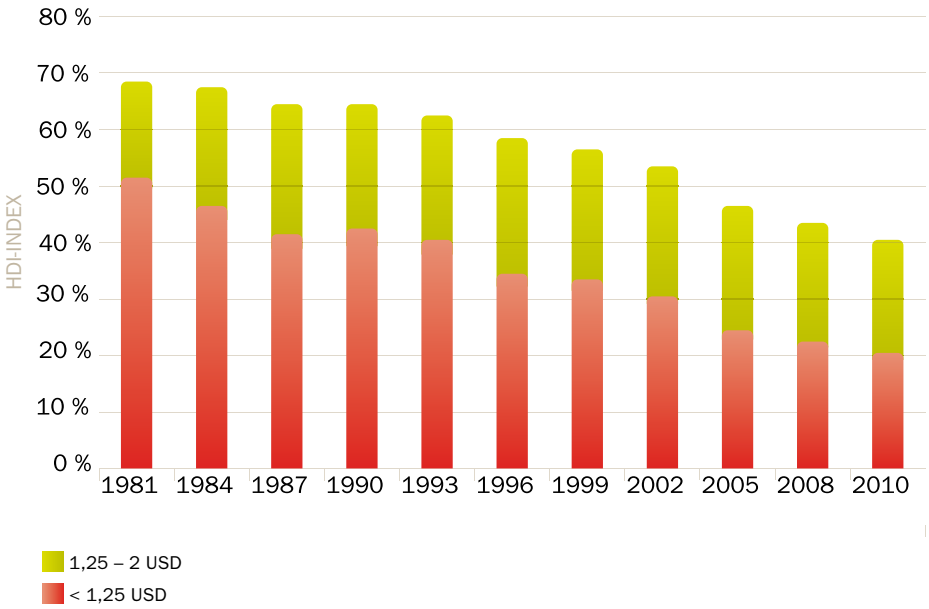


Percentage who live on less than USD 1.25 a day

Source: World Bank

There are many different ways to measure poverty. One of the most common methods is to look at the proportion of people living on less than USD 1.25 a day. In developing countries, the proportion of people living in extreme poverty fell from 52 per cent in 1981 to 21 per cent in 2010. Much of this reduction is a result of strong economic growth in China and India. Both countries have developed from low-income countries to middle-income countries. Despite this, China and India are the countries with the highest number of poor people in terms of the number of individuals.

FIGURE 4.16. 40 PER CENT OF THE WORLD'S POPULATION LIVES ON LESS THAN USD 2 PER DAY

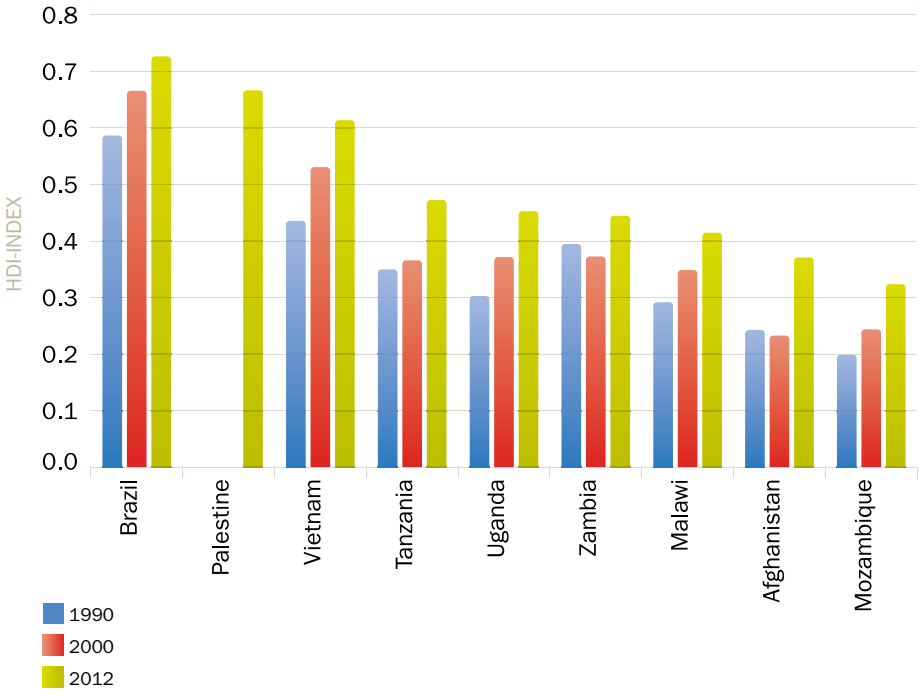


Percentage who live on less than USD 2 a day

Source: World Bank

If the concept of poverty is extended to include more than the people living in extreme poverty, it is common to include everyone who lives on less than USD 2 a day. In 1981, 70 per cent of all people in developing countries lived on less than USD 2 per day. In 2010, this proportion had fallen to 41 per cent. This reduction is clear, even though it is not as strong as the decline in the proportion living on less than USD 1.25 per day.

FIGURE 4.17. WELL-BEING IS INCREASING

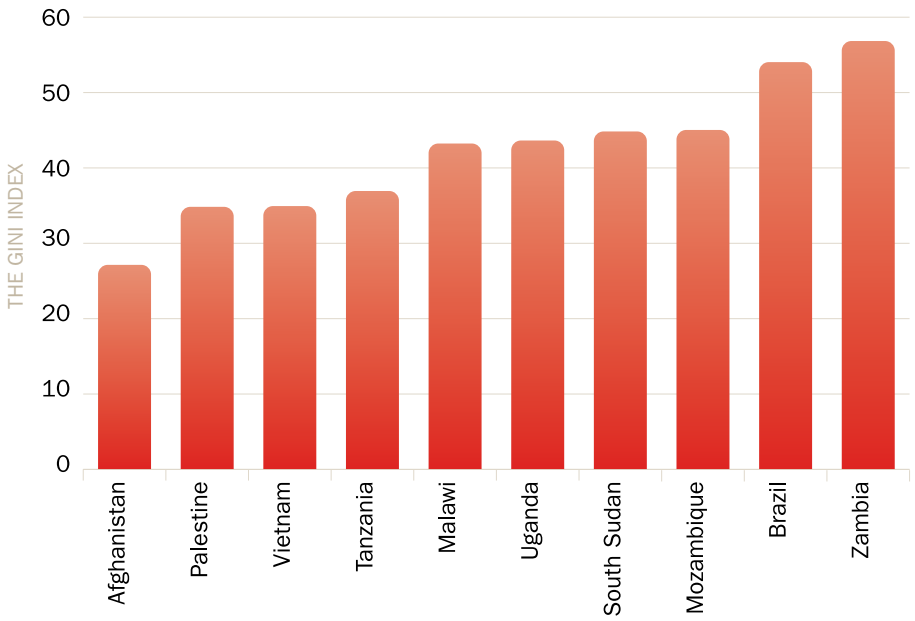


Human Development Index 1990-2012

Source: Human Development Report

The Human Development Index (HDI) provides an overview of the level of human well-being in different countries. The index combines a number of indicators that measure health, education and economic prosperity. The index has a value between 1 and 0, where 1 is the highest level of development. In developing countries, there is a general trend towards increasing levels of human welfare. This trend also applies to the countries that received most development assistance from Norway. All the selected countries have a higher level of human well-being in 2012 than they had in previous years. Among the selected countries, Mozambique has the lowest level of development, with a value of 0.33, ranking the country as number 185 in the index. Brazil is highest with a value of 0.73, which places Brazil in 85th position among the countries in the world. In comparison, Norway has a score of over 0.9 and has been at the top of the HDI for several years.

FIGURE 4.18. HIGH INEQUALITY IN ZAMBIA AND BRAZIL



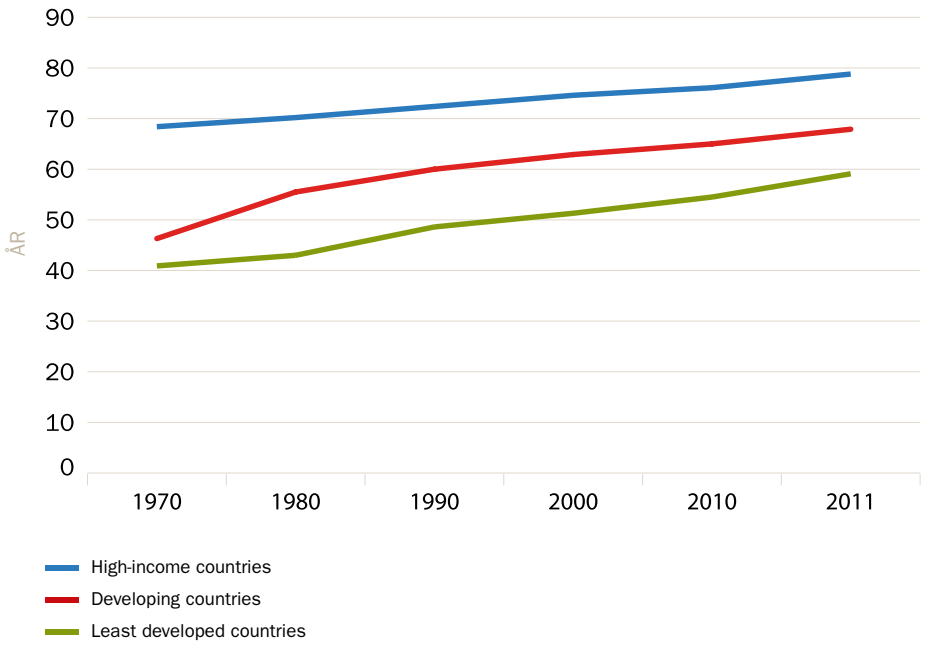
Gini index – latest available figures. 2007-2010

Source: World Bank

The Gini index indicates how resources are distributed in a society, and measures the degree of inequality between rich and poor. The index is expressed as a number between 0 (everyone has the same income) and 100 (one person has all the income). The countries with the lowest inequality in the world have a Gini index of about 25, while the most unequal societies have a value of about 60. Brazil is one of the countries in the selection that has traditionally had the highest level of inequality, but the trend since 2001 has been towards greater equality. In 2001, the Gini value was 60. In recent years it has fallen below 55. In Zambia, the trend has been in the opposite direction. In 2003, the Gini index for Zambia was 42. The value increased to 57 in 2010, making it the country in the selection with the greatest inequality. The country with the lowest inequality in the selection is Afghanistan, where the Gini index is 28. This is higher than Norway, which has a Gini value of 26, but is lower than in many OECD countries.

HEALTH

FIGURE 4.19. LIFE EXPECTANCY IS INCREASING

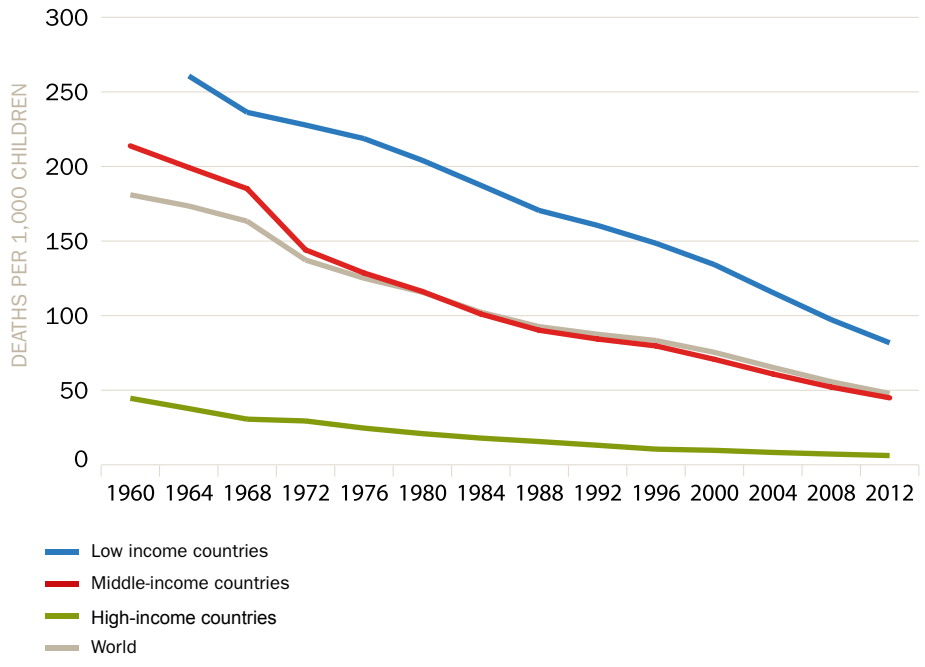


Life expectancy at birth. 1960-2011

Source: World Bank

In developing countries, life expectancy has increased significantly since 1970. Rich countries have also experienced increases in life expectancy, but this trend has not been as pronounced as the improvements in low-income countries. In 1960, life expectancy in developing countries was 47 years. By 2011, this had increased to 68 years, and it is steadily approaching the life expectancy in rich countries. In 2011, life expectancy in developing countries was at almost the same level as it was in rich countries in 1960. There is a similar positive trend if one looks solely at the least developed countries, where life expectancy rose from 40 years in 1960 to 60 years in 2011. Although the trend in these countries is positive, they remain at a level that is significantly lower than in rich countries. In comparison, life expectancy in Norway was 81 years in 2011.

FIGURE 4.20. CHILD MORTALITY IS FALLING



Deaths among children under 5, per 1000. 1960-2012

Source: World Bank

Child mortality is measured by the proportion of children who die before they are five years old. In most countries, child mortality is falling. This is one of the reasons that life expectancy has increased. The largest decline is in the poorest countries, where child mortality fell from 273 per 1,000 in 1961 to 82 per 1,000 in 2012. One of the Millennium Development Goals of the UN is that child mortality will be reduced by two-thirds from 1990 to 2015. Despite a significant decline in child mortality, this will not be sufficient to meet the Millennium Development Goal.

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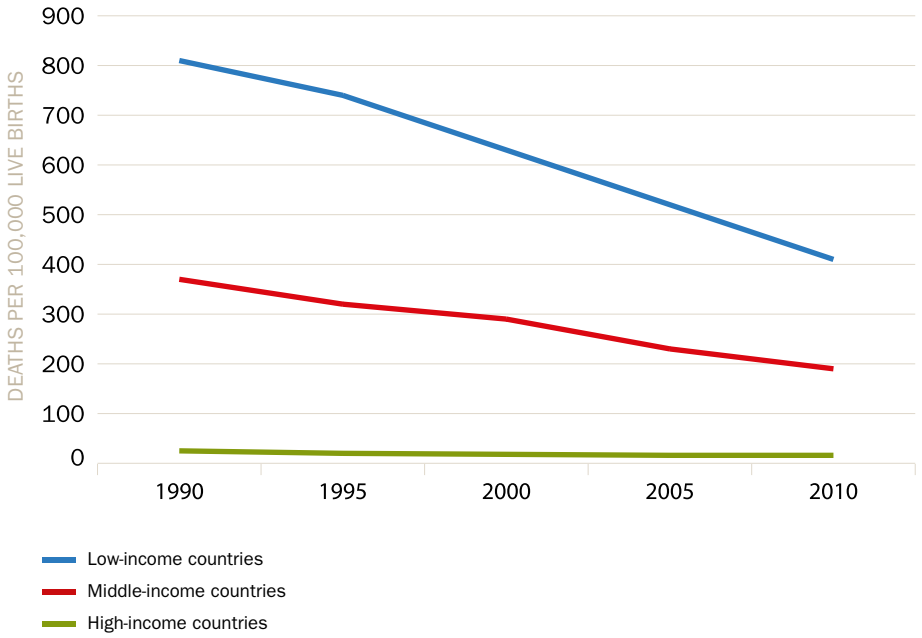
FIGURE 4.21. MATERNAL MORTALITY IS FALLING FASTEST IN LOW-INCOME COUNTRIES

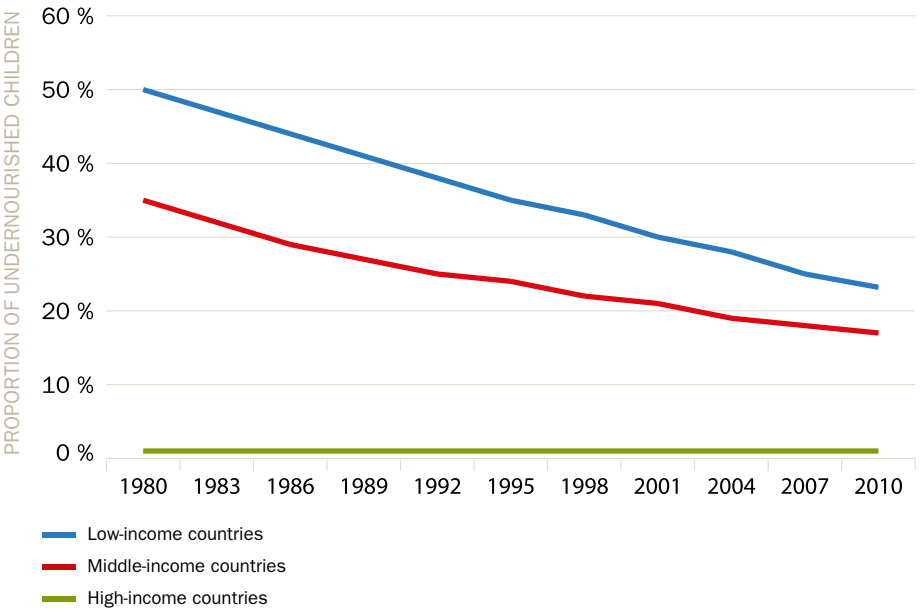


Maternal mortality ratio per 100,000 births. 1990-2010

Source: World Bank

The UN Millennium Development Goal number five is to reduce the maternal mortality ratio by three-quarters. Maternal mortality is measured by looking at the number of deaths related to pregnancy per 100,000 births. From 1990 to 2010, the maternal mortality rate has declined by nearly half. During the period, maternal mortality fell from 810 to 410 in low-income countries and from 370 to 190 in middle-income countries. If the Millennium Development Goal is to be achieved, the level in 2010 must be halved again before 2015.

FIGURE 4.22. FEWER CHILDREN ARE UNDERNOURISHED

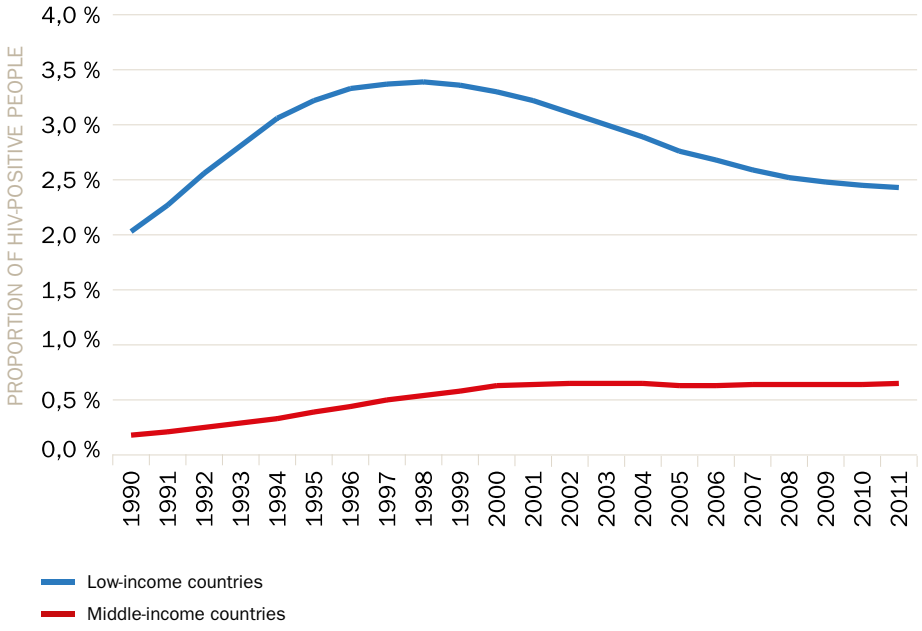


Undernutrition. Percentage of underweight children under 5 years of age. 1980-2011

Source: World Bank

Undernutrition among children is a major obstacle to development. If a child is undernourished over time, this will affect the child's ability to complete an education and to function in the workplace. The percentage of undernourished children has declined significantly since 1980. In both low-and middle-income countries, the proportion of undernourished children has been halved in the last 30 years. In low-income countries, the proportion fell from 50 per cent in 1980 to 22 per cent in 2012, while in middle-income countries it fell from 35 per cent to 16 per cent during the same period.

FIGURE 4.23. THE PROPORTION OF HIV-POSITIVE PEOPLE HAS BEEN STABILIZED

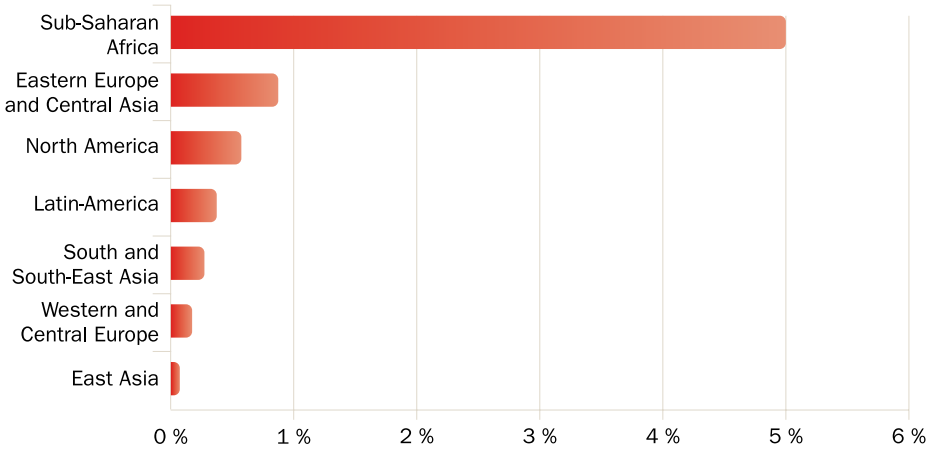


Percentage of HIV-positive people aged 15-49. 1990-2011

Source: World Bank

One of the world's greatest health challenges is the HIV/AIDS epidemic. The percentage of HIV-positive people aged 15-49 increased during the 1990s. The largest percentage increase was in the low-income countries. This proportion has decreased since the late 1990s. In middle-income countries, the percentage increase has been smaller than in low-income countries, but they have not experienced a decline in the 2000s equivalent to that of the low-income countries. If one looks at both low- and middle-income countries together, the proportion of HIV-positive people aged 15-49 has remained relatively stable at 0.87 per cent since 2005. In 2010, about 34 million people were HIV-positive and 1.2 million people died from the disease.

FIGURE 4.24. THE MAJORITY OF HIV POSITIVE PEOPLE ARE IN SUB-SAHARAN AFRICA



Percentage of HIV-positive people aged 15-49 in selected regions. 2011

Source: UNAIDS

The HIV epidemic has hit Sub-Saharan Africa significantly harder than other regions. In 2011, five per cent of people aged 15-49 in Sub-Saharan Africa were HIV positive. This is significantly higher than other regions, where the proportion is less than one per cent.

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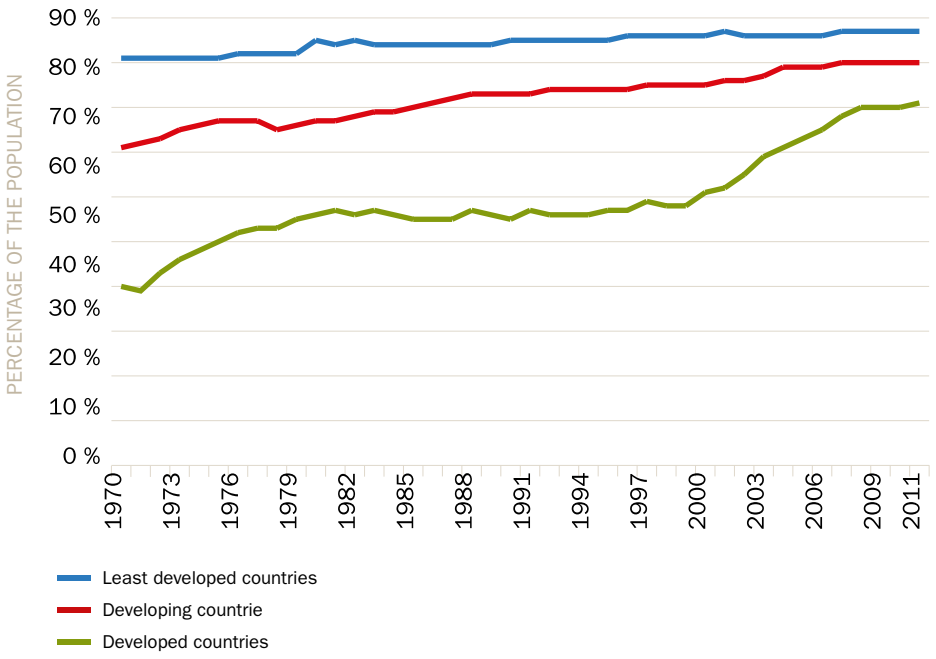
EDUCATION

FIGURE 4.25. THE PROPORTION OF CHILDREN WHO RECEIVE SCHOOLING IS INCREASING IN LOW-INCOME COUNTRIES

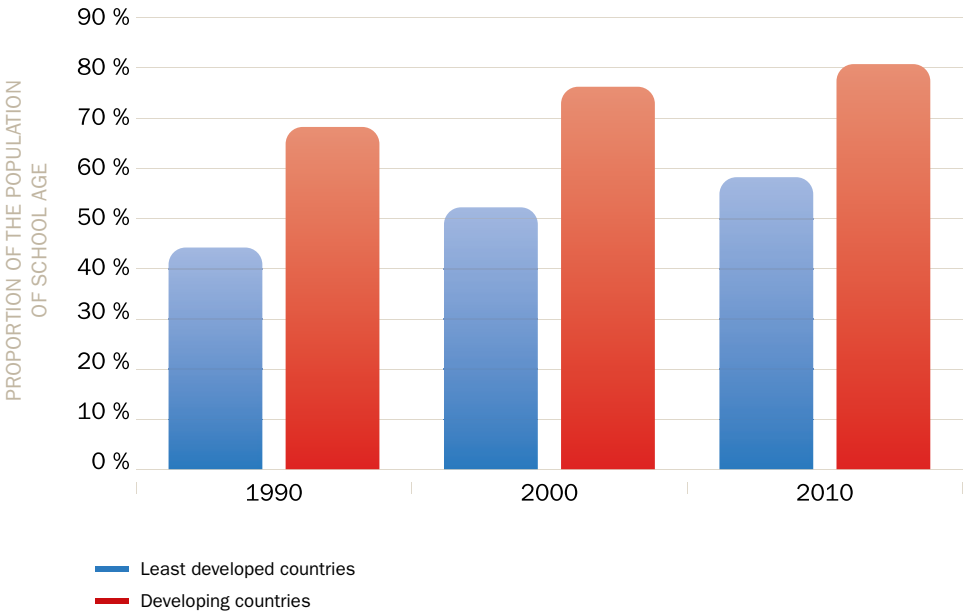


Proportion of children enrolled in primary school. 1970-2011

Source: World Bank

The UN's second Millennium Development Goal is to give everyone access to education. The trend shows that an increasing number of people are receiving primary education. The greatest improvements in the proportion who have access to primary education are in low-income countries. In 1970, 40 per cent of children in low-income countries had access to primary education and the proportion increased to about 55 per cent in the 1980s. Since the launch of the Millennium Development Goals in 2000, the proportion of children in low-income countries with access to education has increased to over 80 per cent in 2011.

FIGURE 4.26. MORE PEOPLE CAN READ AND WRITE



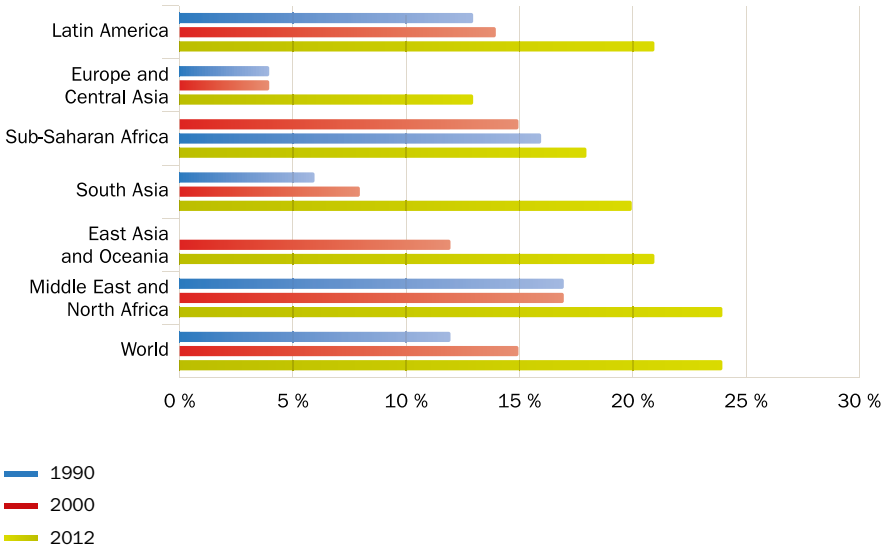
Adult literacy rate (% age 15 and above)

Source: World Bank

There has been a gradual improvement in the proportion of people over 15 who can read and write. For developing countries as a whole, the literacy rate has increased from just under 70 per cent in 1990 to just over 80 per cent in 2010. If one looks solely at the least developed countries, the proportion is considerably lower. Although the literacy rate has increased in this group as well, it was 60 per cent in 2010.

GOVERNANCE

FIGURE 4.27. WOMEN'S REPRESENTATION IN PARLIAMENTS IS NCREASING

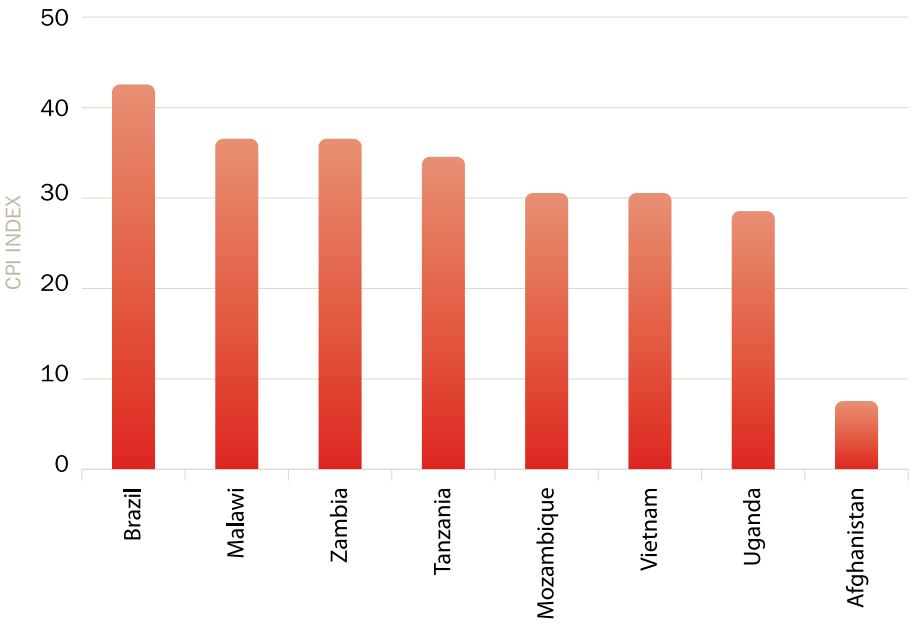


Percentage of women in parliament from 1990 to 2012. Selected regions

Source: World Bank

There is a general tendency towards increasing representation of women in national parliaments. Although the proportion of women in Parliaments worldwide is 21 per cent, this amounts to a significant increase. The most pronounced increase has been in the last 12 years, when the proportion of women rose from 14 to 21 per cent. The region with the lowest proportion of women in government is the Middle East and North Africa, but although the proportion was only 13 per cent in 2012, this is the region with the greatest progress since 2000. From 2000 to 2012, the proportion of women in Parliament more than tripled.

FIGURE 4.28. AFGHANISTAN PERCEIVED AS MOST CORRUPT



Corruption Perceptions Index (CPI). 2012

Source: Transparency International

Transparency International publishes the Corruption Perceptions Index every year. The CPI draws on data from a variety of sources to provide an indication of the perceived level of public-sector corruption in a country. Because corruption is illegal, it is difficult to measure directly. The index does not measure actual corruption, but is based on perceptions of corruption levels. The index has a scale from 0 to 100, where 0 is most corrupt. Of the countries that receive most Norwegian aid, there is generally a perception that the degree of corruption is high. Afghanistan stands out as one of the most corrupt countries in the world. With a score of 8 on the Corruption Perceptions Index, Afghanistan ends up at the bottom of Transparency International's list. Brazil, which is considered the least corrupt country in the selection, has a score of 43 and is ranked in the 69th position. In comparison, Norway and several OECD countries scored over 80 on the Corruption Perceptions Index.

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Photo: Ken Opprann

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Photo: Ken Opprann

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TABLES

Table 1. Norwegian development assistance. Selected figures 2003-2012

Indicator	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Development assistance NOK million	14,469	14,815	17,995	18,827	21,808	22,862	25,624	26,424	26,653	27,644
Development assistance USD million	2,044	2,198	2,794	2,935	3,723	4,006	4,081	4,372	4,756	4,754
Percentage of OECD countries' development assistance	2.9 %	2.7 %	2.6 %	2.8 %	3.6 %	3.3 %	3.4 %	3.4 %	3.6 %	3.8 %
Development assistance per capita, NOK	3,161	3,216	3,878	4,022	4,604	4,764	5,274	5,370	5,346	5,473
Development assistan-ce/GNI %	0.92	0.87	0.94	0.89	0.95	0.89	1.06	1.05	0.96	0.93
Number of recipient countries	112	113	115	113	109	111	114	113	112	111

Table 2. Norwegian development assistance by region from 2003-2012. NOK million

Region	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Africa	4,104	4,226	4,617	4,984	5,344	5,862	5,679	5,736	6,063	5,558
America	544	583	682	697	1,623	845	866	1,367	1,417	2,131
Asia	1,766	1,865	3,359	2,292	2,885	2,924	2,692	3,214	2,788	2,643
Europe	1,009	863	818	804	668	633	630	684	635	665
Oceania	2	3	3	4	4	9	11	11	15	9
Middle East	941	640	751	952	913	905	845	892	907	1,086
Not distributed by region	6,103	6,634	7,765	9,093	10,373	11,683	14,901	14,520	14,828	15,552
Total	**14,469**	**14,815**	**17,995**	**18,827**	**21,808**	**22,862**	**25,624**	**26,424**	**26,653**	**27,644**

Table 3. Norwegian development assistance by recipient country from 2003 to 2012. NOK million										
Recipient country	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Afghanistan	487	456	386	447	553	737	728	726	775	733
Angola	172	167	135	150	125	102	112	80	73	71
Bangladesh	86	161	212	137	233	132	92	102	95	96
Bosnia-Herzegovina	153	115	114	122	102	109	99	110	83	112
Brazil	27	21	18	18	55	34	185	226	407	1,248
Burundi	86	80	66	84	118	145	158	118	97	96
Chile	5	2	102	91	135	200	83	79	-67	188
Colombia	66	57	58	64	78	62	73	86	68	86
Dem. Rep. Congo	121	123	128	138	137	199	176	171	179	189
Eritrea	153	126	121	115	60	51	60	58	45	19
Ethiopia	263	229	245	268	198	213	237	197	163	228
The Philippines	13	13	15	30	246	171	11	106	62	7
Georgia	36	33	54	48	38	75	69	60	57	39
Guatemala	90	87	135	96	87	65	48	57	62	51
Guyana	–	0	–	–	–	–	–	177	219	2
Haiti	14	47	32	51	45	59	27	404	135	129
India	57	89	184	84	176	199	101	145	164	216
Indonesia	46	50	290	66	96	61	81	253	67	83
Iraq	415	125	155	145	99	99	73	47	46	47
Kenya	73	54	63	79	76	121	97	81	111	84
China	85	99	89	92	99	140	136	136	132	141
Kosovo	–	–	–	–	–	–	133	147	107	86
Croatia	101	100	100	96	41	24	23	21	–	–
Lebanon	43	43	50	178	90	62	62	56	68	88
Liberia	64	78	46	57	165	193	96	138	197	203
Madagascar	44	57	76	103	119	129	52	78	72	81
Macedonia	82	85	81	80	55	35	44	45	39	28
Malawi	199	183	316	323	321	368	399	391	375	404
Mali	53	54	89	108	94	85	79	96	75	95
Mozambique	383	412	438	412	469	552	505	445	472	501
Myanmar (Burma)	36	48	38	52	64	169	112	124	105	133
Nepal	143	155	162	263	239	239	284	285	277	236
Nicaragua	90	85	90	162	116	114	112	116	102	89
Nigeria	31	37	19	19	19	36	58	85	66	54
Pakistan	70	55	533	120	181	170	292	502	184	176
Palestine	379	363	477	563	622	661	629	662	628	623
Peru	62	8	21	9	838	2	-46	23	20	30
Serbia	–	–	–	–	239	266	125	122	111	89
Somalia	283	227	202	217	253	252	209	191	472	204
Sri Lanka	199	204	428	239	258	174	221	175	145	116
Sudan	236	385	636	686	700	684	578	705	263	194
South Africa	117	108	93	90	95	108	227	150	214	171
South Sudan	–	–	–	–	–	–	–	–	338	428
Tanzania	477	402	389	483	667	729	731	749	640	539
Former Yugoslavia	310	250	219	209	–	–	–	–	–	–
Uganda	271	281	293	319	403	422	423	432	454	306
Vietnam	82	81	100	98	175	177	100	122	242	270
Zambia	252	252	315	425	436	418	394	327	444	302
Zimbabwe	49	55	87	72	73	119	180	146	125	159
East Timor	50	59	58	93	79	44	53	47	46	45
Other countries	*780*	*739*	*796*	*761*	*653*	*693*	*532*	*623*	*940*	*826*
Not distributed by country	*7,135*	*7,877*	*9,240*	*10,264*	*11,588*	*12,966*	*16,368*	*15,999*	*16,460*	*17,648*
Total	**14,469**	**14,815**	**17,995**	**18,827**	**21,808**	**22,862**	**25,624**	**26,424**	**26,653**	**27,644**

TIL INNHOLD ↑

Table 4. Norwegian development assistance distributed by thematic area from 2003 to 2012. NOK million										
Thematic area	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Good governance	1,713	2,032	2,331	2,886	3,352	3,459	3,896	3,865	3,940	3,859
Health and social sector	1,461	1,563	2,009	1,920	1,869	2,107	2,277	1,725	1,803	1,807
Expenses in Norway and unspecified	2,069	1,700	1,567	1,801	1,909	2,301	4,258	3,823	3,344	3,191
Environment and energy	843	848	1,040	1,107	2,269	1,966	2,366	3,227	3,300	4,963
Multilateral	3,897	4,173	4,581	5,079	5,568	6,056	6,296	6,409	6,692	6,944
Emergency assistance	1,347	1,091	2,227	1,471	1,733	1,760	1,398	2,161	2,115	1,949
Education	1,086	1,293	1,662	1,720	1,576	1,541	1,759	1,601	1,517	1,623
Economic development and trade	2,052	2,114	2,579	2,844	3,534	3,673	3,374	3,612	3,944	3,307
Total	**14,469**	**14,815**	**17,995**	**18,827**	**21,808**	**22,862**	**25,624**	**26,424**	**26,653**	**27,644**

Table 5. Norwegian development assistance by sector 2003-2012. NOK million										
Sector	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
111 – Education, level unspecified	215	295	357	445	454	269	336	320	238	284
112 – Basic education	651	781	1,072	1,065	872	923	1,030	925	1,007	1,056
113 – Secondary education	25	32	51	64	42	52	70	57	49	45
114 – Post-secondary education	194	185	181	146	208	297	323	299	224	238
121 – Health, general	328	263	370	377	404	368	348	347	404	450
122 – Basic health	190	253	333	356	274	456	605	207	370	344
130 – Population policies/programmes	277	269	287	386	399	449	508	457	441	443
140 – Water and sanitation	152	213	282	231	273	255	261	234	129	167
151 – Government and civil society	1,322	1,636	1,814	1,859	2,177	2,283	2,641	2,573	2,654	2,566
152 – Conflict prevention and resolution, peace and security	391	396	516	1,026	1,175	1,176	1,255	1,292	1,286	1,294
160 – Other social infrastructure and services	514	565	737	571	519	579	555	480	458	403
210 – Transport and storage	145	51	64	96	115	9	59	31	23	13
220 – Communications	27	17	19	66	26	63	-26	-30	12	12
230 – Energy generation and supply	439	429	641	616	1,673	1,108	568	1,018	1,537	2,259
240 – Banking and financial services	77	160	109	84	250	221	292	253	764	142
250 – Business and other services	150	217	229	244	264	204	225	183	188	103
311 – Agriculture	298	355	320	370	446	418	500	462	476	557
312 – Forestry	30	46	25	20	30	192	956	1,471	1,026	1,910
313 – Fishing	117	110	208	128	117	123	139	138	152	170
321 – Industry	1	70	77	80	69	47	61	121	95	154
322 – Mineral resources/ mining	21	17	43	57	90	148	162	185	242	205
323 – Construction	2	1	0	0	1	1	-0	0	0	0
331 – Trade policy and regulation	53	55	66	72	121	109	116	113	102	104
332 – Tourism	6	4	36	6	3	28	0	19	72	6
410 – General environmental protection	374	373	374	471	566	666	842	738	737	793
430 – Other multisector	597	565	1,000	877	926	931	661	950	820	1,036
510 – Budget support	372	409	390	577	824	1,162	1,100	1,079	872	653
520 – Developmental food aid/Food security assistance	29	1	0	42	5	8	5	4	3	27
530 – Other commodity assistance	–	–	0	0	0	15	3	3	–	–
600 – Action relating to debt	157	83	15	145	276	187	77	100	122	123
720 – Emergency response	1,228	1,008	2,133	1,380	1,578	1,597	1,179	1,752	1,774	1,622
730 – Reconstruction relief and rehabilitation	119	84	94	91	154	112	89	291	150	119
740 – Disaster prevention and preparedness	–	–	–	–	–	51	130	119	190	209
910 – Administration costs/multilateral	4,601	4,966	5,466	6,120	6,686	7,278	7,683	7,861	8,195	8,481
930 – Refugees in Norway	1,249	750	438	399	456	806	2,533	2,027	1,475	1,319
998 – Unallocated/unspecified	116	157	244	361	335	272	338	344	366	336
Total	**14,469**	**14,815**	**17,995**	**18,827**	**21,808**	**22,862**	**25,624**	**26,424**	**26,653**	**27,644**

Table 6. Development assistance by budget section 2008-2012. NOK million					
Budget item	**2008**	**2009**	**2010**	**2011**	**2012**
140 – The Ministry of Foreign Affairs, administration of development assistance	924	1,029	1,079	1,095	1,109
141 – Norwegian Agency for Development Cooperation (Norad)	177	192	201	206	212
144 – The Peace Corps	–	54	49	49	55
150 – Development aid to Africa	2,679	2,842	2,702	2,610	2,566
151 – Development aid to Asia	817	999	988	942	931
152 – Development aid to the Middle East	245	491	457	532	–
152 – Development aid to the Middle East and Northern Africa	–	–	–	–	509
153 – Development aid to Latin America	246	250	221	192	187
160 – Civil society and democracy development	1,715	1,763	1,747	1,812	1,893
161 – Business development	1,144	482	1,031	1,985	1,890
162 – Transition Assistance	686	625	641	389	365
163 – Emergency relief, humanitarian aid and human rights	2,529	2,448	2,966	3,049	3,030
164 – Peace, reconciliation and democracy	1,770	1,631	1,681	1,620	1,602
165 – Research, skills development and evaluation	648	732	757	790	851
166 – Environment and sustainable development, etc.	–	1,225	1,750	1,325	2,295
166 – Grants for sundry initiatives	402	–	–	–	–
167 – Refugee initiatives in Norway, approved as ODA	806	2,533	2,027	1,475	1,319
168 – Women and gender equality	207	312	292	305	305
169 – Global health and vaccine initiatives	1,542	1,506	1,479	1,695	1,835
170 – UN agencies, etc.	4,013	4,273	4,156	4,324	4,445
171 – Multilateral financial institutions	2,000	1,991	1,949	2,002	2,014
172 – Debt relief and debt-related measures	306	260	270	270	265
51 – Not from the Ministry of Foreign Affairs budget	7	10	10	9	11
530 – Reversals	–	-24	-28	-23	-44
Total	**22,862**	**25,624**	**26,424**	**26,653**	**27,644**

Table 7. Development assistance by type of agreement partner 2003-2012. NOK million										
Type of agreement partner	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Consultants	55	50	66	96	113	86	113	207	157	137
Norwegian private sector	94	129	210	131	78	178	175	175	207	219
Private sector in other countries	162	284	281	248	256	292	567	347	818	372
Public sector in recipient countries	1,623	1,554	1,832	2,008	2,277	2,170	2,105	2,242	1,803	2,084
Norwegian public sector	2,614	2,220	2,282	2,625	3,621	3,446	4,713	4,800	4,630	5,193
Public sector in other donor countries	107	89	98	264	204	244	259	231	476	252
Norwegian non-governmental	2,525	2,579	3,067	3,218	3,397	3,493	3,566	3,620	3,518	3,711
International non-governmental	315	302	382	432	739	829	1,125	1,197	1,500	1,279
Local non-governmental	342	346	403	448	593	623	744	799	899	960
Multilateral organizations	6,541	7,086	9,225	9,151	10,289	11,267	12,105	12,615	12,476	13,266
Public-private cooperation	44	48	50	89	113	136	105	131	106	119
Unspecified	46	127	99	118	128	97	47	61	63	53
Total	**14,469**	**14,815**	**17,995**	**18,827**	**21,808**	**22,862**	**25,624**	**26,424**	**26,653**	**27,644**

TIL INNHOLD ↑

Table 8. Development assistance to Norwegian NGO's 2003-2012. NOK million										
Organization	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Norwegian Red Cross	356	354	449	419	389	415	435	473	456	587
Norwegian Refugee Council	296	300	344	434	488	476	452	552	525	501
Norwegian Church Aid	363	346	397	482	437	489	453	469	408	407
Norwegian People's Aid	267	312	358	421	404	385	385	344	365	354
Save the Children Norway	182	163	187	178	197	223	218	200	183	175
Digni – formerly the Norwegian Missions in Development (Bistandsnemnda)	141	138	145	141	140	142	143	145	151	164
Rainforest Foundation Norway	18	22	25	34	56	83	99	101	115	114
CARE Norway	82	65	93	65	79	76	136	100	70	101
Atlas Alliance	56	56	62	76	76	79	79	80	81	80
Utviklingsfondet [The Development Fund]	43	55	79	35	40	54	68	71	73	73
Doctors Without Borders Norway	34	51	58	64	41	45	29	23	39	60
WWF Norway	10	17	11	20	53	56	60	55	71	59
Strømmestiftelsen	45	50	53	53	64	54	48	48	46	51
Plan Norway	6	10	34	38	46	36	46	36	37	50
FOKUS – Forum for Women and Development	18	17	49	21	24	33	32	39	33	41
Norwac – Norwegian Aid Committee	32	30	33	52	52	50	35	34	24	37
Amnesty International Norway	-0	–	–	0	–	–	–	0	-0	35
SOS Children's Villages Foundation	6	8	16	16	8	7	13	23	15	34
FORUT – Campaign for Development and Solidarity	29	28	50	34	47	37	31	31	31	33
LO – The Norwegian Confederation of Trade Unions	27	25	26	28	28	28	29	29	29	30
Caritas Norge	37	36	56	34	44	38	32	29	23	30
PETRAD	6	6	7	10	18	42	40	40	45	30
AiN – Norwegian Afghanistan Committee	13	7	14	12	15	9	9	14	13	28
United Nations Association of Norway	0	18	30	26	22	28	25	27	28	28
JOIN Good Forces (formerly CRN - Christian Relief Network)	13	18	18	19	18	17	22	32	36	26
YME Foundation	3	5	7	5	12	9	10	10	11	24
SAIH – Norwegian Students' and Academics' International Assistance Fund	17	16	18	18	18	19	20	21	22	22
CMI – Chr Michelsen Institute	13	13	18	18	15	22	39	27	29	21
The Royal Norwegian Society for Development	43	46	42	12	21	23	26	24	16	19
NIS – Nordic International Support Foundation	–	–	–	–	–	–	–	–	– 2	19
KS – The Norwegian Association of Local and Regional Authorities [Kommunenes Sentralforbund]	6	20	22	30	25	24	19	25	22	17
PRIO – International Peace Research Institute, Oslo	20	5	12	21	17	15	16	22	16	16
GenØk – Centre for Biosafety	1	6	8	8	7	11	11	13	10	14
NHO – The Confederation of Norwegian Business and Industry [Næringslivets hovedorganisasjon]	8	11	13	14	14	17	19	17	16	14
The Norwegian Helsinki Committee	9	7	8	14	15	21	19	19	24	13
NFG – Norwegian Forestry Group	12	17	3	5	13	12	14	5	9	13
Mount of Olives Foundation		1		7	-1	1	6	6	6	13
NOC – Norwegian Olympic and Paralympic Committee and Confederation of Sports	9	11	10	8	9	10	11	12	11	13
TMC – Tromsø Mine Victim Resource Center (Tromsø mineskadesenter)	8	7	3	11	17	16	13	12	14	12
HRH – Human Rights House Foundation	–	–	0	2	2	7	11	9	14	11
Norwegian Society for the Conservation of Nature/ Friends of the Earth Norway	1	1	2	4	6	10	13	13	18	11
Vennskap Nord/Sør (Friendship North/South)	7	9	9	10	11	11	12	10	11	11
Rogaland Training and Education Centre			3	4	4	7	14	12	13	10
Norwegian Geotechnical Institute	0	1	1	6	6	5	7	4	7	9
LNU – The Norwegian Children and Youth Council	5	5	5	5	5	8	8	10	9	9
Norsk Energi	–	–	0	–	–	4	7	11	9	8
ForUM (policy think tank for development and the environment)	2	5	6	6	5	5	6	6	8	8
ADRA Norway	4	7	5	4	5	5	5		6	8
FAFO Research Foundation	27	20	9	23	32	18	18	11	17	7
LLH – The National Association for Lesbian, Gay, Bisexual and Transgender People	–	–	–	0	0	2	2	3	4	7
Other organizations	250	236	268	271	353	310	324	321	294	256
Totalt	**2,525**	**2,579**	**3,067**	**3,218**	**3,397**	**3,493**	**3,566**	**3,620**	**3,518**	**3,711**

Table 9. Assistance to multilateral organizations distributed by agreement partner 2003-2012. NOK million										
Organization	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
UN agencies total	**3,970**	**4,147**	**5,605**	**5,452**	**6,182**	**6,209**	**6,883**	**7,178**	**7,032**	**6,963**
UNDP – UN Development Programme	1,130	1,106	1,350	1,436	1,716	1,750	2,015	2,144	2,008	1,851
UNICEF – United Nations Children's Fund	777	900	1,338	1,152	1,135	1,187	1,298	1,319	1,310	1,366
UNHCR – Office of the United Nations High Commissioner for Refugees	328	374	382	360	332	336	400	484	434	481
UNFPA – UN Population Fund	268	248	271	287	394	413	409	449	410	447
CERF – Central Emergency Response Fund	–	–	–	206	350	300	300	375	387	414
WHO – World Health Organization	290	278	397	312	314	351	374	333	369	392
WFP – World Food Programme	359	315	607	336	240	278	240	252	250	316
UNRWA – United Nations Relief and Works Agency	130	130	203	167	219	190	235	221	200	183
UNAIDS – Joint United Nations Programme on HIV/AIDS	110	121	131	201	169	162	162	162	162	169
OCHA – United Nations Office for the Coordination of Humanitarian Affairs	78	87	187	107	195	139	142	197	196	162
UN Women	–	–	–	—	–	–	16	115	165	147
UNEP – United Nations Environment Programme	56	60	62	82	85	119	115	115	103	130
FAO – Food and Agriculture Organization of the United Nations	106	89	166	130	147	131	164	130	142	94
UN-HABITAT – United Nations Human Settlements Programme	23	26	62	66	100	89	101	87	87	93
ILO – International Labour Organization	58	55	52	69	80	81	113	93	88	86
IFAD – International Fund for Agricultural Development	4	75	75	74	80	97	73	92	83	82
UNESCO – UN Educational, Scientific and Cultural Organization	67	40	47	44	51	52	76	64	70	61
UNODC – United Nations Office on Drugs and Crime	-	16	25	25	43	44	52	58	71	54
OHCHR – UN Office of the High Commissioner for Human Rights	37	36	44	51	64	48	35	50	42	47
UNOPS – United Nations Office for Project Services	1	7	1	17	98	103	55	73	58	35
UNIDO – UN Industrial Development Organization	14	29	9	32	42	58	47	29	47	31
United Nations Peacebuilding Fund (Window Two)	–	–	–	–	–	–	–	–	30	31
IAEA – International Atomic Energy Agency	–	–	–	4	2	17	19	24	30	28
DOCO – UN Development Operations Coordination Office	–	–	–	–	–	–	1	1	2	25
DPKO – UN Department of Peacekeeping Operations	–	–	3	–	1	3	7	9	30	23
Other UN agencies	135	154	194	295	322	260	434	299	258	214
IMF total	**24**	**26**	**10**	**54**	**10**	**7**	**72**	**65**	**73**	**43**
IMF – PRGF – Poverty Reduction and Growth Facility	11	–	–	–	–	–	52	50	50	24
Other IMF organizations	13	26	10	54	10	7	20	15	23	19

TIL INNHOLD ↑

Table 9. Assistance to multilateral organizations distributed by agreement partner 2003-2012. NOK million										
Organization	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
World Bank Group total	**1,336**	**1,506**	**2,101**	**1,828**	**1,881**	**2,601**	**2,610**	**2,878**	**2,858**	**3,273**
IBRD – International Bank for Reconstruction and Development	591	223	681	447	350	700	801	873	935	1,486
IDA – International Development Association	584	667	916	846	816	779	821	954	992	780
World Bank	7	392	415	460	476	876	799	817	627	700
IDA – HIPC	125	222	65	65	167	201	107	107	78	115
AMCs – Advance Market Commitments	–	–	–	–	–	–	–	12	131	84
IDA – MDRI – Multilateral Debt Relief Initiative	–	–	–	–	50	–	50	57	68	75
IFC – International Finance Corporation	29	3	23	10	23	46	31	58	27	34
Regional development banks total	**505**	**552**	**591**	**642**	**809**	**871**	**875**	**879**	**789**	**996**
AFDF – African Development Fund	346	346	443	461	488	505	526	533	549	548
AFDB – African Development Bank	44	74	6	37	29	113	141	240	34	220
ASDB – Asian Development Bank	39	28	47	48	129	143	107	23	62	67
ASDF – Asian Development Fund	55	55	55	55	55	55	60	60	60	60
CEB – Council of Europe Development Bank	–	8	8	–	8	–	–	–	–	40
Other regional development banks	22	41	33	42	100	55	41	24	84	61
Other multilateral organizations, total	**705**	**854**	**918**	**1,174**	**1,406**	**1,579**	**1,665**	**1,616**	**1,723**	**1,991**
GAVI – Global Alliance for Vaccines and Immunization	155	290	290	416	470	472	463	491	429	606
GFATM – Global Fund to Fight AIDS, Tuberculosis and Malaria	138	125	152	271	301	375	375	375	450	450
IFFIm – International Finance Facility for Immunisation	–	–	–	33	32	28	37	128	49	146
UNITAID	–	–	–	–	140	140	140	140	102	130
CGIAR – Consultative Group on International Agricultural Research	81	78	85	93	81	88	88	98	110	110
GEF – Global Environment Facility	43	44	44	44	44	44	44	55	112	106
IDEA – International Institute for Democracy and Electoral Assistance	4	4	4	6	30	22	61	45	51	49
NDF – Nordic Development Fund	81	91	57	53	60	158	152	19	58	44
IOM – International Organization for Migration	30	17	40	46	38	22	27	18	51	30
OSCE – Organization for Security and Cooperation in Europe	20	13	13	11	24	13	11	26	23	27
EAC – East African Community	1	6	8	4	5	4	5	6	5	23
AU – African Union	3	5	5	4	1	–	10	4	10	23
Other multilateral organizations	151	183	220	194	181	212	252	211	274	246
Total multilateral organizations	**6,541**	**7,086**	**9,225**	**9,151**	**10,289**	**11,267**	**12,105**	**12,615**	**12,476**	**13,266**

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