Review of Norwegian Health-related Development Cooperation 1988–1997

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Responsibility for the contents and presentation of findings and recommendations rests with the evaluation team. The views and opinions expressed in the report do not necessarily correspond with the views of the Ministry of Foreign Affairs.

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Acronyms

ARPP	Annual Review of Portfolio Performance (The World Bank)
BN	Norwegian Mission Council
COHRED	Council for Health Research Development
CRC	UN Convention on Rights of the Child
DAC	The Development Assistance Committee
DALY	Disability Adjusted Life Year
DANIDA	Danish Development Aid
DFID	Department for International Development
DiS	Centre for Partnership in Development
ENHR	Essential National Health Research
FRIV	Department for Non-Governmental Organisations (NORAD)
GPA	General Programme on AIDS (WHO)
HAPAE	Health and Population Aid Effectiveness Project
HEBUT	The Health and Population Research Programme
HNP	Health, Nutrition and Population
HRD	Human Resource Development
HRP	Human Reproduction Programme
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
IPPF	International Planned Parenthood Federation
IUATLD	International Union Against Tuberculosis and Lung Disease
MCH	Mother and Child Health
MFA	Ministry of Foreign Affairs
MOH	Ministry of Health
NCA	Norwegian Church Aid
NGO	Non-governmental organisation
NIBR	Norwegian Institute of Urban and Regional Reseach
NOK	Norwegian Kroner
NORAD	Norwegian Agency for Development Cooperation
NPA	Norwegian People's Aid
NRC	Norwegian Research Council
NUFU	Norwegian Council of Universities' Committee for Development Research
ODA	Overseas Development Aid
OECD	The Organisation for Economic Cooperation and Development
OED	Operations and Evaluations Development (The World Bank)
OOE	Office of Oversight and Evaluations (UNFPA)
PAHO	Pan African Health Organisation
PHC	Primary Health Care
QAG	Quality Assurance Group (The World Bank)
REG	Regions Department (NORAD)
SAG	Special AIDS Grant
SAP	Structural Adjustment Programmes
SIH	Centre for International Health
SWAP	Sector Wide Approach Programmes
TB	Tuberculosis
TBA	Traditional Birth Attendants
TDR	Tropical Disease Research
UCT	Universal Coverage of Immunisation
UNAIDS	United Nations AIDS-programme
UNDP	United Nations Development Programme

UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Fund
WB	The World Bank
WHO	World Health Organisation

Executive Summary

The Norwegian Ministry of Foreign Affairs (MFA) has commissioned a comprehensive study of Norwegian development cooperation in health development during the ten-year period 1988–1997. The purpose of this study is to:

- Review Norwegian policies and strategies for aid to health.
- Give an overview of Norwegian support to health development in terms of volume, channels, and areas of support.
- Assess evaluations, reviews, and research related to health development cooperation and identify gaps in knowledge.

Methodology

The study has mainly been conducted as a desk study using statistical data and by reviewing documents. This information has been supplemented by discussions with representatives from the MFA and NORAD as well as key people in the Evaluation Departments of major international agencies.

The statistical overview of Norwegian support for health development is drawn from a number of sources: annual reports, a Government White Paper, a special report, and data files. The main data sources for bilateral aid are the official registration of projects at the MFA and NORAD, which follows the international standards of the Development Assistance Committee (DAC) of OECD. This study includes only projects registered under DAC sector 7 (health and population). The Norwegian contribution through multilateral organisations for health purposes has been estimated according to the general health-related percentage that is presented by the different agencies themselves.

The statistical data concerning development-related health research is also drawn from several sources. Data on health research in relation to country and regional programmes is taken from the official registration of projects, DAC, and includes projects registered under DAC sector 7, which are characterised as research-related. The Norwegian Council of Universities' Committee for Development Research (NUFU)-related information is based on a comprehensive database established by the University Council. The information about projects supported by the Norwegian Research Council (NRC) is based on existing written material from NRC. Information on health research support through international organisations is based on data provided separately by the various departments in the MFA.

The evolution of policy and strategy in Norway is based on a review of relevant Government White Papers, Parliamentary Bills 1988–1997, various sector strategies and guidelines, letters of allocation from the MFA to NORAD for the last three years and important speeches and papers that indicate political priorities. An overview of the international scene is based on key publications and reports.

Reports from evaluations and project reviews implemented from 1988 to 1997 either by the financing institutions or the development aid organisations themselves, have been reviewed. The focus has been Norway, but some comprehensive evaluations carried out internationally have been identified. The reports were also registered in a database that summarises the main information from the evaluations and reviews. Some reports were reviewed in greater depth to find out to what extent these provide information about achievements and results.

There is no common system for the registration of any of the areas studied. Since NORAD has applied the same system throughout the period, the registration of statistical data provides an opportunity for comparison over time, but does not cater to new approaches in development cooperation. Different people may interpret the criteria for registration differently and projects with the same characteristics may be registered in different categories. When it comes to research-related information, the DAC system has its obvious limitations and does not provide information

that allows of meaningful classification. The NUFU database is the most comprehensive system, but it could be developed further into a comprehensive information system in which data on all development-related health research funded by Norwegian authorities could be incorporated and made accessible. None of the Norwegian actors in development cooperation have a systematic overview of the evaluations and project reviews undertaken and the collection is a result of time-consuming work. The lack of accessibility and systematisation is a major obstacle not only to collecting and analysing information in relation to a study like this, but also to systematic learning in this area in general.

Norwegian Policies and Strategies

The review of the evolution of the MFA/NORAD policy and strategy starts out by providing a broad overview of international health policy development, since Norwegian policies for health development cooperation must be seen in this context. This study shows that Norwegian policies in this area closely follow international development. Until 1992, Norwegian health development cooperation was guided by the general policies set out in Government White Papers and operationalised through annual Parliamentary Bills. Specific guidelines and strategies for some specific areas within health development cooperation have since then been developed (Strategy for Assistance to Children in Norwegian Development Cooperation, Guidelines for Development Aid to AIDS Control in 1992, and Norwegian Strategy for Population and Development in 1995). NORAD technical advisors developed an internal technical guideline for health sector support in 1995 (1995 "Technical Guideline"). There is still no comprehensive policy paper for health development cooperation.

Policy Trends

Norway has had fairly consistent policies and priorities regarding health development cooperation during the past ten years. These may be briefly summarised as: focus on primary health care and basic health services; mother and child health; and infectious diseases including HIV/AIDS. The strategies in pursuing these policies and priorities have, however, changed and have followed policy developments internationally. Family planning and population control were given special weight in the beginning of the period and the goal of 10 per cent of total development aid to health was directly linked to these areas. During the last part of the period, the focus has changed towards reproductive health and rights with a decrease in maternal mortality as a stated objective. The goal of 10 per cent of total aid to health development is currently linked to basic health services.

Recent Developments

Support for building appropriate institutional frameworks and capacities has become increasingly important in recent years and thus also support for the reforms needed to achieve this. This has also influenced attitudes towards how donor financing for the health sector should be organised. Norway is, along with other countries, striving towards a mode of operation different from previous project support, that is to say, a sector-wide approach to programming. Budget support was already mentioned in the 1984 White Paper and confirmed in 1986 as a strategy to ensure basic health services to entire populations. Since then this is only mentioned in the "1995 Technical Guideline". The latest documents from the technical department indicate that Norway is more explicitly searching for a balance and synergy between interventions aiming at the control of specific diseases and a systems approach to health sector support and development.

Policies Related to Channels for Support

The same principles that have guided the use of multilateral institutions (50 per cent of total aid), international agencies and NGOs (30 per cent of bilateral aid) as channels for Norwegian development cooperation have applied to support for health development. There has been no variation in significance throughout the period. The reasons given for the use of multilateral organisations as channels for Norwegian development cooperation have increasingly been more clearly articulated. Norway should make the most of its participation on boards, increase the earmarking of financial resources to promote Norwegian development aid policy, and choose areas which influence the total policy of the organisation concerned. Since 1991 it

has been a stated policy that support for MCH/FP should be channelled mainly through multilateral organisations. Norway will also promote a clearer division of roles and a better balance between the World Bank and the UN in terms of technical assistance, promote the increased participation of Norwegian institutions and resource centres in multilateral aid activities as well as increase the recruitment of Norwegian citizens for work in international organisations.

Research Policies
There has been no formulated policy or strategy for development-related research in general or for development-related health research in particular. According to the White Papers for the period, research should contribute to the assurance of quality development aid. Each of the research programmes has formulated objectives and purposes. In 1999, a strategy for strengthening research and higher education in relation to Norwegian development cooperation was approved.

Norwegian Support to the Health Sector – A Statistical Overview

Norwegian support to the health sector has increased both in terms of absolute numbers and when deflated to 1997 value (i.e. increased by 1/3). The share of bilateral development aid, which includes direct country support, support through NGOs and bilateral support through multilateral organisations, has varied throughout the period. Following a relatively significant decrease in the beginning of this decade, it has, since 1995, been close to 9 per cent of total development cooperation. Adding the non-earmarked support channelled to multilateral organisations, the Norwegian support to health-related development cooperation adds up to 11–12 per cent of total aid.

According to Channels
The share of bilateral development aid channelled through non-governmental organisations has more than tripled in the period. Currently more than half of the bilateral development aid to health is channelled through NGOs as compared to 1/5 in 1988. The increase is due mainly to increased funding through Norwegian NGOs, which in 1997 represented 41 per cent of total bilateral aid to health. The relative importance of local NGOs as receivers of Norwegian support for health-related activities has decreased. They receive only a minor share as direct funding. However, the Norwegian NGOs cooperate to a large extent with local NGOs that may be considered the end receivers of a large part of the funds channelled through Norwegian NGOs. The NGO support channelled through the MFA and the Regional Department has increased the most.

The share of bilateral funds channelled through multilateral agencies as bi-multi-bi or multi-bi support has increased significantly through the period from about 13 per cent to about 33 per cent. Multilateral aid defined as non-earmarked funds for multilateral agencies has been the main channel of support to health with half of total aid to health. Particularly the World Bank and UNFPA have been given increased importance as channels for Norwegian support to health-related activities both through increased multibilateral funds and non-earmarked funds. UNICEF on the other hand has been given less importance as a channel for support to health. Due to policy decisions, previous support to health and sanitation is being phased out and earmarked funds are currently directed towards female education, children's rights, and slowly towards early childhood development. In addition the calculated share of Norwegian non-earmarked funds is also less than before as the share of the organisation's total resources for health has decreased. WHO received in 1992–1996 less non-earmarked funds than in preceding years. The last couple of years, both non-earmarked and earmarked funds have increased. Tropical Disease Relief (TDR) received in the period 1993–1998 by far the largest amount followed by Diarrhoeal Diseases, Human Reproduction, and Immunisation. Tuberculosis started to receive support in this period and it is increasing. NORAD has provided very little bi-multi-bilateral support for WHO country operations. However, it has given substantial support for PAHO Central American projects and has, since 1996, initiated cooperation with AFRO as well. As a result, WHO is currently receiving more than it did before the decline at the beginning of

the decade. As a result of all these developments, bilateral country support has decreased significantly. Mozambique is currently the only country receiving any direct support of significance.

According to Health and Population
The analysis is complicated by the fact that on average through the period, 27 per cent of the activities are registered as unspecified/other. Some NGOs use this category frequently. MCH and family planning has been the largest sub-sector with an average of 35 per cent of total aid to health. It decreased between 1989 and 1993/95, but has since increased significantly every year. Still, it has not reached the level of support in 1989. The observed increase is due to a dramatic increase in support through multilateral organisations that represented 72 per cent of the multi-bilateral budget in 1997. Support to MCH services through NGOs has also increased, but bilateral support has continued to be low. The sub-sectors nursing, immunisation, and control of epidemics and hospitals and health centres have seen some increase and were about 15 per cent and 10 per cent respectively of the total budget in 1997. The latter is mainly due to an increase through NGOs. Support to AIDS-related projects and programmes increased steadily from 1989 to 1995 when it reached 18 per cent of total. Support to AIDS is currently channelled equally through NGOs and the multilateral organisation UNAIDS. In 1997 more than 7 per cent of total aid to health was in support of tuberculosis control programmes through all channels. Support to health administration has remained low throughout the period.

Regional and Country Profiles
Africa and Asia received approximately the same level of support to health in 1988 (41 per cent of total aid to health). However, as the level of support in Asia has decreased throughout the period, support to Africa has increased considerably and in 1997 60 per cent of the expenditure was allocated for projects in Africa, as against 19 per cent for projects in Asia. Support for health in Latin America has increased during this period from 5 per cent in 1988 to 12 per cent in 1998. Norwegian support to health varies from country to country. In 1997, Mozambique was the major recipient of aid to the sector, closely followed by Zimbabwe. In Mozambique the major part is bilateral aid (direct country support) whereas in Zimbabwe a major share is channelled through multilateral organisations (multi-bilateral). In Bangladesh there has been a similar situation to Zimbabwe in terms of how funds have been channelled. In Tanzania, which has received a share similar to that of Bangladesh, the main part is bilateral funds. It is, however, hard to identify a rationale for these variations as both the volume and profile are different in countries with comparable socio-economic status and health status.

Development-related Health Research
The organisation and structure of development-related health research is complex. The management of different programmes is the responsibility of various institutions and different departments provide funding. All these actors have different ways of registering. It is therefore difficult to obtain an accurate overview of the activities that have been implemented during the period studied and to paint a true picture of the volume and content of the research. It is also difficult to identify clearly how roles and responsibilities have been divided between the four channels described below. This study includes research funded by Ministry of Foreign Affairs and NORAD through four channels;

i) Health research as part of NORAD country and region-specific programmes,[1]

ii) The Health and Population Research Programme of the Norwegian Research Council (NRC–HEBUT)

iii) The Norwegian Council of Universities' Committee for Development Research and Education (NUFU)

iv) Co-financing of research activities in international organisations.

1. DAC code 64 is not included with the exception of the NUFU grant that is analysed separately. DAC 64 includes support to non-sector-specific research activities.

NUFU and NORAD Country and Region Specific Programmes

The support for research-related projects corresponds to 4 per cent of bilateral and 3 per cent of multi-bilateral funds. All in all, 142 projects equivalent to NOK 165.4 million are registered as research related.[2] This includes funds for 39 projects under the NRC/HEBUT programme (NOK 24.5 million of the NOK 35 million programme cost). It is important to note that more than double the amount to NRC/HEBUT has been in support of *one* research project, namely the joint Ministry of Health and University of Bergen AIDS project in Tanzania (1989–1995).

The amount of funds for research activities increased significantly from 1988 to 1991 when it stabilised between NOK 20–25 million until 1997 when it decreased considerably. The aforementioned project in Tanzania along with the NRC/HEBUT programme received in some years between 50–75 per cent of what was granted for research-related activities and the Tanzania project more than 50 per cent on its own. It is important to note that, apart from this Tanzania project, there is limited research for country-specific programmes. Evaluations such as the ones of Special Aids Grant, Children's Strategy, and WHO are defined as research and included here. Health-related research through NUFU has increased throughout the period. Through 1991–98 it has amounted to NOK 110 million and 26 per cent of total NUFU funds.

Profile of Research Financed through NUFU and NRC

The main objective of the NRC–HEBUT programme has been to raise inter-disciplinary capacity and capability in Norwegian research institutions in terms of population and health issues in developing countries. The main purpose of the NUFU programme is, on the other hand, to advance the capacity of the higher learning and research institutions in developing countries to carry out research and offer research-based training programmes through collaboration between relevant institutions in Norway and in developing countries. The programmes are different not only in terms of objectives but also in how they are constructed. The one is demand-driven, and the other has clear direction and instruction. This has provoked discussions on how to strike a fair and productive balance between disparate concerns such as programme instructions, academic freedom, and financial predictability.

There is a major problem in classifying both health research and the researchers, and there is a need to devote time to the elaboration of a productive and meaningful classification of research. However, in general terms one may state that the profile of the NUFU and NRC–HEBUT-financed research projects has mainly been medical with a focus on biological determinants of health in general (epidemiological, bacteriological, vaccines etc.) and more specifically children's health and issues related to reproductive health. Approximately 1/3 of NUFU funds have been in support of *one* institution, namely the Armauer Hansen Research Institute in Ethiopia specialising in leprosy research. This may be explained by the fact that this institution had received considerable support through the MFA before the establishment of the NUFU programme and that there was a need to find a "home" for the support. Only 17 per cent of the NUFU projects and one of the NRC projects focused on health systems, administration and/or intervention. Very few of the NCR projects are interdisciplinary. No political scientists have been involved but sociologists and anthropologists have been fairly well represented. The NUFU database does not provide comparable information about the researchers involved.

Health Research through International Organisations

Support for research through international organisations and multilateral funding has been considerably higher than through the above-mentioned channel. WHO has for the last five years received more than NOK 220 million for the support of two research pro-

2. The support must cover the generation of new knowledge or synthesising of available knowledge. This also includes dissemination of research results and research collaboration. If the research component is part of a larger project, only the research part shall be included. If the research part is not earmarked, the whole project shall be recorded as research when the research component is estimated at 50 per cent and more of total costs and as zero if this component is estimated at less than 50 per cent.

grammes: Tropical Disease Research (TDR) and the Human Reproduction Programme (HRP). The first has included support for other activities than TDR itself such as the Global Forum on Health, which in 1998 alone received US$ 1.8 million. The World Bank has also received Trust Funds for health systems research activities. This has amounted to NOK 3 million during the last couple of years. Norway has supported the Council of Health Research Development (COHRED), an NGO established in 1993, with the goal of promoting the efforts of developing countries to carry out so-called "Essential National Health Research" (ENHR). The support has, however, been limited. In addition to support for the Global Forum on Health, Norway has also supported the Alliance for Health Policy/Systems Research, both organisations established in 1997. It has been difficult to track the actual amount of financial support to these programmes.

Results of Health-related Research

Measurable results of the two research programmes may be assessed through the numbers of articles and publications and the production of academic degrees. The review shows that considerable numbers of articles and publications have been produced. The NRC-supported research has produced eleven PhDs of which two are undertaken by researchers from developing countries, six master's degrees of which two are undertaken by researchers from developing countries. All of the degrees, twenty-four master's degrees and six PhDs under the NUFU programme, are claimed to be undertaken by researchers in developing countries. Norwegian universities have through their own means financed several degrees in connection to NUFU and several faculties have connected the quota programme scholarships to the NUFU programme–hence enhancing the synergy effect.

There has been no evaluation of the impact on institutional sustainability and whether the programmes have resulted in an increase in the capacity and capability of the research institutions in developing countries. Country-level assessments of the NUFU programme indicate, however, that there has been a positive impact on the capacity of research institutions in developing countries.

Evaluations and Project Reviews of Norwegian Health-related Development Cooperation

There is no comprehensive system of registering reports and follow-up of evaluations and project reviews undertaken by any of the NORAD departments or by the NGOs. The collection of 132 reports that are included in this study is a result of time-consuming work by all parties involved searching through archives, brain storming and consulting key people. The sample does not claim to be either exhaustive or representative in statistical terms, but does provide useful information for this particular purpose. The sample includes 83 evaluations of NGO projects and programmes, some mid-term reviews of Norwegian bilateral country programmes, as well as some evaluations of specific projects/programmes. The MFA has commissioned two thematic evaluations (Special AIDS Grant and Strategy for Children in Norwegian Development Cooperation), one of the functions of the International Planned Parenthood Federation (IPPF) at the country level as well as an evaluation of the Norwegian Multi-Bilateral Programme under UNFPA; it has also participated actively in the multi-donor studies of WHO.

General Characteristics of the Evaluations/Reviews

Strictly speaking, most of the evaluations are reviews as they are undertaken during the life of the project. Most often the evaluation has a combined focus, but when there is a specific focus it is most likely to be policy/strategic or technical issues. Very few focus specifically on financial, administrative or organisational issues. Nearly all of the evaluations made use of conventional evaluation methods. The quality of the method applied has not been assessed systematically. The impression from the in-depth study is that many do not follow a specific format for evaluation and the quality seems to suffer from lack of consistency and a proper analysis of information. This is particularly true of NGO evaluations. Evaluation of results in terms of effectiveness and relevance is therefore difficult.

Do the reports address the various aspects of results?
The NGO reports seldom explicitly state whether the project is coherent with Norwegian development cooperation policies or those related to health development support and whether the project interventions contribute to the goals of Norwegian development cooperation and those of health development support. The reports do, however, generally seek to assess the effectiveness of the intervention and most were judged to be modest in terms of effectiveness. However, lack of measurable targets and indicators in many of the projects limit the possibility of assessing effectiveness in a proper way. Reports that relate to bilateral country programme projects tend to address these issues more explicitly. Two-thirds of the reports assess cost effectiveness in some way or another. The achievements are judged to be modest or marginal. The judgement is, with the exception of World Bank reports, based on general information without any proper analysis in economic terms. Three-quarters of the reports discuss the relevance of intervention and, in more cases than not, relevance is judged to be high by the evaluators. The reviewers of the reports in this study tended, however, to judge the relevance as moderate more often than the evaluators did.

The Knowledge Gap
The study summarises what information the evaluation reports provide about the results of Norwegian development cooperation in terms of health and identifies gaps in knowledge and the need for further analysis and synthesis. This is mainly connected to the issues of relevance and the effect of the different channels on aid to health.

- The evaluation reports of NGO intervention hardly provide a basis to assess the relevance and effect of the NGO at the project level and less so at a higher level and with a broader perspective.

- The multilateral organisations have undertaken several project and programme evaluations of their own interventions at the country level. These may have a country focus (WB/WHO), a programmatic focus (UNICEF/WHO), or a thematic focus (UNFPA/WHO). There is no systematised information concerning the relevance and effect of Norwegian support through these multilateral organisations as a tool for promoting Norwegian policies and priorities in this area, nor the institutional and organisational conditions that need to be in place to assure effect and relevance.

In relation to development-related health research there is a need for further information in the following areas:

- the relevance and effect of total research activities

- the organisation and structure of research as well as the synergy effect of support through the various channels

- the contribution of research to policy processes and the formulation of development cooperation policies

- the contribution made towards strengthening institutions and providing researchers in developing countries with the skills and ability to plan and implement research

- the effect of institutional collaboration

- the degree and relevance of the involvement of the Norwegian research community in research through international organisations

1. Introduction

1.1 Background and objective of the report

The Ministry of Foreign Affairs (MFA) has begun the ambitious task of acquiring information about the results and impact of Norwegian development cooperation at higher levels (e.g. country, sector etc.) than has been done previously. The intention is that this "new" approach to evaluating Norwegian development cooperation will be built up through the systematic and long-term accumulation of information and experience. New evaluation studies should be based on the concept of a "gap" in relation to information about the results of Norwegian development cooperation, and tailored to areas and issues of concern. As the first sector to adopt this approach, the MFA has commissioned a comprehensive study of Norwegian development cooperation in health development during the ten-year period 1988–1997. Health has throughout the period been a priority sector for Norwegian development cooperation. More so, after the 1995 World Summit for Social Development in which there was a mutual agreement between countries to allocate on average, 20 per cent of ODA and 20 per cent of national budgets respectively to basic social services.[3] Support for health is channelled through different channels. Decisions about support and assessment of achievements are made by a number of different people located at various levels and in different institutions, to the best of their knowledge. Connections and relationships are often lost on the way.

This review confirms that numerous evaluations and reviews have been undertaken at project and possibly some at programme level. However, the review also shows that assessment and studies of results at higher level are scarce. The purpose of this study[4] is to:

- Give an overview of Norwegian support to health development in terms of volume, channels, and areas of support
- Collect and assess evaluations, reviews, and research related to health development cooperation nationally and internationally
- Identify areas where there is a need for further information and synthesis of experiences.

There is continuous discussion and changes in policies and strategies in relation to development cooperation generally and to health development specifically. Therefore, a review of Norwegian support to the health sector includes a review of the actual policies and strategies at the time that the interventions were planned implemented.

1.2 Methodology

The study has mainly been conducted as a desk study using statistical data and reviewing documents. However, the information has been supplemented by discussions with representatives from the MFA and NORAD as well as key people in the Evaluation Departments of major international agencies. A seminar was held to discuss the draft report and the proposed evaluation plan that was based on identified "knowledge gaps".

1.2.1 Statistical material

a) The statistical overview of Norwegian support for health development is drawn from a number of different sources such as annual reports, Government White Papers, special reports, and data files. The main data sources for bilateral aid are the official registration of projects at the MFA and NORAD, which follows the international standards of the Development Assistance Committee (DAC) of OECD. This study includes only projects registered under DAC sector 7 (health and population). The DAC data do not include

3. Programme of Action of World Summit for development § 88 c.
4. The study forms the basis for a proposal for a long-term evaluation plan of Norwegian support to health and development, which is presented separately. The evaluation is both summative and formative in design and contributes to future policy development and approaches to health development support.

ordinary multilateral assistance (pure multilateral support). The Norwegian contribution for health purposes has been estimated according to the general health-related percentage that is presented by the different agencies themselves.

b) The statistical data concerning development-related health research is also drawn from several sources. Data on health research in relation to country and regional programmes is taken from the official registration of projects (DAC) and includes projects registered under DAC sector 7, which are characterised as research-related.[5] These projects may be more or less research-based or oriented.

Research activities registered under DAC sector 64[6] are not included, with exception of the Norwegian Council of Universities' Committee for Development Research (NUFU) grant, which is analysed separately and based not on information from this data source, but from information provided directly by NUFU. NUFU-related information is based on a comprehensive database established by the University Council.

The information about projects supported by the Norwegian Research Council (NRC) is based on existing written material from NRC. It also comprises an evaluation by the Programme Committee of the research programme in question.

Information on the support of health research through international organisations is based on data provided separately by the various departments in the MFA.

5. The support must cover the generation of new knowledge or the synthesising of available knowledge. This also includes the dissemination of research results and research collaboration. If the research component is part of a larger project, only the research part of the whole shall be included. If the research part is not earmarked, the whole project shall be recorded as research when the research component is estimated at 50 per cent and more of total costs, and as zero if this component is estimated at less than 50 per cent.
6. DAC 64 includes support to non-sector-specific research activities.

1.2.2 Review of documents

a) Collection and assessment of policy documents, nationally and internationally.

The overview of the Norwegian scene is based on a review of:

1) Relevant Government White Papers (no 36 from 84/85, no 34 from 86/87, no 51 from 91/92, no 19 from 95/96)
2) Parliamentary Bills 1988–1997
3) Various sector strategies and guidelines
4) Letters of Allocation from the MFA to NORAD for the last three years.
5) Important speeches and papers that indicate political priorities.

The letters of allocation were very general in nature and did not provide any significant additional information. Key officers in the MFA and NORAD were interviewed about possible relevant speeches held by officials. Very little was traced – a speech held by Minister Kari Nordheim Larsen at the 1995 International Union of Associations for Tuberculosis and Leprosy D (IUATLD) Conference where she reiterated Norway's commitment to IUATLD objectives. In July 1998, there was a press release by Minister Hilde Frafjord Johnson[7] indicating increased support to HIV/AIDS control interventions in years to come. A recent letter[8] from the MFA/MOH to the WHO Director General indicates which areas Norway currently considers important for WHO's effort as a specialised agency.

The overview of the international scene is based on key publications and reports included in the list of references.

b) Reports from evaluations and project reviews implemented from 1988 to 1997 either by financing institutions or development aid organisations themselves, have been collected. The focus has been Norway, but some comprehensive evaluations carried out internationally have been identified. We have included reports identified

7. UD fakta, juni 1998: AIDS hindrer utvikling.
8. MOH/MIDHR: Letter of 12.10.98.

as evaluations or reviews by the organisations themselves, which we think meet the main characteristics of an evaluation or review.[9] Some reports use the term evaluation or review in the title, but do not meet these criteria. These have not been included.

A number of institutions and organisations were asked to provide information about evaluations and reviews implemented by them. These institutions and organisations include:

- Various offices within the Norwegian Ministry of Foreign Affairs
- Various departments in NORAD (Archives, HRD, NGO)
- The most prominent NGOs in terms of health development support: Norwegian Peoples Aid, Norwegian Red Cross, Norwegian Church Aid, Redd Barna. Norwegian Missionary Organisations, as well as some smaller organisations that are working with strategic themes such as the Norwegian Heart and Lung Association, Norwegian Students' and Academicians' International Aid Foundation, and Caritas
- Bilateral organisations in other countries (DFID, DANIDA)
- UN organisations; UNICEF and UNFPA
- Financial institutions; World Bank

The reports were registered in a database that summarises the main information from the evaluations and reviews. i.e., evaluation characteristics: purpose, focus, various aspects of methodology and implementation. Some reports were selected for in-depth assessments to find out to what extent these provide information about achievements and results of interventions in the following categories:

- Norwegian general development cooperation policies
- Norwegian policies related to health development support
- Effectiveness
- Cost effectiveness
- Relevance

The selection criteria have been somewhat arbitrary. Some were selected in consultation with organisations that indicated which reports, according to their judgement, provide interesting information. We have also tried to include a variety of organisations and types of projects. It is therefore not a random sample in strict research terms.

1.2.3 Discussion of Need for Further Evaluation

The selection of institutions to visit was based on the following criteria: (i) involvement in studies and research of interest to this study; (ii) important channel for Norwegian support for health development; (iii) potential to contribute towards development of appropriate methods for measuring the results and impact of development cooperation.

Based on these criteria and considering the time allocated for the study, we made brief visits to DFID, the World Bank, UNICEF and UNFPA and the OECD office in Paris. As there had already been two independent multi-donor evaluations of WHO, one of the extra budgetary Fund and one of country-level functioning where Norway played a major role, we decided not to include a visit to WHO in this study. We also had discussions with the consultants involved in a similar exercise in relation to Danish support for health-sector development, commissioned by DANIDA.

1.2.4 Limitations

Norway has applied the same statistical system for the registration of project-related data

9. Definition of terminology that may be used: Monitoring: Continuous self-assessment process implemented by project implementors themselves; Review: Assessment activities implemented jointly by implementors and national and external administrators; Evaluation: Independent and impartial assessments implemented towards the end of a programme phase. Participatory evaluations: Uses various participatory methods, techniques and tools such as PRA, RRA. etc.

during the entire ten years. This has provided a good basis for describing trends in support during this period. However, there are also obvious limitations, as the classification system does not necessarily cater to new approaches in strategies and modes of operation. The registration of combined or integrated projects is also difficult. The actual registration is done in a number of places and by different people, and different categories and posts are interpreted in different ways. The data do not specify country-specific support for multilateral organisations (bi-multi-bi). There may be some minor discrepancies from other sources and presentations. It is also worthwhile keeping in mind that the statistical data presented in this study is deflated according to the official consumer price index and presented in 1997 NOK. To cover the major gaps and uncertainties, the mere statistical review has been supplemented by qualitative information.

There is no common system of registration and the overview of development-related health research is based on the information collected from various data sources as described above. The data have large differences in terms of volume and quality thus complicating analysis and presentation. The DAC data is essentially developed as a management instrument and provides limited information about the project. It is hardly sufficient for a meaningful classification of projects by major orientation, by main disciplinary orientation, or by classical outcomes. NUFU maintains a well-designed database of all its projects, including the health projects, with a series of relevant variables. However, although valuable, the database does not contain information on the geographical and functional "careers" of the research fellows, and thus is unable to provide information concerning the institutional sustainability of the NUFU programme.

No comprehensive system of registering evaluation and project review reports and follow-up currently exists. The evaluation department in the Ministry of Foreign Affairs has only an overview of the evaluation the department itself has commissioned. The office for non-governmental organisations in NORAD has no systematic overview of evaluations and reviews of NGO development cooperation, and other departments in NORAD have no comprehensive overview of evaluations/ reviews that could easily be used to select reports.[10] The NGOs that we contacted, with the exception of one, had no systematic registration of reports. The reports we have been able to collect are therefore a result of time-consuming work, not only by us, but by all parties we have consulted. Some NGOs have used internal "brainstorming methods" to identify reviews and reports, others have searched through archives. In NORAD, the secretary in HRD has searched in the archives using a list from the Archive department and a guide provided by us.[11] We have also consulted advisors and consultants working in NORAD and in the MFA. Not all documents known to exist have been located and therefore not included in the database. Some documentation may be found in the different embassies.

Therefore, the overview and assessment does not claim to be exhaustive. The sample presented here may be highly fragmented and arbitrary. However, taking all these limitations into consideration, we think that using the information carefully, it is helpful to this exercise. The database established may be used as a starting point for a more systemised registration of evaluations and reviews.

10. The current archive registration system does have a code for evaluation and reviews. However, it contains not only an overview of reports, but a lot of related information which makes it difficult to access. A new system is underway.
11. Project number (e.g. BGD 009…), midterm reviews, evaluations, PCR, PAR, etc).

1.3 Study Team and Structure of the Report

A team of three consisting of Sissel Hodne Steen, Ingvar Theo Olsen, and Jon Eivind Kolberg has undertaken the study. Each of the team members has had major responsibility for the study components. Ingvar Theo Olsen has been responsible for the statistical review of Norwegian support for the health sector, Jon Eivind Kolberg for the review of development-related health research and Sissel Hodne Steen for the review of policies and the collection and review of evaluations and project reviews. She has also been the project leader.

The report has four main chapters. Chapter 2 describes the evolution of Norwegian policy and strategy. Chapter 3 gives a statistical overview of Norwegian support to health followed by an in-depth assessment of Norwegian support for the development-related health research in chapter 4. Ultimately, chapter 5 gives an overview of evaluations and project reviews collected and assessed for the purpose of identifying “knowledge gaps”.

2. Norwegian Policies and Strategies for Health-related Development Cooperation

This chapter reviews the evolution of the MFA's/NORAD policy and strategy in relation to health support. It starts out by putting these developments in an international context as Norwegian policies must be seen in the context of policy development internationally. Norway has also committed itself to resolutions made in International Conferences. To evaluate the results of Norwegian development aid to the health sector, these commitments have to be taken into account. However, the relevance, appropriateness, and feasibility of these policies may only be assessed in light of how they are interpreted and implemented in complex and changing political, social, and economic challenges at the country level.

2.1 The International Policy Context

The period to be addressed in this exercise, 1988–1997, started ten years after the Alma Ata conference where Ministers of Health committed themselves to achieve Health for All by 2000 (Alma Ata Declaration) through a Global Strategy for Primary Health Care. By 1988 it had proved hard to operationalise and implement the vision in practice not least due to the potential political consequences of the strategy.

There seem to be several trends in international health policy development, which may be ideologically different and have different actors in the lead:

The WHO conferences and initiatives:

1988 The Riga Conference, convened by WHO, confirmed the Alma Ata strategy although it did point out a number of problems in implementation. It even underlined the importance of intensified social and political obligation, commitment, and priority action to the poor, *equitable* distribution of resources, need to strengthen district health systems and to *empower* people and communities

1991 The WHO Conference in Sundsvall, Sweden, reiterated the fact that health gains depend on *social justice and equitable redistribution of resources internationally and nationally* and that there is a need to create an environment that releases the individual's own capacity for health action through *empowerment*.

WHO started to draw attention to the negative consequences of structural adjustment programmes and established a new programme for countries in greatest need.

After mid-decade, the *Rights* aspects of health and social welfare has increasingly become a legitimate perspective. Equity is again receiving attention in international health policy debates after a period of attention to efficiency. In 1997 several international meetings focusing on issues related to equity in health in different parts of the world and under different umbrellas took place.

Increased concern about under-resourced health services, inefficiency of systems, and the unlikeliness of increased public spending have led to an increased focus on **cost-efficiency** in health care. Although UNICEF launched the Bamako Initiative focusing on community management of user fees already in 1987, this agenda has predominantly been a **World Bank**-led process:

1987 The policy study *Financing Health Services in Developing Countries: an Agenda for reform is published.* It recommended that governments concentrate spending on public goods, charge user fees for public sector curative services, establish insurance systems to raise additional revenues, encourage greater use of voluntary providers, and decentralise management to improve effectiveness and efficiency. The operational departments in the WB interpreted this as a diminished role of the state in social service provision.

1993 **The World Development Report** (WDR) proposes a three-pronged approach to government policies for improving health:

- *Foster an environment that enables households to improve health*
- *Improve government spending on health by concentrating resources on compensating for market failures and efficiently financing services that will particularly benefit the poor*
- *Promote diversity and competition*

The policy response indicated in the WDR 93 is to promote overall growth, but pursue economic growth policies that will benefit the poor, expand investment in schooling, and promote the rights of girls and women. In practical terms, the WDR 93 focused on a definition of cost-effective basic or essential and affordable health services based on an analysis of Global Burden of Disease using DALYs as a measurement, and the improved management of these government health services through decentralisation and contracting out of services. The remaining services should be financed privately through policies that encourage social or private insurance. **The focus is poverty rather than equity**.

The debates in the years to follow demonstrate divergent views on health development cooperation:

> *technical prescriptions vs. comprehensive approach to a public sector that caters to the poor, and a market-based private sector for the rest of the population vs. a reinforcement of the public sector for a more effective role in matching the supply and demand of the entire population*

The discussions at the Ottawa meeting in 1993 after the publication of the WDR may provide an illustration. The EU community challenged the National Burden of Disease Studies as a tool for determining priorities and strategies and made the following statement:

> *The better use of scarce resources requires an understanding of the broader organisational, institutional, political and cultural context within which the health sector operates. What we need now is practical guidance for investment in systems and institutions that helps countries and donors make the best use of scarce resources in improving the health of their people.*

In spite of the divergent views there seems to be an increasing understanding that health development is about support for the household to mobilise and utilise support for health action, and that the ultimate goal for health sector development is improved health outcomes. Different actors frequently refer to the DAC targets for health outcomes as targets for interventions.[12]

12. DAC report "Shaping the 21st Century: The Contribution of Development Cooperation".

UN Conferences in the Nineties – Increased Focus on Social Development

- Five UN conferences on the social sector were held from 1990 to 1995. All had consequences for health development policies:

- The declaration adopted at the 1990 World Summit for Children included a politically salient agenda for health. The plan of action has specific goals related to nutrition and child health as well as defined goals in the areas of protection of girls and women and education. The focus was the UN Convention on the Rights of the Child (CRC).

- The 1994 International Conference on Population and Development (ICPD), represents a sharp turning point from the 1984 conference, as the perspective is no longer focused on population growth and fertility control, but "places human beings at the centre of population and development activities". Empowering women is an important end in itself. The Programme of Action enunciates the right to universal, comprehensive reproductive health care pointing out that education and access to resources is essential for empowerment.

- The 1995 World Summit on Social Development confirmed the Programme of Action agreed to in Cairo. It brought the social issues strongly back onto the development agenda and prepared the ground for new initiatives in this sphere. The 20/20 Initiative aims at *ensuring that all people have access to basic services* .

Health Sector Strategies and Policies in Selected International Agencies

These processes and milestones in the international context are reflected in different ways in the policies and strategies of bilateral and multilateral agencies. We have limited the following overview to multilateral agencies before addressing the Norwegian context:

World Bank (follows closely the trend previously described as WB-Led)

1980	*1984*	*1993*	*1997*
Health Policy:	*WDR: Pop. and Dev:*	*WDR:*	*HNP strategy:*
Basic Health Infrastructure	Government responsibility.	Cost-effective	Improve HNP outcomes
CHW/paraprofessionals	to reduce mortality and	Essential health services	Enhance performance of
Logistics and supplies	morbidity		health care systems
MCH/FP			Sustainable health care
Management			financing

UNFPA (especially influenced by ICPD and the Women's Conference in Beijing)

1973	*1993*	*1994*
Mandate: Population and FP	Mandate confirmed	After ICPD:
Build knowledge and capacity	*Programme areas:*	*Programme areas:*
Promote awareness	Family Planning	Universal access to RH incl. FP + sex. health
Assist dev. countries	IEC	Support pop. and dev. strategies
Assume a leading role in UN	Data Collection	Promote awareness of pop. & dev.
Policy formulation		Advocate mobilisation of resources.

UNICEF (especially influenced by World Summit for Children)

1970s–80s	*1990*	*1995*	*1997*
Child Survival and Development	*Nutrition Strategy*	*Health Strategy*	*Implementation Plan*
Universal Child Immunisations	Breastfeeding	Management of childhood diseases	
Revitalising PHC:	Vit. A supplementation	Malaria control/Guinea Worm	
Eradication		Adolescents' and Women's Health	
Bamako Initiative	Micro nutrients (?)	Safe Motherhood (IEC)	
		Prevention of mother/child transmission of HIV/AIDS	
		Strengthening government capacity to ensure essential health services for children, adolescents and women.	

Aid Instruments – towards Sector-wide Approaches

The growing interest in securing national leadership for a country's health sector development, institutional structures, and capacity for regulating and managing a national health system has led to thinking about how donor financing for the health sector should be organised in order to support reform processes. Following the intentions in the WDR 1993, the World Bank in 1994 started to talk about Sector Investment Programmes that would ideally involve all donors in the sector in supporting national programmes.

Several international meetings on sector-wide approaches have since then taken place; first in Copenhagen, then in Dublin.[13] Several countries are now, along with their partners, striving towards a mode of operation different from the previous project support for a SWAP.

2.2 The Norwegian Arena

In general, the policy and strategy development in Norway closely follows international developments. It is important to note that until 1992 there have been no particular *health* policy and strategy papers. Health development cooperation has been guided by the policies set out in the Government White Papers and operationalised through the yearly Parliamentary Bills.

13. A document co-sponsored by WHO describing the discussions and concepts is published.

White Papers and Parliamentary Bills

An analysis of the White Papers effective during the ten-year period, does not indicate that there have been any drastic policy changes. Health development cooperation is seen as an important contribution to the overall development goals of *improved economic, social and political situation* for the population within the frame of sustainable development. In 1986, rather than using sustainable development, it was emphasised that cooperation should be tailored in such a way as to avoid creating dependency. The 1991 White Paper uses the term *people-centred development* and *people's participation* rather than sustainable development. The principle of "recipient orientation" initially guided the cooperation. The 1992 White Paper added *"recipient responsibility"*. The 1995 White Paper underlines the fact that a clear definition of roles and responsibilities is a prerequisite for sustainable development. Already since 1984 the intention has been that 10 per cent of development aid be allocated to health. However, the UN conferences and the goal of 20/20 are strongly reflected in the 1995 White Paper. This was followed up through Parliamentary Bills, which put more emphasis on the social sector and indicate an increase in resource allocations.

The focus has throughout the years been the *poor.* However, the strategy has changed – from poverty orientation to poverty reduction to combating poverty.

The 1984 White Paper emphasises the *human right to satisfy basic needs*. In the White Papers to follow this does not appear as clearly as it did in 1984. Human Rights are emphasised in later White Papers in relation to population policies: on the one hand, women have the right to decide on family size; on the other hand, support to population programmes require assurances that human rights are not violated.

The main policy throughout the years has been to strengthen *Primary Health Care*. In the 1995 White Paper, the term basic services is introduced and defined as PHC including family planning. The focus has been on children and women through MCH services. In the eighties the term *family planning including MCH* is used and it is emphasised that FP should be integrated into MCH services. The emphasis changed in 1991 when it was stated that 10 per cent should be allocated to *MCH and family planning*. In 1984 it was formulated as family planning including MCH. Safe Motherhood, maternal mortality, is given increased importance and becomes more and more specific. In the 1995 White paper, obstetric care and research to improve statistics and registration of maternal mortality is specifically mentioned. The focus is *reproductive health* rather than family planning – a direct response to ICPD.

Systems development has become increasingly important. In 1991 it is mentioned for the first time that Norwegian aid should contribute to improving efficiency. The latest White Paper stresses the fact that Norwegian cooperation should strengthen public sector capacity to deliver basic services and strengthen administrative capacity.

Disease control has been part of Norwegian priority policies throughout the period. AIDS prevention is mentioned for the first time in 1986 and has been the focus throughout the following years. Lately policy signals[144] do, however, indicate that interventions should also consider the socio-economic implications of the epidemic.

14. UD fakta: AIDS hindrer utvikling.

Budget support (recurrent cost) was mentioned as a strategy to assure basic health services to the entire population already in the 1984 White Paper and confirmed in 1986. Since then this has only been mentioned in the "1995 technical guidelines".

Policies in relation to channels for health development cooperation:
The Conservative government (1984) intended to increase the proportion of aid channelled through bilateral aid. However, the Labour government that took over and created an additional White paper (1986) confirmed the previous policy of 50 per cent through multilateral and 50 per cent through bilateral channels. The 1991 White Paper not only confirmed this distribution, but indicated that it would be desirable to increase the resources channelled *multilaterally as the potential for influencing aid is much higher* than through bilateral aid. The support to MCH/FP should be channelled mainly through multilateral organisations. This is confirmed again in 1995. It is even more explicitly spelled out that Norway should *make the most of its participation on boards, earmark financial resources (rather than project financing) to promote Norwegian development aid policy, and choose areas which have a larger influence on the total policy of the organisation.* One of the areas to be given special attention and effort through earmarking, is the *development of primary health services. Norway wishes to encourage the multilateral organisations to take a broader approach (rather than the control of specific disease).*

Concerning technical assistance and use of expertise, the 1995 White Paper, states that the government will

- on the one hand, promote a clearer division of roles and a better balance between the World Bank and the UN in terms of technical assistance;
- on the other hand, promote increased participation by Norwegian institutions and expert communities in multilateral aid activities especially in fields where Norway has special advantages including an increase in the recruitment of Norwegian nationals for international organisations.

In 1986, it was stated that the increase of funds channelled through *NGOs* witnessed in recent years would not continue at the same pace. In 1991, it was stated that 1/3 of bilateral aid in general should be channelled through NGOs. The 1995 White Paper reiterates the importance of maintaining close cooperation with NGOs. It states that the substantial increase in government support through NGOs generates a need to focus greater attention on the qualitative aspects of their efforts: "quality assurance and achievement of results, should be just as important criteria for aid provided through NGOs as for aid allocated through other channels". The Parliamentary Bills have also underlined that the NGO *sector should be subject to the same criteria and quality requirements as development aid in general.* This is also spelled out in the "1995 Technical Guideline" (referred to later).

Otherwise, the rationale for using NGOs as channels for support for health development is the same as for development cooperation in general, but not stated explicitly in relation to health. However, the NGOs should concentrate their efforts in fields in which they have special competence.

The Parliamentary Bills of the eighties do not provide any additional guidelines for the allocation of resources. They are much more elaborate and specific in the nineties and give concrete guidelines for how resources given to the different organisations are supposed to be used. A summary of the Bills according to the time period of the White Paper in effect, is given in Annex 1.

Policy documents especially related to Norwegian support to health and development:
The Ministry of Foreign Affairs has approved the following three sector papers, namely:

- Guidelines for Development Aid to AIDS Control (1992)
- Strategy for Assistance to Children in Norwegian Development Cooperation (1992)
- "A question of women's right to choice" Norwegian Strategy for Population and Development (1995)

A fourth paper is an *internal guideline (1995) for health sector support in NORAD* developed by the technical advisors in the Technical Department. This guideline, hereafter called "1995 Technical Guideline", provides a frame for the approved sector papers, as the presentation below demonstrates.

The "1995 Technical Guideline" outlines the strategic choices for Norwegian support to the health sector which are, in accordance with the White Papers, based on the assumption that health is a prerequisite for human welfare and has a great impact on economic growth. The basic assumption is that NORAD support forms part of a strategic approach to the health sector having national plans and priorities as its point of departure. It constitutes the following ten strategic choices:

1. All people have the *right to basic health services.* It is a public responsibility to assure a just distribution of such services.

Support for any intervention, regardless of the channel,

2. should consider the *total need of the sector,* assessed on the basis of national plans for the sector and in light of institutional capacity and competence in the recipient country. NGOs play an important role in the health sector. Their support should be evaluated according to how they contribute to national plans and priorities.

3. should contribute to the improvement of the *quality of basic health services.*

NORAD support should contribute to

4. *public institutions having the necessary capacity* to take the overall responsibility to direct and co-ordinate, both at the central and local levels in public administration, and to strengthen the relationship between the public and private sector.

5. necessary *reforms in the health sector* especially through interventions that strengthen the capacity of relevant institutions to plan and implement the reforms (including national health systems research).

6a. v*ulnerable groups having access to health services*,

The Strategy for assistance to children (1992) sets out the following direction for support to children: Greater emphasis on child-targeted efforts in sectors, which are particularly important for children.

- Funds should be channelled in such a way that they make use of the special advantages of the various organs and the expertise they command.
- Closer focus on children in relevant sectors such as health and education in bilateral assistance.

Priority areas: children's rights linked to public administration, health and nutrition, education, care and early stimulation of children, interventions for children in difficult circumstances.

and

6b. health services for children, school health programmes, *tuberculosis and AIDS* control as an *integrated part of national primary health services.*

Guidelines for Development Aid to Aids control (1992)
Interventions should

- Strengthen preventive work especially through health education aiming for behavioural change.
- Take a community-based approach
- Support interventions for STD treatment
- Assure safe blood transfusion and increase the use of condoms.
- Reduce individual and societal consequences of the epidemic by strengthening individual and community coping mechanisms and supporting counselling and interventions for care of AIDS victims,
- Contribute to plan for meeting the socio-economic consequences of the disease through demographic analysis, multisectorial collaboration, the fighting against discrimination of HIV/AIDS victims, assure ethicaly sound research
- Combat increase in TB infection following HIV infection through improved co-ordination with national TB programmes.

AIDS should be integrated into long-term development cooperation through all channels. Sub-Saharan Africa is the priority.

7. *Reproductive health* is a special priority in Norwegian development cooperation.

The Norwegian Strategy for Population and Development (SPD–1995)
The overall aim of Norwegian support for population and development is to support countries to follow a population and development strategy that contributes to strengthening the population's reproductive health thereby improving the quality of life for current and coming generations. This includes support for economic and social development that contributes to people's possibility to explore its full potential having basic reproductive rights that protect against disease and violence and that promotes safety around sexuality and sexual life.

There are two main priority areas for intervention, namely
Reproductive health services and Reproductive rights.

8. NORAD should be willing to give *budget support*

9. Technical support, primarily in *an institutional setting*, is a possible instrument in support for the health sector

10. The same guidelines should apply when evaluating all bilateral support regardless of channel

A *Task Force* on the social sector was established internally in NORAD as an effort to operationalise and follow-up the intentions of the 20/20 Initiative. The group made a considerable effort to identify countries and ways of increasing support to the social sector. Participation in sector-wide approaches is not only a guiding principle for a mode of operation, but can also be seen as a facilitating instrument to increase support to the social sector.

Norwegian policy on International Development with special reference to health

White Paper 36 (1984-85)	White Paper 34 (1986 -87)
Poverty orientation. Emphasises the ***human right*** to satisfy basic needs. Increased support to agriculture, water, education and health especially primary. At **least 10% of total volume of development aid** should be allocated for family planning including interventions for mother and child health.	Poverty orientation – priority to poorest countries Contribute to improved economic, social and political situation of the population and tailored in such a way that it avoids creating dependancy. Although the focus on **basic needs is maintained** and even if possible there should be **increased support to health**, there should be more weight on other interventions that support economic growth. Increased support to organisations working with health, family planning and children. **Focus on aid for children.**
Strengthen Primary health care esp. in rural areas: Disease prevention Local participation and intersectorial action for improved health Integrated district development programmes seen as an effective tool **Family planning** should be integrated in MCH services Support to population programmes require assurance that human rights are not violated where strengthening of women's rights and status is considered central	**Strengthen PHC esp. MCH** Immunisation, Family planning, Health and Nutrition Education to reduce number of deliveries, abortion and maternal mortality. The right to decide the size of the family is a human right on one side. On the other side; Support to population programmes require assurance that human rights are not violated where strengthening of women's rights and status is considered central Support intervention to make abortion safe Regulation of drug sector **AIDS prevention** will be central in Health and population programmes. PHC and population programmes should be tailored to assure the right and possibility of women and men to survive in the grave situation. (support to GPA)
Due to financial crisis **budget support** may be considered.	Support to assure **recurrent cost**
Channel: Increase in Aid should be given through bilateral aid. However, a great part of the support to Family planning through multilateral agencies and international organisations. As a consequence of the relevant focus of Mexico conference, it could be considered to increase the support to FP beyond the current 10%.	**Channel:** The aim is 50/50% between multilateral and bilateral. So rather than decrease the proportion of funds through multilateral agencies, this should be maintained or even increased. Important to stimulate the development banks to lend to health and education. The increase in funds channeled through NGOs that one has witnessed the last years will not continue at the same pace. Need for consolidation.

Norwegian policy on International Development with special reference to health

White Paper 51 (1991-92)	White Paper 19 (1995 -96)
Poverty reduction and promote people's centred development through support to education, health interventions and increased people's participation Strengthen women's status, control population growth and improve children's situation **Goal of 10% of total development aid to MCH and family planning should be maintained.**	Combat poverty. Contribute to improved economic, social and political situation of the population within the frame of sustainable development. Comprehensive perspective and approach to development cooperation. Follow-up of UN conferences: ICPD, Social Summit and Beijing. 20/20.
Focus on **basic needs** **Improve efficiency and strengthen social services and make these available for everybody**	**Strengthen public sector capacity** to deliver basic services through strengthening technical and implementing capacity esp. Local authorities and administrations. Norwegian institutions to play a role.
Primary Health Care: focused on women, children and family planning. "safe motherhood" Increased support to intervention to control child diseases and tropical diseases as well as AIDS epidemic **Population control** as follow-up of the Rio conference	Focus on **PHC and obstetric care.** Separate strategies for children. Contribute to development of basic social services i.e. PHC including FP and support to **strengthening administrative systems.** **Reproductive health approach.** Focus on quality improvement and integrated services. Population policy central to combat poverty. **Research** about maternal mortality as well as improvement of statistics and registration.
Channel: Support to MCH/FP mainly through multilateral/international organisations. **1/3 of bilateral through NGOs.** Wish to continue or even increase support through multilateral system as potential for influence on aid is much higher than through bilateral aid. Equal distribution between bilateral and multilateral aid.	**Channel:** Maintain the high level of UN involvement, Make the most of participation in boards and earmarking of financial resources promote Norwegian development aid policy and to those areas which give larger influence on the total policy of the organisation. Focus on women and PHC. Increased support to PHC as follow-up of 20/20. Focus on contributing to effective PHC. Until now a major part of Norwegian support to international health e.g. through WHO has been on control of particular diseases. Norway wishes now to promote that the multilateral org. takes a broader approach. Bilaterally focus on health services. Strengthen voluntary agencies competence and capacity to implement the ICPD/Social Summit action plan. Regional focus more than country.

Future Directions

The latest Parliamentary Bill (1999) reiterates the Government's commitment to the social sector and states that the proportion for health should reach 10 per cent of total development cooperation within the year 2000. It indicates increased support in the fight against HIV/AIDS, malaria and tuberculosis. The press release in June 1998 by the MDC also indicates an increased support for AIDS – underlining not only the individual aspects of the disease, but also the socio-economic consequences that need more far-reaching interventions than the previous focus on prevention. The multilateral agencies are mentioned again as important channels for health support and it is stated that continued support to UNICEF and UNFPA is justified "*through good results at the country level*" without more specific verification. In line with the 1995 White Paper, this Parliamentary Bill underlines the need for *health systems support* referring to Norwegian support through the World Bank and WHO.

The recent letter to the Director General of WHO[15] gives an indication of the current policies and priorities and falls in line with the latest Parliamentary Bill. It draws attention to the need to improve the health situation of the poorest segments of the world population in which the (i) HIV/AIDS epidemic is central. In addition to HIV/AIDS, the letter points out three additional areas that should be given greater attention on the part of WHO: (ii) combating tuberculosis; (iii) fighting malaria; and (iv) supporting the development of sustainable health systems.

The establishment of a chief advisor on the social sector reiterates the commitment to the social sector and to putting the 20/20 Initiative into action. The strategic notes[16] that guide future investments confirm the previous statements especially in the "1995 Technical Guideline". Interventions to reduce maternal mortality, to improve reproductive health and strengthening the fight against infectious diseases are still central concerns in Norwegian aid to health with the focus on access, quality and institutional capacity. This requires a systematic approach to health sector reform and distribution, health services for MCH services, maternal and women's health, reproductive health including appropriate services for adolescents, integrated services for the prevention and treatment of infectious diseases, access and rational use of essential drugs.

Norwegian NGOs and Their Policies for Health Development Cooperation

The different NGOs included in this study have very different bases for health development cooperation. Only some organisations have developed explicit goals and strategies for social sector involvement or for health sector support for a specific health-related issue such as AIDS (Caritas, NCA, and NPA), others have not. For some organisations these are recent events, and did not guide the operations during the ten-year period studied. Redd Barna now uses the term *integrated development,* and health is not explicitly addressed anymore. However, the study only collected some documents and reviewed others. Therefore a more in-depth assessment should be done in connection with the evaluation exercise.

2.3 Summary

The review of policies and strategies nationally and internationally suggests that the Norwegian policy environment follows international trends and developments closely. It does not indicate that Norway has been in the forefront of these developments. However, Norwegian influence on the results of UN conferences and on the policies and priorities in the multilateral and international organisations may have been substantial. This remains to be proved.

It is worth noting that there were no health policy papers before 1992 and the White Papers and Parliamentary Bills up to 1992–1995 guided health development cooperation. There is still no comprehensive policy paper for health development cooperation. It is also noteworthy that none of the White Papers and Bills state that improved health outcome (mortality, morbidity) is the aim and objective

15. MOH/MIDHR. 12 October 1998: Letter to Dir. Gen. Dr. Brundtland.
16. Sosial sektor utvikling: Strategiske og operasjonell valg. Bakgrunnsnotat: grunnleggende sosiale tjenester.

of interventions in the health sector. The general aim for development aid "to contribute to the improved economic, social and political situation" provides the frame for health sector cooperation.

In the *officially approved* documents referred to above, the perspective is poverty reduction, rather than equity. General rights perspectives form the basic principles for development cooperation and early in the ten-year period this is stated as a human right and basic need. None of the White Papers formulate this explicitly as a right to health care. However, the SAC underlines the child's right to health and nutrition and SPD has reproductive rights as one of its two priorities for intervention. In the *guidelines and papers from the technical department*[17] the rights perspective and equity come through in a more explicit way. These also define improved health outcome as an overall aim for health development cooperation.

Norway has had fairly consistent policies and priorities regarding health development cooperation during these ten years. One could summarise these as primary health care and basic health services, mother and child health, and infectious disease control. The strategies in pursuing these policies and priorities have changed, however, following international developments. An example of such a development is the focus on family planning and MCH in the beginning of the period, followed by MCH and family planning in the late Eighties and the beginning of the Nineties, to a focus on reproductive health and rights after ICPD in 1994. Support for building appropriate national institutional frameworks and capacity has become increasingly important and the mode of operation different, from project support to programme support to sector support.

In terms of the divergence of opinion that may be seen in the international community, Norway seems to fall more in the "group" which would support strengthening the national capacity for delivering basic health services, directing and co-ordinating, regulating and controlling rather than seeking technical solutions. The latest documents from the technical department indicate that Norway is more explicitly searching for a balance and/or a synergy between interventions directed towards control of specific diseases and a systems approach to health sector support and development.

17. The "1995 Technical Guideline".
1998: Bakgrunnsnotat: Grunnleggende sosiale tjenester.
1998: Sosial Sector utvikling: strategiske og operasjonelle valg.

3. Statistical Review of Norwegian Health-related Development Aid

3.1 Data Sources

The aim of this chapter is to review the available data on Norwegian health-related development aid in the period 1988–1997. The data are broken down into channel (multi-, bi- and multi-bilateral aid), sub-sectors, regions, countries etc. These are drawn from a number of different sources such as annual reports, Government White Papers, special reports, data files etc. As mentioned in the introduction, the main data source is the DAC 7, which is in line with the OECD. This reporting system gives a comparable overview of resources provided by donor countries. These data do not include ordinary multilateral assistance, but do include funding earmarked to countries but channelled through these agencies (multi-bi). Nor do they specify bilateral funds channelled through multilateral agencies earmarked for countries (bi-multi-bi), nonetheless they are otherwise the most comprehensive set of data. Since NORAD has applied the same system for data for the entire ten-year period, it also provides a good basis for comparison over time, but does not reflect changes in ways of operating.

For comparison over time most of the data has been deflated according to the official Norwegian consumer price index and is presented in 1997 NOK. Other data are presented in volume (i.e. number of projects, man-years etc.).

Due to the deflated numbers and the fact that data has been drawn from a number of different sources, there may be some minor discrepancies from other sources. It has not always been possible to follow up such deviations in detail, and the figures should thus be handled more as rough indications than as exact figures.

Bilateral aid is defined as aid channelled through NGOs and public state-to-state support. *Multi-bi aid* is defined as funds earmarked for specific countries, but channelled through multilateral agencies. (Bi-multi-bi is registered as multi-bi aid, although not consistently.) *Multilateral aid* is defined as general funds channelled through multilateral agencies, and in the database also as earmarked funds that are not country-specific.

3.2 Overview of Health-related Aid

Total and Health-related Aid

This section provides an overview of total aid and health-specific aid through bilateral and multi-bi channels. The figures are initially presented in nominal values. The nominal increase in total general aid has been 43 per cent, whereas the increase in health-related multi-bi and bilateral aid has been 67 per cent. Multilateral aid will be discussed and specified later in the document.

Table 1: Total and health-related aid

Year	Total aid	Total multi	Multi-bi & bi	Health rel. multi-bi & bi	Total no. of health proj.
1988	6 424 500	2 744 794	3 679 706	346 962	237
1989	6 343 800	2 558 040	3 785 760	336 382	200
1990	7 551 100	2 869 001	4 682 099	391 245	246
1991	7 635 300	2 933 508	4 701 792	369 233	320
1992	7 910 500	2 934 300	4 976 200	380 060	309
1993	7 193 400	2 521 767	4 671 633	365 511	373
1994	8 021 500	2 180 400	5 841 100	420 425	411
1995	7 923 600	2 137 300	5 786 300	538 274	406
1996	8 571 339	2 475 902	6 095 437	536 038	430
1997	9 209 400	2 559 705	6 649 695	580 134	386
Total	76 784 439	25 914 717	50 869 722	4 264 264	μ = 332

Source: DAC & Govt. White Paper. Nominal values.

In the following the data have been adjusted according to the official Norwegian consumer price index[18] and is presented in deflated figures (1997 NOK). Total aid has increased by 12.7 per cent. Although the share for health purposes has been relatively stable over the period, there has been a real term increase of 31.4 per cent in allocations through this channel. During the ten-year period the share of total multi-bi and bilateral aid to health care has been 8.4 per cent on average, with the highest in 1988 (9.4 per cent) and the lowest in 1994 (7.2 per cent). This increase is also illustrated in Fig. 1 below, where it becomes apparent that the increase has been mainly from 1993/94 and onwards.

Table 2: Total and health-related aid, deflated figures

Year	Total aid	Total multi	Multi-bi & bi	Health rel. multi-bi & bi	per cent of tot. mbi- & bilat.
1988	8 173 664	3 490 437	4 679 325	441 427	9.43
1989	7 717 518	3 112 282	4 606 008	409 224	8.89
1990	8 821 379	3 351 718	5 469 874	457 062	8.36
1991	8 627 458	3 313 846	5 311 393	417 212	7.85
1992	8 731 236	3 238 882	5 492 732	419 492	7.64
1993	7 759 871	2 721 252	5 041 183	394 294	7.82
1994	8 533 511	2 320 434	6 216 238	447 261	7.20
1995	8 228 037	2 220 326	6 011 076	558 955	9.30
1996	8 791 117	2 539 845	6 252 858	549 783	8.79
1997	9 209 400	2 559 705	6 649 695	580 134	8.72
Total	84 593 190,20	28 868 726	55 730 381	4 674 845	8.38

Source: DAC & Govt. White Paper
(1997 = 100)

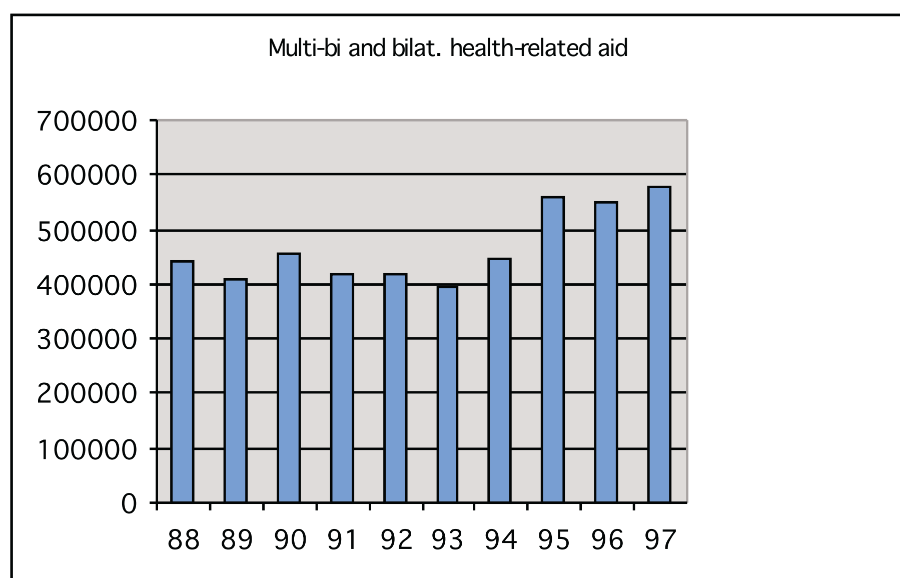

Fig. 1: All figures in thousand NOK

Channels for Aid

The health-related *bilateral* and *multi-bi* development aid is presented in Table 3 and Fig. 2, which show both the total real term allocations and the share of each of the two channels per

18. The Official Norwegian consumer price index according to Statistics Norway: 1988: 78.64;1989: 82.19; 1990: 85.60; 1991: 88.52; 1992: 90.60; 1993: 92.67; 1994: 93.97; 1995: 96.26; 1996: 97.48; 1997: 100.00.

year. Traditional bilateral development aid has been the main channel during the ten-year period with an average of 76 per cent of total aid through the two channels. In 1994 there was a major change in the general trend, as multi-bi became far more significant than in earlier years. Multi-bi as a channel for aid to the health sector reached its peak in 1996, not only in real terms, but also as a share of the total (38 per cent).

Table 3: Health-related bilateral and multi-bi aid

Year	Bilateral	%	Multi-bi	%	Total
1988	324 628	74	116 799	26	441 427
1989	361 243	88	47 981	12	409 224
1990	390 791	86	66 271	14	457 062
1991	360 706	86	56 506	14	417 212
1992	358 299	85	61 193	15	419 492
1993	342 824	87	51 470	13	394 294
1994	290 500	65	156 761	35	447 261
1995	400 040	72	158 915	28	558 955
1996	339 964	62	209 818	38	549 783
1997	402 974	69	177 160	31	580 134
Total	3 571 971	76	1 102 874	24	4 674 845

Source: DAC & Govt. White Paper

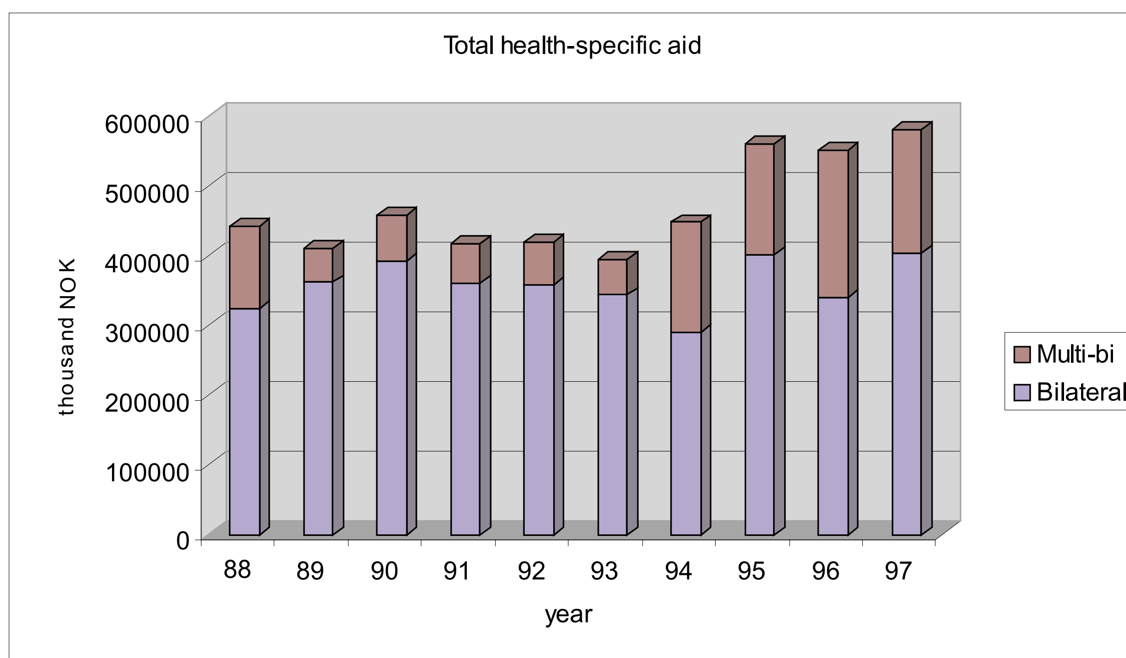

Fig. 2

Multilateral aid is by our definition non-earmarked funds to multilateral agencies (UN, international development banks and financing institutions etc.), and is thus not easily broken down by sectors and sub-sectors. Nevertheless, the various multilateral agencies provide figures on their allocations to different sub-sectors. A rough estimate according to channel is presented in Table 4. This indicates that both in 1996 and in 1997 about 12 per cent per cent of total Norwegian development aid was allocated for the health sector. Multilateral aid was the main channel for support to the sector with an estimated 48–50 per cent of total aid to health.

In 1996 about 20 per cent of total aid channelled through all multilateral agencies was allocated for the health sector, whereas the corresponding figures for multi-bi was 15.9 per cent and only 7.4 per cent for bilateral aid (including bi-multi-bi).

Table 4: Total and health-related aid 1996 and 1997

Million NOK	1996 Total aid	1996 Health-related	1996 Per cent	1997 Total aid	1997 Health-related	1997 Per cent
Bilateral	4483.4	332.4	7.4	4798.6	403.0	8.4
Multi-bi	1281.1	204.6	15.9	1316.5	177.2	13.5
Multilateral	2368.5	475.0	20.0	2559.7	553.8	21.6
Total (net)	8472.8	999.0	11.8	9209.4	1134.0	12.3

Source: DAC, Govt. White Paper, estimates for multilateral agencies

The 1996 figures are rough estimates drawn from an internal report from the MFA[19] combined with other sources (reported shares to health from the multilateral agencies) and should thus be treated with caution. However, the exact figures are very difficult to obtain and will differ according to source.

NORAD has also calculated the percentage allocated to health in 1995–1998.[20] However, these figures differ somewhat from those presented in this document. For bilateral and multi-bi aid these are 10 per cent and 8.72 per cent per cent respectively. This discrepancy is not elaborated on further in this document, but NORAD stressed that it should be looked into more thoroughly.

Fig. 3 illustrates all health-related aid according to channel in 1996. In the DAC database bi-multi-bi (earmarked bilateral aid channelled through multilateral agencies) is not specified. At least part of this is registered as multi-bi, but it also seems that a share is registered as bilateral aid.

19. MFA Multilateral Department: Økt bistand til helse og utdanning. En drøfting av muligheter og kanaler for en opptrapping av innsatsen.
20. Letter from NORAD to MFA, Bilateral Department, 13 October 1998.

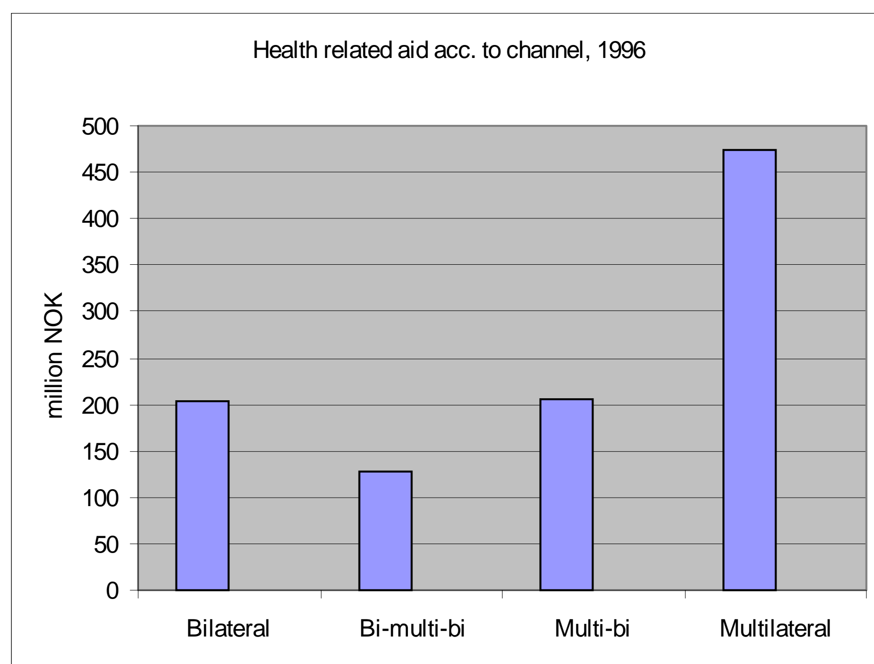

Fig. 3: Sources: Økt bistand til helse og utdannelse, MFA internal paper, June 1997 DAC data base, 1998

NGO and non-NGO

There has been an increase in real-term bilateral and multi-bi aid and a significant change towards using NGOs as a channel for Norwegian development aid. The total bilateral/ multi-bi aid to the health sector increased in the ten-year period due mainly to the 237 per cent increase through NGOs, in spite of the 25 per cent decrease in public (*non-NGO*) bilateral aid to the sector in the same period. Currently about 56 per cent of this type of aid to the sector is channelled through NGOs, as compared to 22 per cent in 1988.

A major part of this has been channelled through *Norwegian NGOs*, which are currently in charge of 41 per cent of total bilateral aid to the health sector. *Global NGOs* are the second largest channel whereas *regional and local NGOs* receive only a minor share as direct funding. Nevertheless, it is important to stress the fact that the DAC database registers the channel according to the primary receiver regardless of who the final receiver is, and as a number of the Norwegian NGOs operate as partner organisations, the picture is more varied.

According to DAC registration the share of total bilateral health aid channelled through *research institutions* has been insignificant (0,02 per cent of total),[21] although about 4 per cent of the total is characterised as *research as compared to 3 per cent of the multi-bi.*

21. There seems to be some confusion related to registration since only FAFO is registered as a research institution while e.g. TAN 074 is registered as operated by an NGO.

Table 5: NGO and non-NGO aid (bilat. & multi-bi)

Year	NGO	Non-NGO
1988	95 547	345 880
1989	141 213	268 011
1990	168 199	288 863
1991	182 471	234 741
1992	177 637	241 855
1993	194 374	199 920
1994	210 380	236 881
1995	276 223	282 732
1996	280 919	268 864
1997	322 158	257 976
Total	2 049 121	2 625 724

Source: DAC

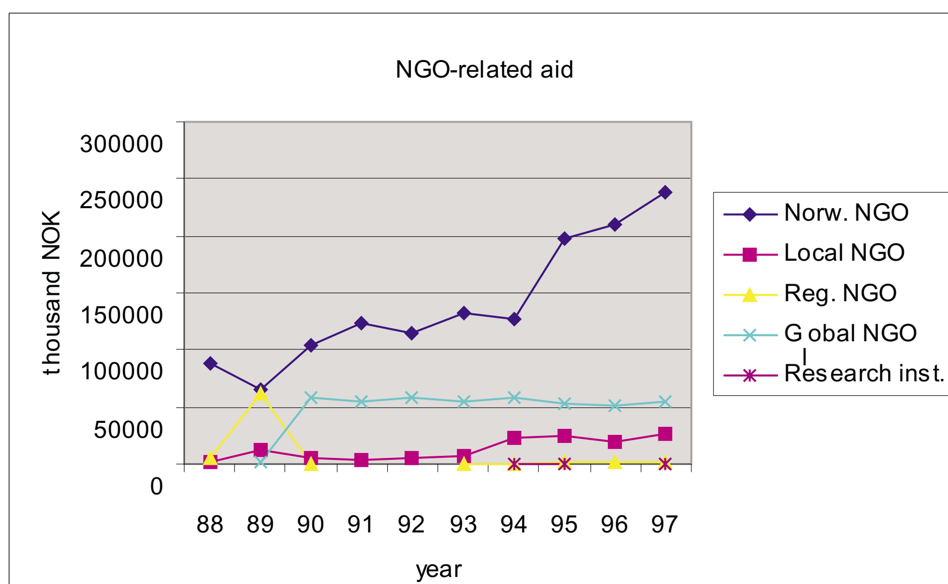

Fig. 4

There are three main channels for support to NGOs: Bilateral Department/MFA, Regions Department (REG/NORAD), and Department for Non-Governmental Organisations (FRIV/NORAD).

MFA

In 1997 about 50 per cent of total health-related NGO support was channelled over MFA budgets (NOK 160 million). More than 2/3 of this was support to Norwegian NGOs (but has often a different final destination), whereas 1/3 was support to Global NGOs, where the majority (NOK 45 million) was a general contribution to IPPF (International Planned Parenthood Federation). The distribution was 44 per cent to Africa, 15 per cent to Asia, 8 per cent to Europe and 32 per cent unspecified/global.

REG/NORAD

In 1997 about 17 per cent of the total health-related support to NGOs was channelled through the Regions Department in NORAD. About 55 per cent of the total funds over this post were allocated to NGOs operative in Africa in 1997 (NOK 88.7 million), as compared to 31 per cent to Asia (NOK 49.8 million) and 10 per cent to Latin America (NOK 15.7 million). A total of NOK 130 million or 81 per cent of this was channelled through Norwegian NGOs.

FRIV[22]/NORAD

The allocations through FRIV have increased during the period 1992–97 and were NOK 107.6 million in 1997. Nevertheless, this increase was larger in the other two channels for NGOs (MFA and REG/NORAD). In 1992 about 48 per cent of the NGO funds were channelled through FRIV as compared to 33 per cent in 1997. The six largest NGOs were accountable for 69 per cent of the total health sector contribution through FRIV. It is important to note that BN and FBS[23] (Funksjonshemmedes Bistands Stiftelse) as the largest of these are umbrella organisations for Norwegian mission organisations and for interest organisations for persons with different disabilities, and they represent a number of organisations. The four largest single NGOs in the health sector have been the Norwegian Red Cross, Norwegian Church Aid, Norwegian Peoples' Aid and Redd Barna (Save the Children).

Norwegian Peoples' Aid has had the highest relative growth in the health sector over the five years period, whereas Redd Barna no longer defines activities as health. Although BN still has a relatively high percentage allocated for hospitals (DAC 73), this has been reduced over the past few years, and is currently about 35 per cent of the total BN budget

22. FRIV has later changed its name to SIVSAM (Civil Society).
23. FBS has later changed name to the Atlas Alliance.

from FRIV. In FBS 82 per cent is registered as nursing, vaccination, disease and control of epidemics (DAC 73).

Among the "four large" organisations, Norwegian Peoples' Aid is the organisation with the highest proportion of projects registered as "unspecified" (DAC 79), with 77 per cent of total, as compared to the Norwegian Red Cross with 56 per cent, whereas NCA registered only 9 per cent as unspecified. The two latter have a high focus on AIDS in their work (34 per cent and 54 per cent).

A regional grant was introduced in the early nineties. It has been claimed that only a marginal share of this has been allocated for health. However, calculating this would require considerable work, and it has thus been left for others to do, i.e. through an evaluation.

Table 6: Health-related aid through FRIV/NORAD

FRIV Health	BN	FBS	N.Red Cross	N.Church Aid	N.Ppl.Aid	Redd Barna
1992	34 394	5 482	7 736	8 720	2 225	5 744
1993	28 703	6 653	4 252	5 723	191	5 860
1994	26 546	9 987	5 627	3 797	1 409	4 836
1995	22 291	7 695	4 174	5 253	4 172	7 524
1996	22 098	10 957	5 945	4 603	11 712	5 081
1997	30 170	14 348	8 171	7 527	13 592	0
Total	164 202	55 122	35 905	35 623	33 301	29 045

Source:

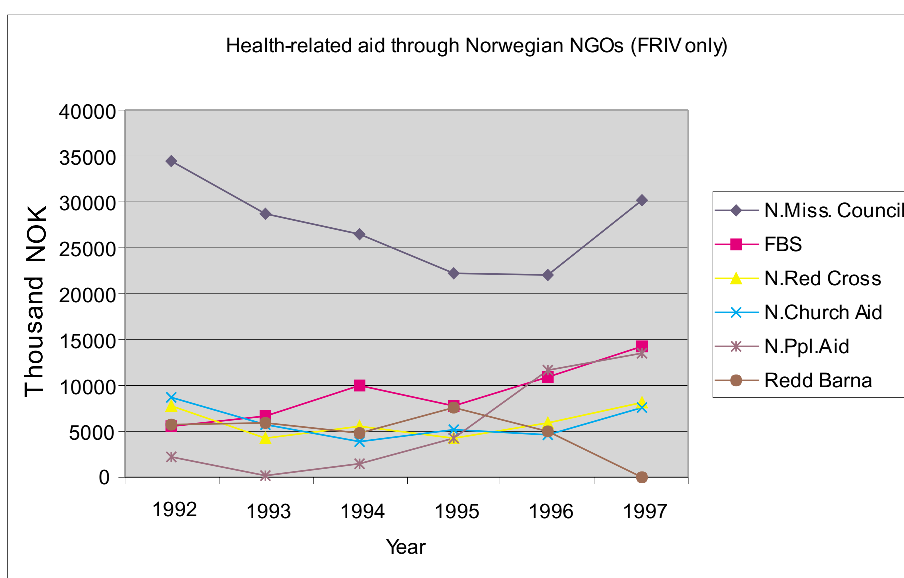

Fig. 5

Multi-bi aid

In the following the multi-bi aid specified for health purposes is presented. The deflated and aggregated figures for the ten-year period indicate that the World Bank has since 1993 become the largest single multilateral agency in terms of Norwegian earmarked funds (multi-bi), and in 1997 this was about 42 per cent of total. The UNICEF grant has fluctuated from year to year, and was the third largest in this category in 1997. UNFPA was the second largest from 1993/94 registered as multi-bi, but should probably have been registered as bi-multi-bi.

This is also a more general problem, as bi-multi-bi is classified as multi-bi. In addition there is a distinction between earmarked funds through the multilateral agencies for *special programmes*, which are defined as multilateral aid, and funds specified for *countries*, which is classified as multi-bi. An example of this is funding to TDR/WHO, which is classified as earmarked funds for health, but multilateral.

Table 7: Health-related multi-bi aid (thousand NOK)

	UNICEF	UNFPA	WB	UNDP	PAHO	WHO	Total
88	30 280	20 566	53 401	3 837	6 539	1 272	115 896
89	23 479	19 465					42 944
90	51 389	12 850	17 065	467	6 949	526	89 246
91	25 424	12 429	695		7 524	2 373	48 445
92	27 988	12 395	7 666		8 382	2 208	58 638
93	25 869	6 365	43 150		7 228	2 020	84 632
94	33 191	18 702	63 830	1 596	5 460	33 872	156 651
95	24 004	14 434	71 651		3 694	42 738	156 521
96	50 105	40 909	69 231	8 172	1 318	23 674	193 408
97	30 339	50 561	73 600		5 400	14 976	174 876
Total	322 069	208 676	400 288	14 072	52 493	123 659	

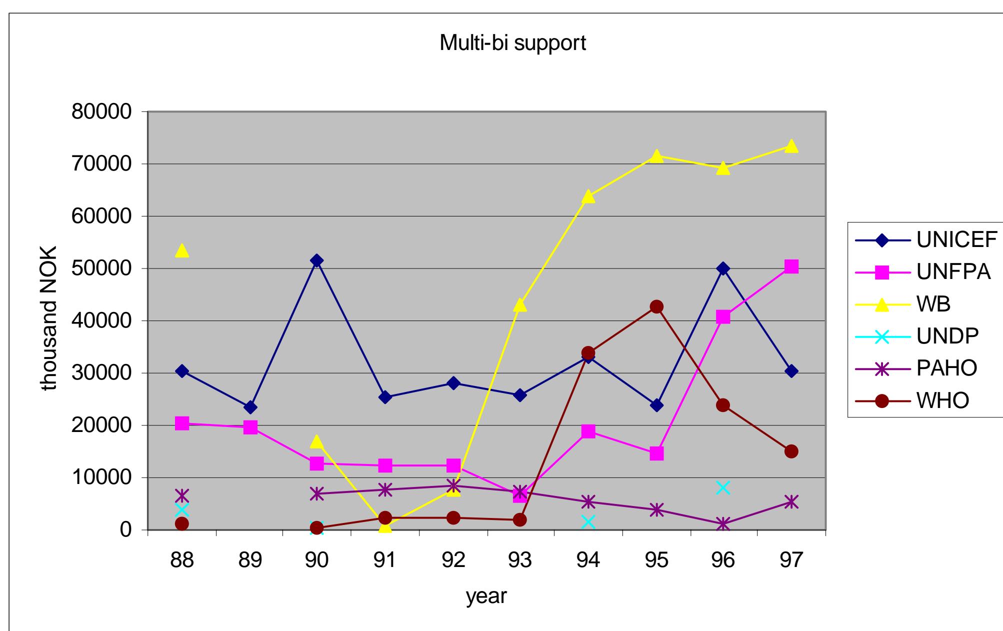

Fig. 6

Multilateral aid

Although there was a real-term decrease in total general multilateral aid up to 1995, it has increased since and is currently about NOK 2.8 billion. The Norwegian contribution for health purposes has been estimated according to the general health-related percentage presented by the different agencies, and earmarked funds are thus not included in these figures.

The share for health purposes has been relatively stable at around 15 to 17 per cent of total multilateral funds over the ten-year period, but has increased somewhat in the past few years and was around 18 per cent in 1996 and 1997. Fig. 7 indicates that there has been an increase not only as a share of the total, but also in real terms. Total health-related aid through the channel was NOK 505 million in

1997, as compared to NOK 430 million in 1996 and NOK 403 million in 1995 (all figures are deflated according to the consumer price index, where 1997 = 100).

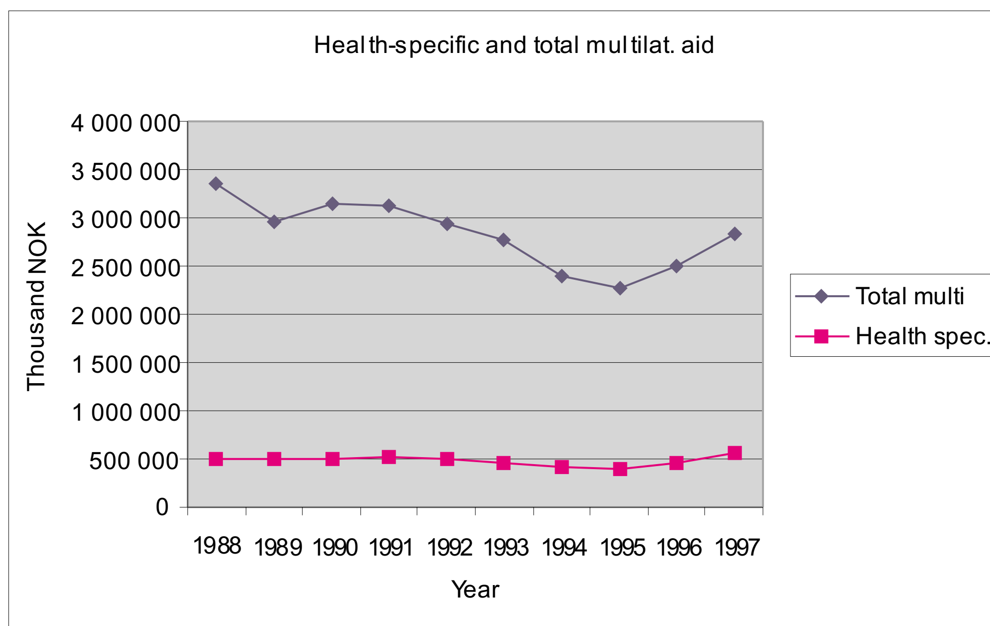

Fig. 7

In the following the significant multilateral agencies within the health sector are listed and discussed in some detail. The significant agencies with regard to Norwegian health care support are WHO, the World Bank, UNICEF, UNFPA, UNDP, IPPF,[24] and IUATLD.[25] In 1990 UNFPA took over from UNICEF as the largest in terms of Norwegian support, and was NOK 140 million or about 28 per cent of total in 1997. As a comparison WHO received NOK 121 million (24 per cent) whereas the estimated general health support for UNICEF was NOK 89 million (18 per cent). It is important to stress that the ear-marked funds are not included in the figures presented here as this by definition is registered as multi-bi support.

Around 1994–95 the general contribution became more equally distributed among the agencies, particularly as the general funds for WHO and UNICEF were reduced. The exception from this is UNFPA, which remained at a high level throughout the period. The funds for WHO and UNICEF have since increased again.

In order to get the overall picture Table 7 and Fig. 6 may be compared to Table 8 and Fig. 7.

24. International Planned Parenthood Federation
25. International Union Against Tuberculosis and Lung Disease

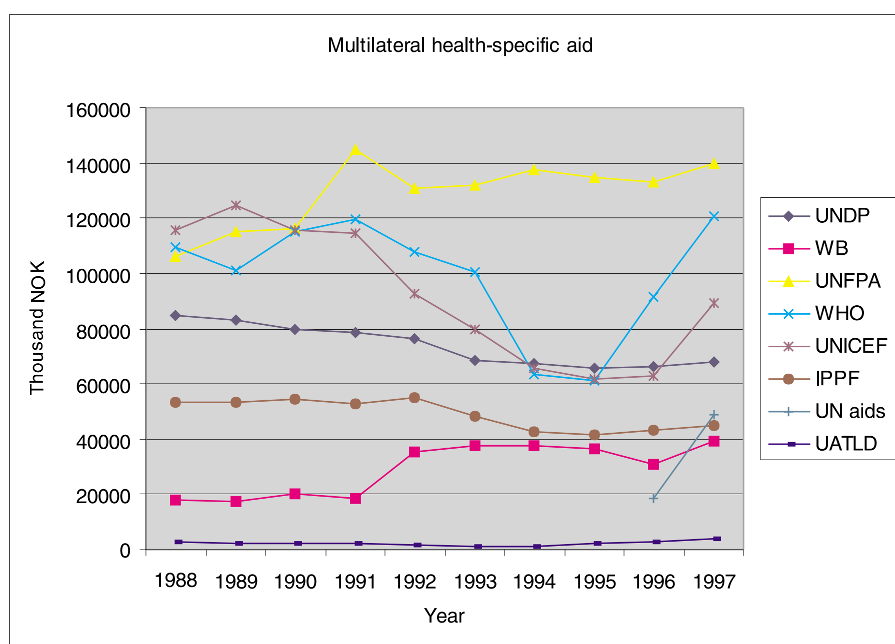

Fig. 8: Multilateral funds, 1988–97

Table 8: Multilateral health-specific aid, deflated figures

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
UNDP (1)	84 847	83 066	79 907	78 373	76 556	68 479	67 532	65 670	66 092	67 680
WB (2)	18 166	17 663	20 272	18 271	35 221	37 864	37 548	36 732	30 831	39 076
UNFPA (3)	106 247	114 909	116 121	144 746	130 574	132 147	137 766	134 476	132 821	140 000
WHO	109 556	100 976	115 308	119 758	107 795	100 341	63 644	61 285	91 657	120 663
UNICEF (4)	115 649	124 793	115 537	114 576	92 715	79 935	65 617	61 558	62 769	89 430
IPPF	53 435	53 528	54 322	52 542	55 188	48 544	42 553	41 537	43 077	45 000
UN AIDS									18 462	48 879
UATLD	2 545	2433	2 336	2 260	1 656	1 079	1064	2 077	3 077	4 000
TOTAL	490 445	497 368	503 804	530 526	499 704	468 388	415 724	403 335	448 785	554 728

% Health-specific aid

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
UNDP (1)	12 %	12 %	12 %	12 %	12 %	12 %	12 %	12 %	12 %	12 %
WB (2)	3,3 %	3,3 %	3,3 %	3,3 %	6,5 %	6,5 %	6,5 %	6,5 %	6,0 %	7 %
UNFPA (3)	70 %	70 %	70 %	70 %	70 %	70 %	70 %	70 %	70 %	70 %
WHO	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
UNICEF (4)	45 %	46 %	43 %	39 %	35 %	30 %	24 %	24 %	24 %	33 %
IPPF	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
UN AIDS									100 %	100 %
UATLD	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %

Sources: See text
(1) Estimated, 12% is described as Social Services
(2) Average for 1997–91 and 1992–97
(3) Estimated 70% for health in 1988–93
(4) Estimated 24% for health in 1994 and 1995
(5) Other international development banks are not included

Multilateral and Multi-bi

The health-related multilateral and multi-bi support according to agency is presented in the following. This shows that the trends generally follow the same patterns that the multilateral aid follows as the multi-bi figures are relatively lower than the multilateral.

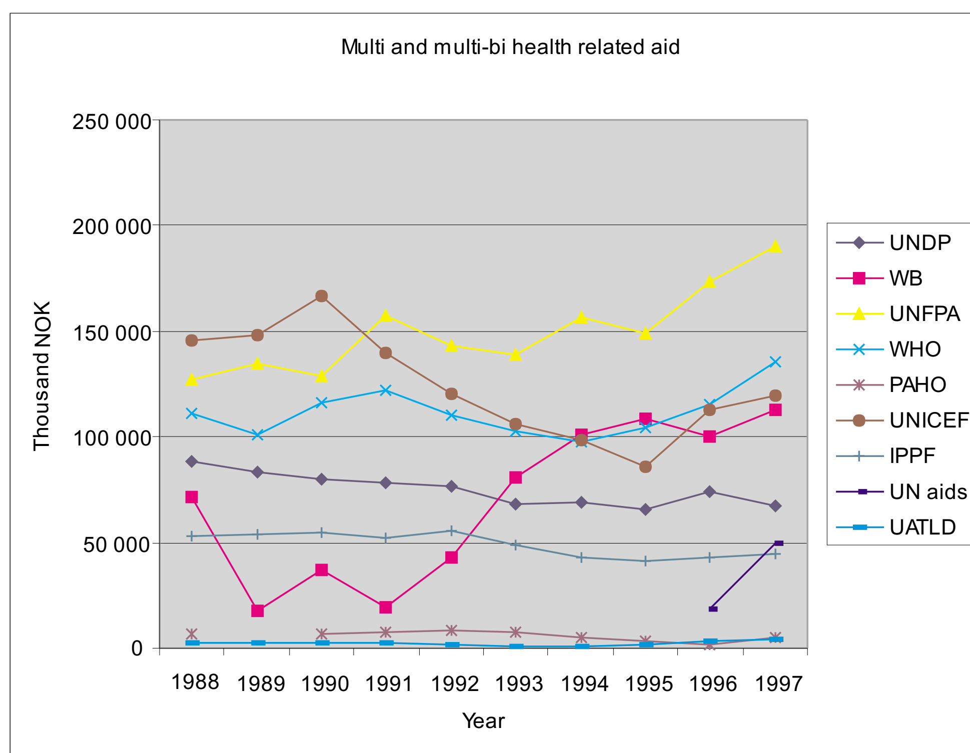

Fig. 9

An exception is the World Bank, where multi-bi was 65 per cent of total support to the sector in 1997. In this figure WHO follows a less bulky trend, indicating that a higher share of the funds have become earmarked (see multi-bi).

Table 9: Multilateral and multi-bi health-related aid

Multilat. and multi-bi	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
UNDP	88 684	83 066	80 374	78 373	76 556	68 479	69 128	65 670	74 264	67 680
WB	71 567	17 663	37 337	18 966	42 887	81 014	101 378	108 383	100 062	112 676
UNFPA	126 813	134 374	128 971	157 175	142 969	138 512	156 468	148 910	173 730	190 561
WHO	110 828	100 976	115 834	122 131	110 003	102 361	97 516	104 023	115 331	135 639
PAHO	6 539		6 949	7 524	8 382	7 228	5 460	3 694	1 318	5 400
UNICEF	145 929	148 272	166 926	140 000	120 703	105 804	98 808	85 562	112 874	119 769
IPPF	53 435	53 528	54 322	52 542	55 188	48 544	42 553	41 537	43 077	45 000
UN AIDS									18 462	49 469
UATLD	2 545	2 433	2 336	2 260	1 656	1 079	1 064	2 077	3 077	4 000
Total	606 340	540 312	593 049	578 971	558 344	553 021	572 375	559 856	642 195	730 194

World Bank

In the past few years the World Bank has become the world's main contributor to the health sector. In 1970 the Bank became involved in population activities, in 1977 nutrition and in 1980 health. The Health, Nutrition and Population Programme has increased from 3.3 per cent per cent of total lending in

the period 1987–91 to 6.5 per cent in 1992–96, decreased a bit in 1997, but is committed to continued growth at US$ 7.8 billion in 1998–2000 (1998: 6.9 per cent of total). The bulk of lending in the sector is directed at public sector provision of basic health services. Projects approved after 1995, however, more often experiment with mechanisms to motivate private /public partnerships.

The focus has been on a) Specific Disease Control, b) Nutritional Improvements, and c) Family Planning and Reproductive Outcomes. There has been a continuous growth in the focus on systemic reforms, from 16 per cent of total in 1970–84, to 33 per cent in 1985–89 and 48 per cent in 1995–97.

The Bank was active in 91 countries in 1970–97, but four countries accounted for 42 per cent of the lending. India accounts for 20 per cent HNP lending, Brazil 8.6 per cent, China 6.8 per cent and Indonesia 6.6 per cent. When Bangladesh and Nigeria are included, 50 per cent of the lending has gone to just six countries.[26]

UNICEF

Total UNICEF programme expenditures were US$ 804 million in 1995, US$ 684 million in 1996, and US$ 673 million in 1997 and have thus been reduced by 16 per cent over the period. There is also a trend towards a higher share of supplementary and emergency funds and lower share of general resources. In 1997 it was 58 per cent supplementary and emergency funds and 42 per cent general.

In the fiscal year of 1997 about 33 per cent of the UNICEF programme expenditure was allocated to health, as compared to 36 per cent in 1993. There is thus a 21 per cent reduction in real terms from US$ 286 million to US$ 225 million in this period. The Norwegian contribution increased from NOK 202 million in 1988 to NOK 271 million in 1997.

Norway is currently the second largest contributor to UNICEF. Norway has for a long time supported projects and programmes earmarked for health and sanitation, but as these programmes have later become central parts of the general work of UNICEF and are thus supported over the general contribution, i.e. non-earmarked. In some of the main partner countries ("hovedsamarbeidslandene") NORAD will use UNICEF as the channel for support (e.g. Uganda).[27]

In 1997 UNICEF collaborated with 161 countries, consisting of 46 in Africa, 37 in the Americas, 33 in Asia, 19 in the Middle East and North Africa, and 27 in Central and Eastern Europe and the Baltic States. Accordingly, the allocations were 38 per cent for Sub-Saharan Africa, 31 per cent for Asia, and 12 per cent for the Americas.

UNFPA

Norway provided 9.7 per cent of the total amount contributed to UNFPA in 1997 and was fourth in donor ranking.[28] From 1988 to 1997 there has been a 32 per cent increase in real term contribution, from NOK 156 million to NOK 206 million.

Between 1977 and 1993 Norway's contribution to UNFPA's trust funds was US$ 27.5 million. In 1994 the MFA decided to end trust fund financing through UNFPA for "political and administrative reasons" in favour of providing additional funding to general resources. General contributions have since remained low. However, NORAD continues to fund projects, and between 1995 and 1997 the contribution to trust funds was US$ 17.9 million (bi-multi-bi) to projects in Ethiopia, Tanzania, Nicaragua, Uganda and Mozambique.

UNFPA allocates about 70 per cent of its general resources for health purposes, mainly defined as reproductive health. As a share of the general contribution from Norway in 1997 this was equivalent to NOK 144 million.

WHO

By definition all WHO activities are health-related and therefore 100 per cent of the general support is defined as health. This showed a

26. World Bank, Lessons from Experience in HNP, Sept. 1998.

27. UNICEF, Global and Regional Overview, 1998
UNICEF Annual Report 1998
MFA, UNICEF99. DOC, 1999

28. UNFPA, donor profile.

decrease from 1992 to 1995 due to concerns about the performance of the organisation. Norway has provided substantial extra budgetary funds for programmes and in the same period the extra budgetary funds (EBF) increased substantially. Information provided by WHO for the period 1993–1998[29] shows that TDR has received by far the largest amount (NOK 176 million), followed by Diarrhoeal Diseases (NOK 52 million), Human Reproduction (NOK 45 million) and Immunisation (NOK 40 million). Tuberculosis started to receive funds in this period and has so far received NOK 25 million. GPA received NOK 58 million in the two last years of its life (1993 and 1994). By then it had received more than NOK 280 million. The TDR support hides miscellaneous activities such as support for Global Health Forum.

NORAD has provided very little bi-multi-bi support for WHO country operations. However, it has allocated substantial support for PAHO's Central American projects (women's health and decentralisation) during this ten-year period. Since 1996, NORAD has initiated cooperation with AFRO as well.

3.3 Types of Aid

In the DAC database the definitions of project aid, programme aid, and technical collaboration are as follows:

> *Project aid*
> Financial and/or other type of support for single/individual development projects. NB! Parallel financing is registered as project aid.
>
> *Programme aid*
> This is aid provided according to agreements between Norwegian authorities and a recipient country regarding activities consisting of 1) several projects within a sector such as roads, water or energy; 2) several projects directed towards a specific geographical area, including different sectors; 3) general support to balance of payments, debt relief etc. NB! May also include support to multi-bi programmes like the World Bank SAP.
>
> *Technical collaboration*
> Aid contributing to the development of overall capacity and knowledge in different areas. All activities directed towards the development of human resources through strengthening skills, knowledge, technical know-how and productivity. Aid in terms of personnel, technical aid, and also information is included in this. One important area is institutional development based on the development of human resources.

There are several problems related to the interpretation of these definitions and how registration is done. Much of the registration of projects is carried out at the local representation or in the various offices of NORAD and the MFA, and is thus not consistent. From the above definitions it is not obvious how, for example, projects or programmes of institutional collaboration should be registered. An example is the Health Sector Collaboration Programme between Norway and Botswana, consisting of a number of projects within one programme, focusing on institutional development through institutional collaboration. This is currently registered as Health Administration (see country profiles).

The overview in Fig. 10 should therefore be interpreted with caution. It shows that over the ten-year period there is a strong tendency for bilateral support to focus increasingly on project support, whereas there has been a decline in programme support. This, however, could be due primarily to the substantial increase in NGO projects. The trend is reversed through the multilateral channel, where there was a major increase in programme support from 1993 onwards.

Support to technical collaboration has been stable or increased slightly over the period, both through bilateral and multilateral channels. There have not been significant changes in aid through goods and import support in this period, and this remains at a low level.

29. All figures are converted at the NOK/US$ rate 7.35.

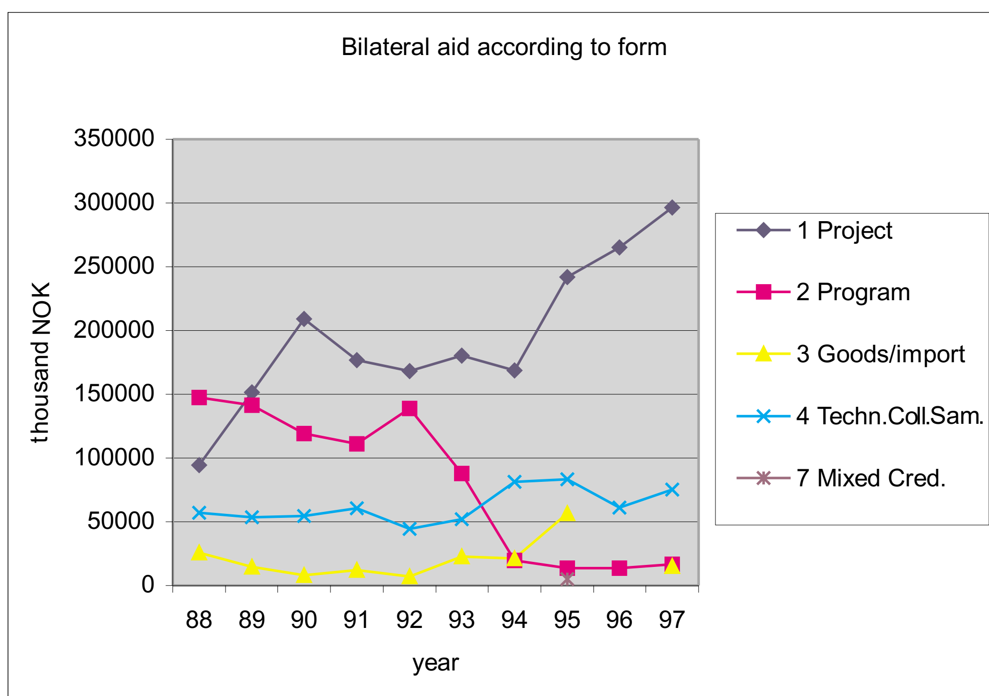

Fig. 10

3.4 Aid According to Sub-sectors

As described earlier the registration in the DAC database is done according to sub-sectors.[30] The limitations of the database were discussed earlier in this chapter, but are summarised as follows: It does not include general multilateral aid, it does not specify bi-multi-bi aid, the category "other/unspecified" limits the information, the actual registration of the data is not done uniformly. The development of these sub-sectors over the past ten years is illustrated in the chart below (Figs. 11, 12, and 13).

MCH and family planning has been the largest sub-sector with regard to expenses with an average of 35 per cent of total. Expenses for *AIDS*-related projects and programmes increased steadily before 1995 and reached 18 per cent (NOK 90 million) of total, but have since been reduced to about 9 per cent (NOK 50 million) in 1997. Other support to AIDS work is currently channelled through ordinary multilateral (UN AIDS, NOK 48 million). *Hospitals and health centres* have also seen some increase and were about 10 per cent of total budget in 1997, whereas *nursing, immunisation and control of epidemics* were 15 per cent of total.

The most striking trend when distinguishing between bilateral and multi-bi aid is the increase in *MCH and family planning* through multi-bi since 1993. In 1997 this sub-sector represented 72 per cent of the multi-bi budget for health (NOK 128 million.). Through the bilateral channel there has been an equivalent decrease from 52 per cent of total in 1989 to 15 per cent in 1997. *Health administration* has remained low throughout the period, as has *dental care.*

30. The health-related sub-sectors are registered under DAC 7, Health and Population. These include the following, 70 Hosp., health centres, 71 Dev. health centres, 72 MCH, fam. pl., 73 Nursing, immunis. 74 Health admin., 75 Dental care, 76 AIDS, 79 Other health & pop.

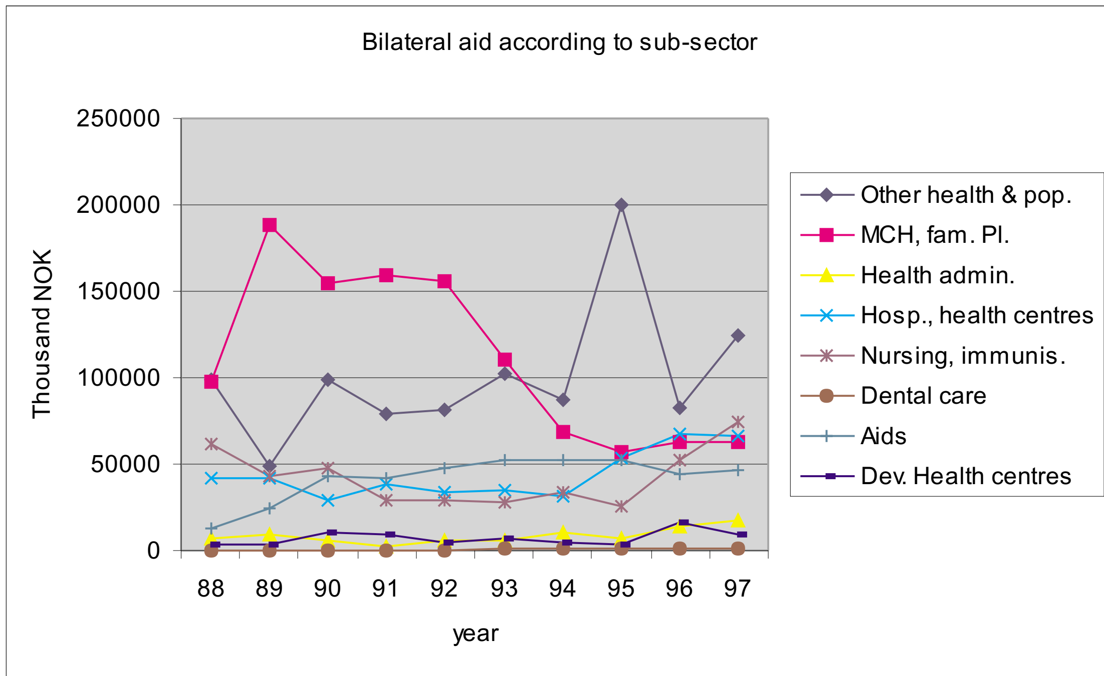

Fig. 11

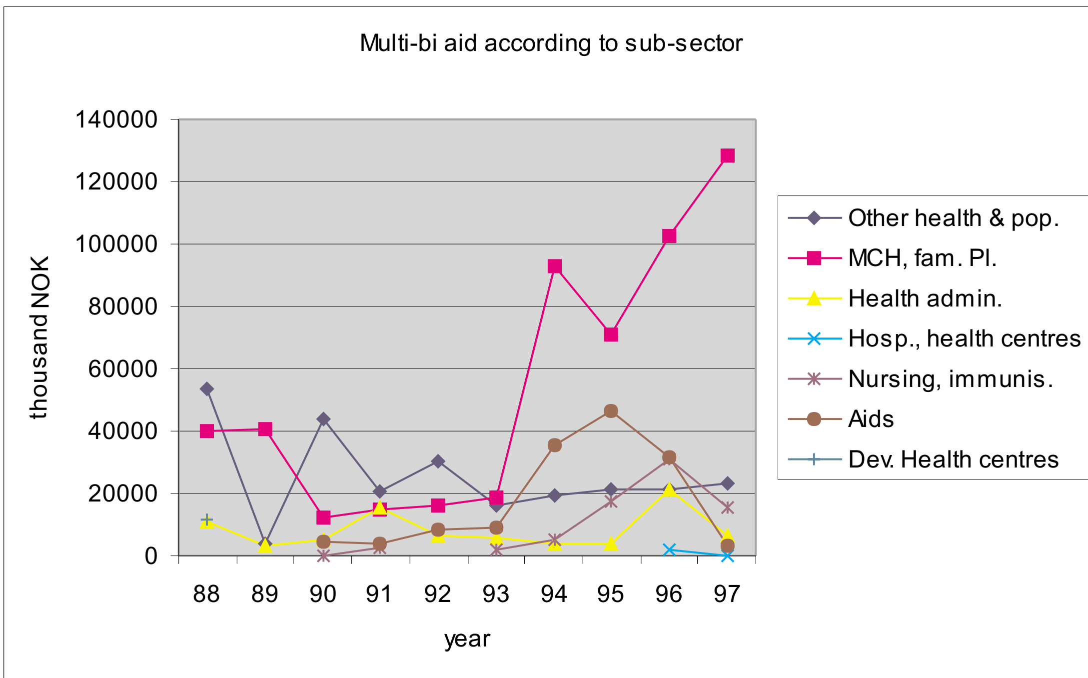

Fig. 12

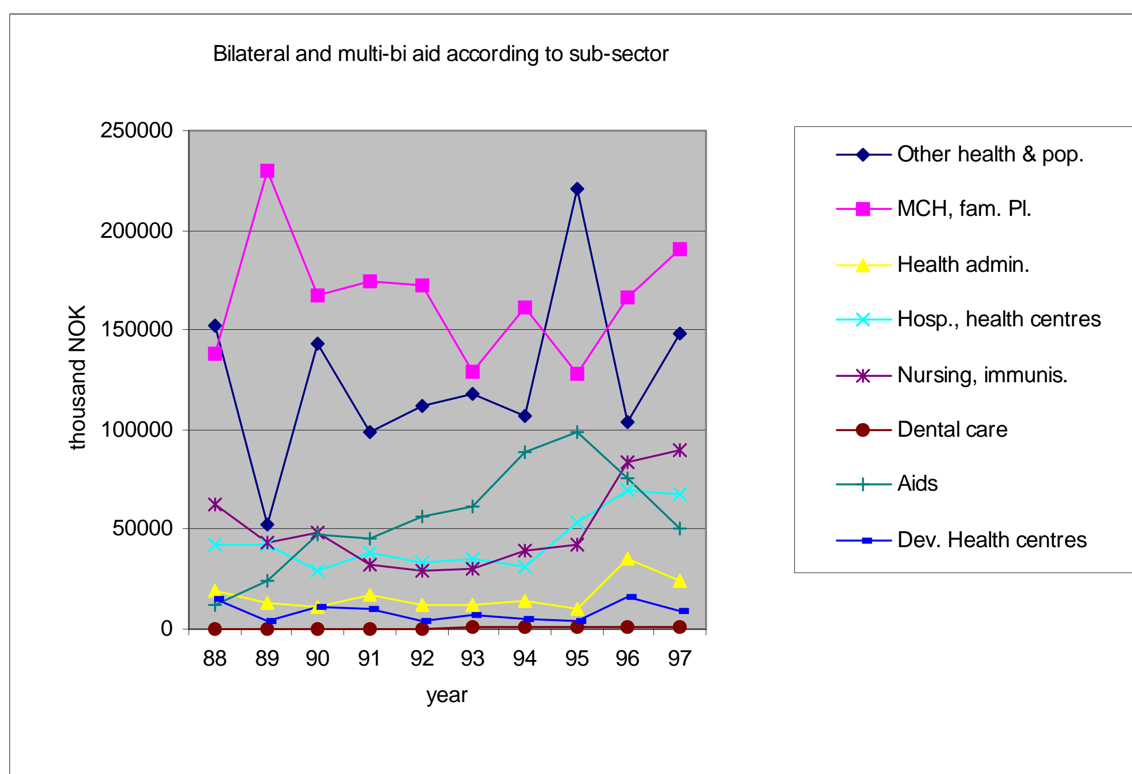

Fig. 13

NGOs have had an increased relative role in *AIDS* as well as *MCH and family planning*. Although *development of health centre*s has remained a low percentage of the total budget, this has changed dramatically from non-NGOs to almost entirely NGOs. NGOs used 12 per cent of their total health budget on *AIDS* as compared to 5 per cent in the non-NGO channel (UN AIDS received 9 per cent of total health-related multilateral aid).

The NGOs registered a higher percentage as *other* or unspecified in 1997 than in 1988. In 1997 about 1/3 of the total NGO health budget was unspecified, as compared to 1/4 in 1988. For non-NGOs the share for unspecified was reduced from 1/3 in 1988 to 1/6 in 1997.

Table 10: Sub-sectors according to NGOs and Non-NGOs

Percent of total sub-sector		1988			1997	
	NGOs	Non-NGO	Total	NGOs	Non-NGO	Total
Other health & pop.	16	84	100	71	29	100
MCH, fam. pl.	6	94	100	28	72	100
Health admin.	15	85	100	18	82	100
Hosp., health centres	86	14	100	93	7	100
Nursing, immunis.	24	76	100	55	45	100
Dental care	100	0	100	100	0	100
AIDS	50	50	100	75	25	100
Dev. health centres	13	87	100	93	7	100
	22	78	100	56	44	100

Source: DAC

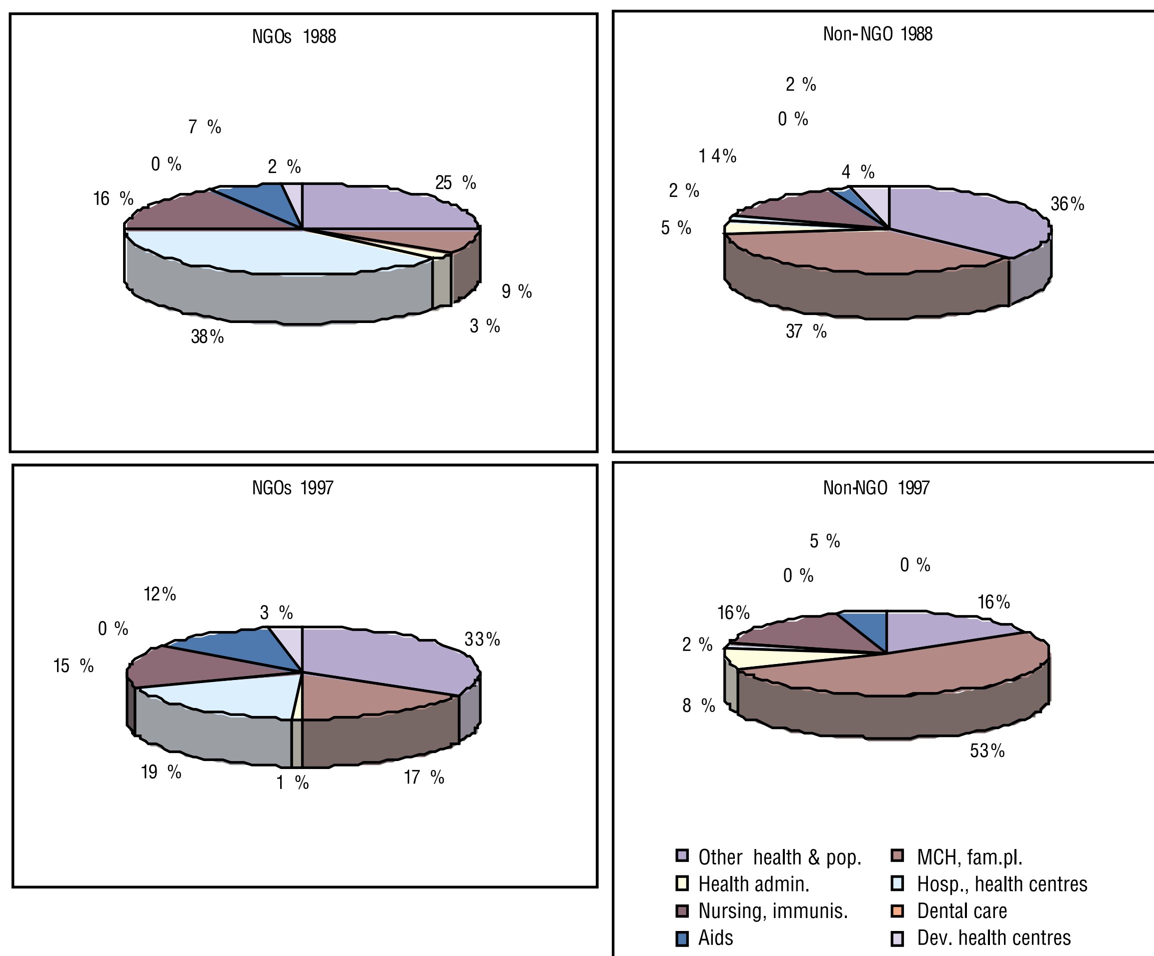

Fig. 14: NGO and non-NGO support according to sub-sectors in 1988 and 1997

Other/unspecified reached a peak in 1995 with 40 per cent of total health-related aid, and has on average been about 27 per cent of total aid through the channels. This is alarmingly high provided the database can be relied on as a source of detailed information. In 1990 as much as 67 per cent of the multi-bi funds were registered in this category whereas it reached a peak of 50 per cent of the bilateral channel in 1995. The lowest figures in this category were registered in 1989, with 14 per cent of the bilateral and 8 per cent of the multi-bi channel. The use of *other* should be looked into more thoroughly and improvements should be suggested in order to limit the use of the category as much as possible.

Table 11: Sub-sector "Other" as percent of total health-related aid

Year	Bilateral	Multi-bi	Total
1988	31	46	35
1989	14	8	13
1990	25	67	31
1991	22	36	24
1992	23	50	27
1993	30	31	30
1994	30	12	24
1995	50	13	40
1996	24	10	19
1997	31	13	25

Source: DAC sub-sector 79 "Other"

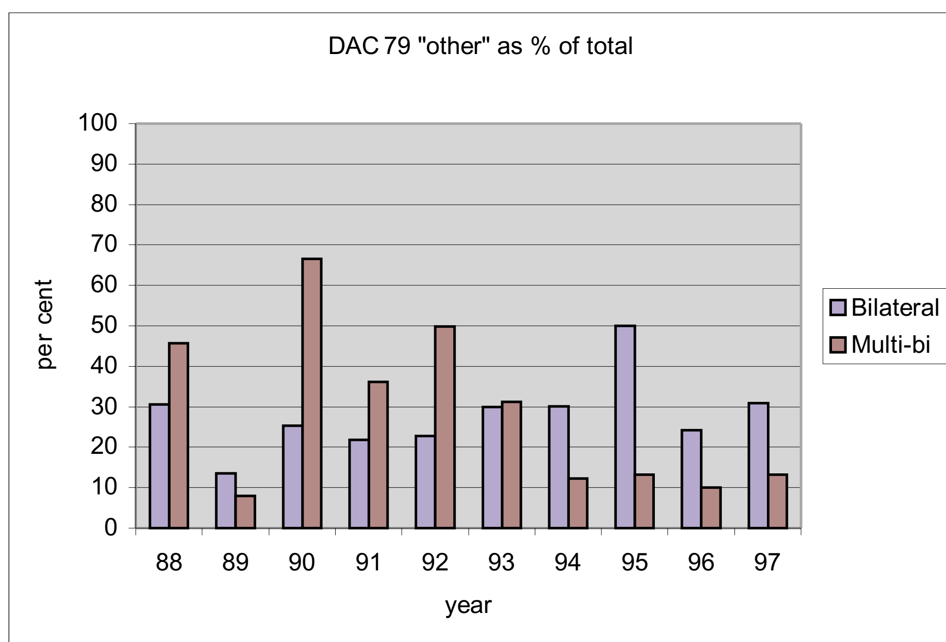

Fig. 15

3.5 Aid According to Regions

The total number of health-related projects has increased over the ten-year period from 237 and 200 in 1988 and 1989 respectively to 386 and 430 in 1996 and 1997 respectively. Over the entire period a majority of these projects have been in Africa (on average about 50 per cent), whereas an increasing number of the projects have been located in Asian countries (in 1997 about 34 per cent). In Latin America there has been an average of 26 projects each year (about 7 per cent) whereas in Oceania there has been an average of 42 projects per year.

Since 1993 a limited number of projects have been established in Europe, primarily in former Yugoslavia, and include more support to hospitals and health centres than in other countries, (in total about 80 per cent of the funds for the region). These have been mainly health projects operated by Norwegian NGOs.

The pattern is similar when looking at expenses. In 1997 about 60 per cent of the expenses were allocated for projects in Africa, whereas 19 per cent were in Asia and 12 per cent in Latin America. In 1988 the picture was quite different as both Asia and Africa received about 41 per cent of the funds, whereas Oceania received 12 per cent and Latin America only 5 per cent.

In all regions the majority of the funds is channelled through Norwegian NGOs, whereas the non-regional funds described as Global, are channelled through Global NGOs, mainly IPPF and IUATLD.

When looking at the sub-sectors for each region, MCH/family planning in *Africa* is the major one, followed by nursing and immunisation, AIDS and hospitals/health centres. In *Asia* the picture is similar, where the family planning and population programme in Bangladesh makes up a large part, but also other MCH/family planning projects, followed by nursing/immunisation and hospitals/health centres. Also in *Latin America* MCH/family planning plays a vital role, whereas health administration is the second largest post, mainly through multi-bi, and AIDS. In Europe, or the former Yugoslavia, support to health units like hospitals and health centres has received more than 80 per cent of the funds for the region.

Table 12: Number of health-related projects according to regions

Year	Africa	Asia	Europe	Latin Am.	Oceania	Global	Total
1988	115	75		18	29		237
1989	93	61		17	29		200
1990	124	70		26	26		246
1991	160	86		25	49		320
1992	165	68		27	49		309
1993	157	107	9	41	59		373
1994	224	103	3	40	41		411
1995	211	99	20	21	55		406
1996	222	127	25	16	39	1	430
1997	169	133	15	24	45		386
Grand Total	1640	929	72	255	421	1	3318

Table 13: Health expenditures according to regions

Year	Africa	Asia	Europe	Latin Am.	Oceania	Global	Total
1988	185 319	180 346		23 990	51 772		441 427
1989	111 399	189 134		69 584	39 107		409 224
1990	194 761	147 025		77 089	38 188		457 062
1991	176 789	132 132		73 513	34 779		417 212
1992	185 434	127 064		74 930	32 064		419 492
1993	169 286	111 038	10 385	78 132	25 454		394 294
1994	238 816	99 298	1 257	88 821	19 068		447 261
1995	291 023	109 968	46 481	84 194	27 290		558 955
1996	296 097	130 970	35 651	56 085	30 376	602	549 783
1997	347 796	111 776	19 022	67 791	33 749		580 134
Total	2 196 719	1 338 750	112 797	694 129	331 847	602	4 674 845

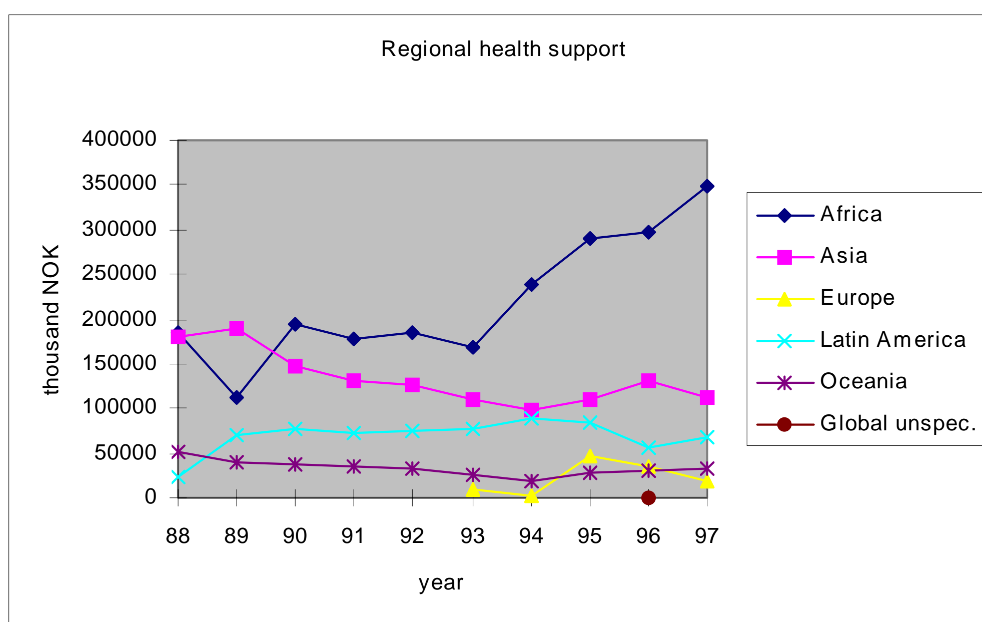

Fig. 16

3.6 Aid to Selected Countries

In the following the six countries where Norway has had a key role in health care are presented and contrasted. They are: Botswana, Bangladesh, Nicaragua, Mozambique, Zimbabwe, and Tanzania. The graphs include a comparison of the six countries with regards to the volume of health-related aid in 1997, where multi-bi and bilateral aid are separated. Each country is then illustrated in terms of the DAC sub-sectors over the past ten-year period, followed by a profile of the bilateral and multi-bi aid according to sub-sectors in 1997.

In 1997 Mozambique was the highest recipient of aid to the sector, closely followed by Zimbabwe. However, there is a major difference between the two countries concerning how this is channelled. In Mozambique the major part is bilateral aid, whereas in Zimbabwe a major share is channelled through multi-bi. The World Bank is the largest recipient or channel, whereas UNFPA, UNICEF, and WHO also are significant actors. In Bangladesh there is a similar situation where multi-bi has also been the main channel, and the World Bank programme on family planning has been the major part. Tanzania receives a similar share but the main part in this country is bilateral funds, whereas the multi-bi share is within MCH and family planning. The smaller ones, Nicaragua and Botswana, are different, in the sense that Botswana is almost entirely bilateral, whereas Nicaragua is a mixture between multi-bi and bilateral.

When comparing the development of sub-sectors in the different countries, it becomes apparent that most of them have increased their emphasis on MCH/family planning, and that this is mainly multi-bi support. Unfortunately "other health and population" is another major "sub-sector", which provides little or no information whatsoever.

In *Zimbabwe* MCH/family planning has been the major sub-sector since 1994, and received in 1997 about 69 per cent of the total support. As a comparison, AIDS received about 8 per cent. Norway co-finances the World Bank-financed Family Health Programme. UNFPA also receives Norwegian funds. Bilateral Norwegian support includes family health and population, AIDS, nutrition etc.

Mozambique shows a different development, where the total funds have increased and include nursing/immunisation and MCH/family planning as the major posts, whereas a significant proportion is identified as "other". In 1997 MCH/family planning was 31 per cent of total, and nursing & immunisation slightly less. Another characteristic of the country is the ongoing work for the "Sector Wide Approach Programme" (SWAP), in which Norway is participating actively. The Norwegian multi-bi support has been channelled through UNDP (pool for technical assistance), UNFPA (reproductive health), and UNICEF (decentralised health services). The support through UNICEF is being phased out. Bilateral aid includes support to an integrated family health programme, including MCH services, drugs and equipment, TB/Leprosy programme, which is currently being transferred to an integrated infectious disease programme, whereas the NGOs work with integrated health, eye care, and AIDS.

Tanzania has been characterised by support to AIDS-related activities (the national AIDS programme), which has been bilateral support, and the major sub-sector since 1989. The MCH/family planning programme has been financed through multi-bi, mainly through UNFPA and UNICEF. The work by Norwegian NGOs includes support to hospitals especially through mission organisations, AIDS-work etc.

In *Nicaragua* the situation is more complex, and about 19 per cent of total funds were allocated for AIDS in 1997, whereas MCH/family planning received about 52 per cent. The latter has been a priority throughout the ten-year period. Other sub-sectors received only marginal amounts. The World Bank works within health sector reform, and is supported by Norway, as is the UNFPA family health and population programme, and some work by IDB. As in a number of other countries the NGOs work within a variety of sub-sectors.

Bangladesh has been characterised by a large MCH/family planning programme which is supported by a large number of donors through a consortium lead by the World Bank (the family planning and population consortium). Norway has supported this programme through multi-bi support and participated in the consortium during the years it supported the programme. Norway is currently phasing this support out. The NGO programmes have been within hospitals/health centres, AIDS and integrated programmes.

In *Botswana* Norway has played a key role in the development of the health sector, mainly through technical personnel (district medical officers). However, currently there is a focus on institutional development through institutional collaboration, and this is registered as health administration. Basically this is a five-year programme co-financed by Botswana. The collaboration includes research in equity and decentralisation, capacity-building in health systems research, quality management, health information systems, training of medical students etc.

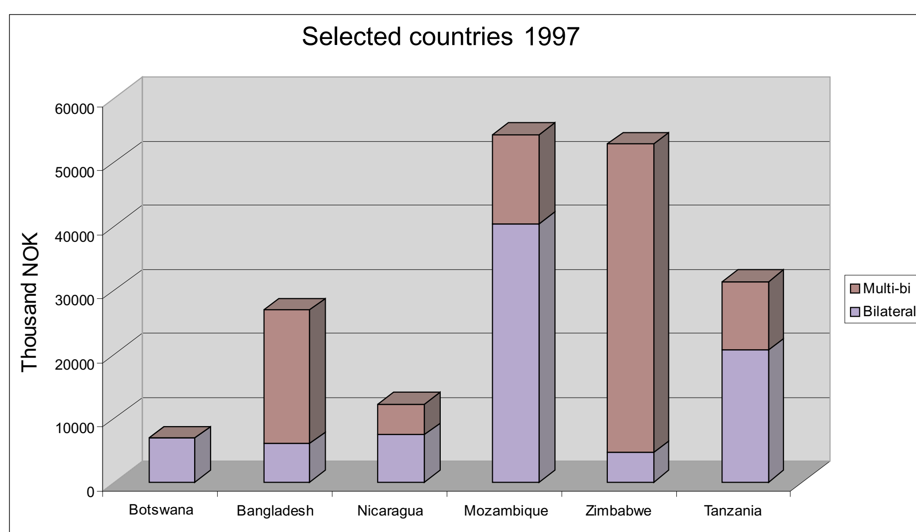

Fig. 17

3.7 Profile of Norwegian Health-related Aid in 1997

In the following a summary of the profile of Norwegian development aid in 1997 is presented. This partly overlaps the previous presentation, as it is intended to be able to be read separately without prior knowledge.

Total Aid According to Channel

Norwegian development aid is channelled through the following: Bilateral, multilateral, and multi-bi, where the latter represents earmarked funds channelled through multilateral agencies. In addition there is a channel called bi-multi-bi, which represents earmarked bilateral funds channelled through multilateral agencies.

The following data is drawn mainly from the DAC database, and does not specify the bi-multi-bi channel, which is included in the multi-bi figures. It is unclear whether parts are included in the bilateral figures. The figures for health-specific multilateral have been estimated according to the official shares of general funds presented by the individual agencies.

In 1997 the multilateral channel was the largest channel for health-specific aid both in total figures (NOK 554 million) and as a share of total funds to the channel (21.6 per cent). Multi-bi was considerably lower as a total (NOK 177 million), but was relatively high as a share of total funds through channel (13.5 per cent), whereas bilateral had the lowest share for health purposes (8.4 per cent). The estimated total health-related aid through all channels was about NOK 1.1 billion, or 12.3 per cent of all development aid.

Table 14: Total aid and health-related aid by channel

1997	Total	Health-related	Per cent
Bilateral	4 798 600	402 974	8.4
Multi-bi	1 316 500	177 169	13.5
Multi	2 559 705	553 849	21.6
Total aid	9 209 400	1 133 992	12.3

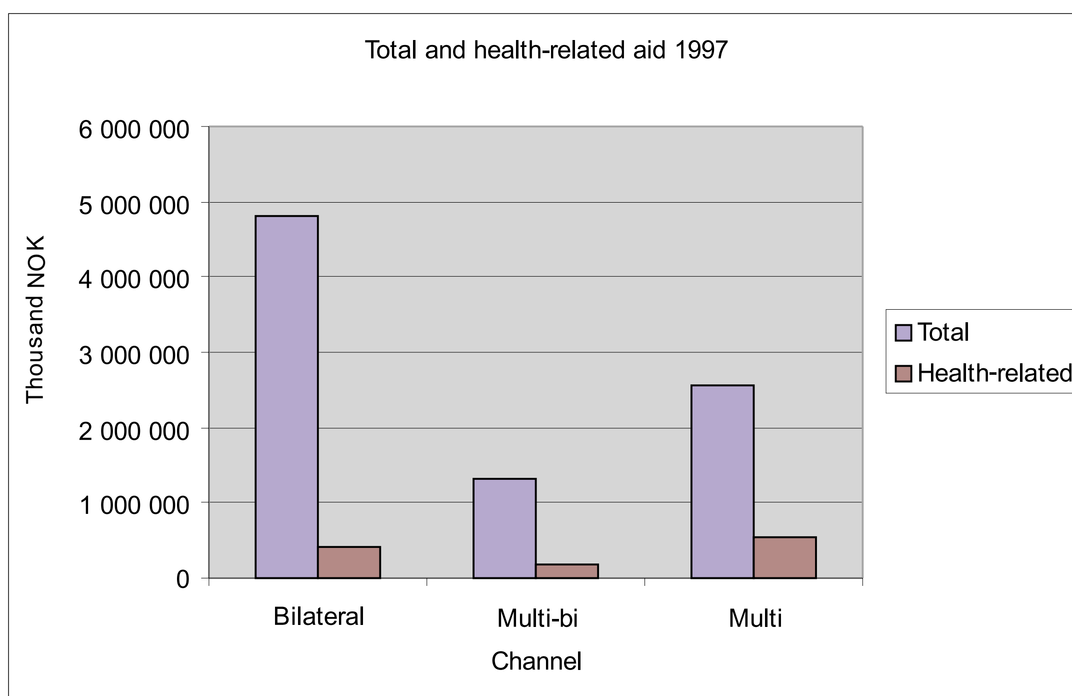

Fig. 18

Bilateral

An increasing share of the public bilateral support is addressing different aspects of the system, with an emphasis on MCH/family planning and immunisation. It is also worth noting that a relatively high proportion of the support not is specified.

Currently about 56 per cent of the bilateral aid to the sector is channelled through NGOs, as compared to 22 per cent in 1988. About 41 per cent of this is channelled through Norwegian NGOs, whereas global NGOs are the second largest channel and regional and local NGOs receive only a minor share as direct funding.[31]

31. It is important to stress the fact that the DAC database registers the channel according to the primary receiver regardless of who the final receiver is.

There are three main channels for support to NGOs: the Department for Non Governmental Organisations (FRIV/NORAD), the Regions Department (REG/NORAD), and the Bilateral Department/Ministry of Foreign Affairs.

In 1997 about 17 per cent of the total health-related support to NGOs was channelled from the Regions Department in NORAD. The funds are divided between different Sections or offices, namely the Section for Volunteer Service (NOK 5.7 million) and the various regional sections (Country Programmes [the embassies]). About 55 per cent of the total funds over this post were allocated to NGOs operative in Africa in 1997 (NOK 88.7 million),

as compared to 31 per cent to Asia (NOK 49.8 million) and 10 per cent to Latin America (NOK 15.7 million). A total of NOK 130 million or 81 per cent of this was channelled through Norwegian NGOs. In addition the Regions Department administers the "Regional Grant" (NOK 161.5 million), which is intended to create innovative or competitive types of activities.

In 1997 about 50 per cent of total health-related NGO support was channelled over MFA budgets (NOK 160 million). The distribution was 44 per cent to Africa, 15 per cent to Asia, 8 per cent to Europe and 32 per cent unspecified/global. More than 2/3 of this was support to Norwegian NGOs, whereas 1/3 was support to Global NGOs, where the majority was a general contribution to IPPF (NOK 45 million).

In 1997 about 33 per cent of the NGO funds were channelled through FRIV. The six largest NGOs were accountable for 69 per cent of the total health sector contribution through FRIV.

Table 15: Aid channelled through NGOs, FRIV only

NGO	1997
BN	30170
FBS	14348
Norwegian Red Cross	8171
Norwegian Church Aid	7527
Norwegian People's Aid	13592
Redd Barna	0

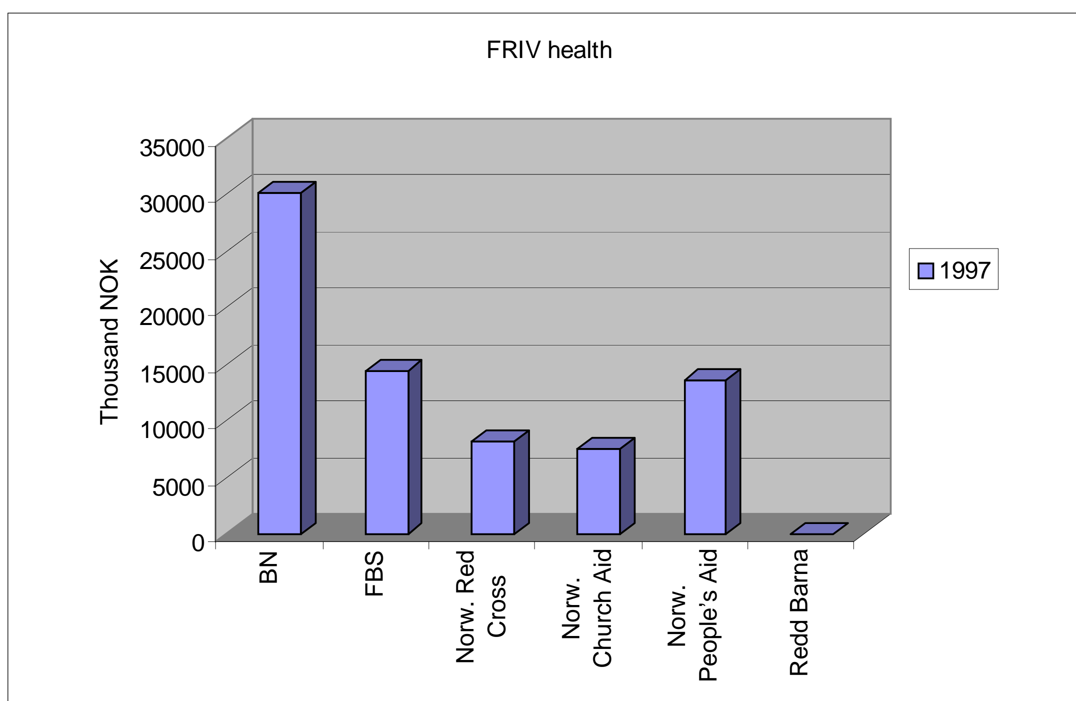

Fig. 19

Multi-bi

In the following the multi-bi aid specified for health purposes is presented. Multi-bi aid is the share earmarked for specific tasks in specific countries. As already discussed the bi-multi-bi funds have not been specified in the DAC database and are included in this post. The World Bank is the largest single multilateral agency in terms of Norwegian earmarked funds (multi-bi), and in 1997 this was about 42 per cent of total. UNFPA is the second largest registered as multi-bi, but should probably have been registered as bi-multi-bi. The UNICEF grants were the third largest in this category in 1997. This is further illustrated in Table 16 and Fig. 20.

Table 16: Multi-bi support according to agency

Agency	1997
UNFPA	50 561
WB	73 600
WHO	14 976
PAHO	5 400
UNICEF	30 339

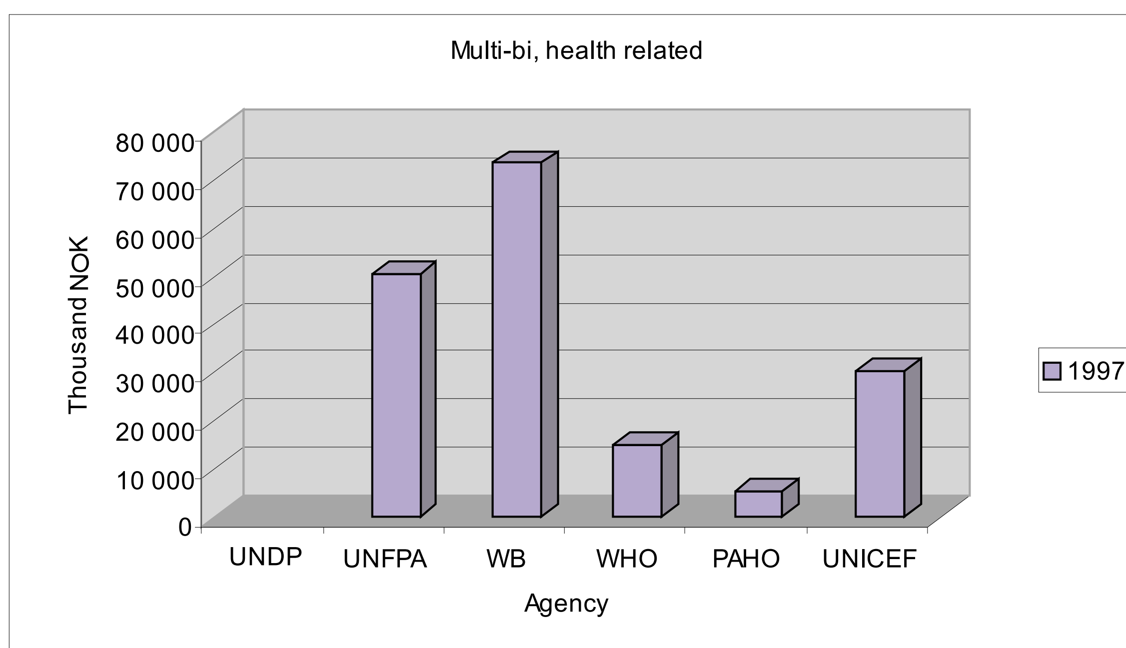

Fig. 20

Multilateral

Total health-related aid through the channel was NOK 554 million in 1997. In 1990 UNFPA took over from UNICEF as the largest in terms of Norwegian support, and was NOK 140 million or about 28 per cent of total in 1997. As a comparison WHO received NOK 121 million (24 per cent) whereas the estimated general health support for UNICEF was NOK 89 million (18 per cent).

The total health-related share is estimated according to the official figures presented by the various agencies. There is a relatively high degree of uncertainty related to these figures, but they are probably the most accurate available.

Table 17: Multilateral health-related aid 1997

	1997	Per cent
UNDP*)	67 680	12
WB	39 076	7
UNFPA	140 000	70
WHO	120 663	100
UNICEF	89 430	33
UN AIDS	48 000	100
IPPF	45 000	100
IUATLD	4 000	100
TOTAL	553 849	22

*) Includes social sector

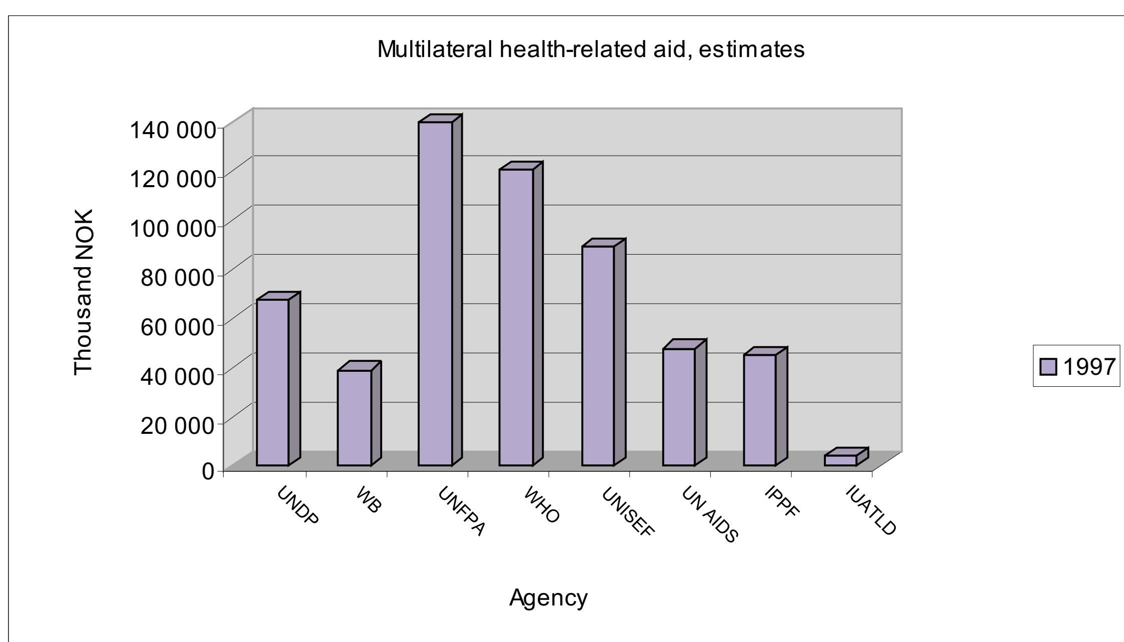

Fig. 21

Sub-sectors

As mentioned the DAC database does not include general multilateral aid, nor does it specify bi-multi-bi aid. The category "other/ unspecified" limits the information, and the actual registration of the data is not done uniformly.

MCH and family planning is the largest sub-sector with regard to expenses with 33 per cent per cent of total. Expenses for *AIDS*-related projects have been reduced to about 9 per cent (NOK 50 million) in 1997. AIDS projects and programmes were almost entirely channelled through bilateral aid. *Hospitals and health centres* were about 10 per cent of total budget in 1997, whereas *nursing, immunisation and control of epidemics* was 15 per cent of total.

The most striking trend when distinguishing between bilateral and multi-bi aid is the increase in multi-bi since 1993. In 1997 *MCH and family planning* represented 72 per cent of the multi-bi budget for health (NOK 128

million). The bilateral channel had an equivalent decrease and it was 15 per cent of total in 1997. *Health administration* is low as is *dental care*.

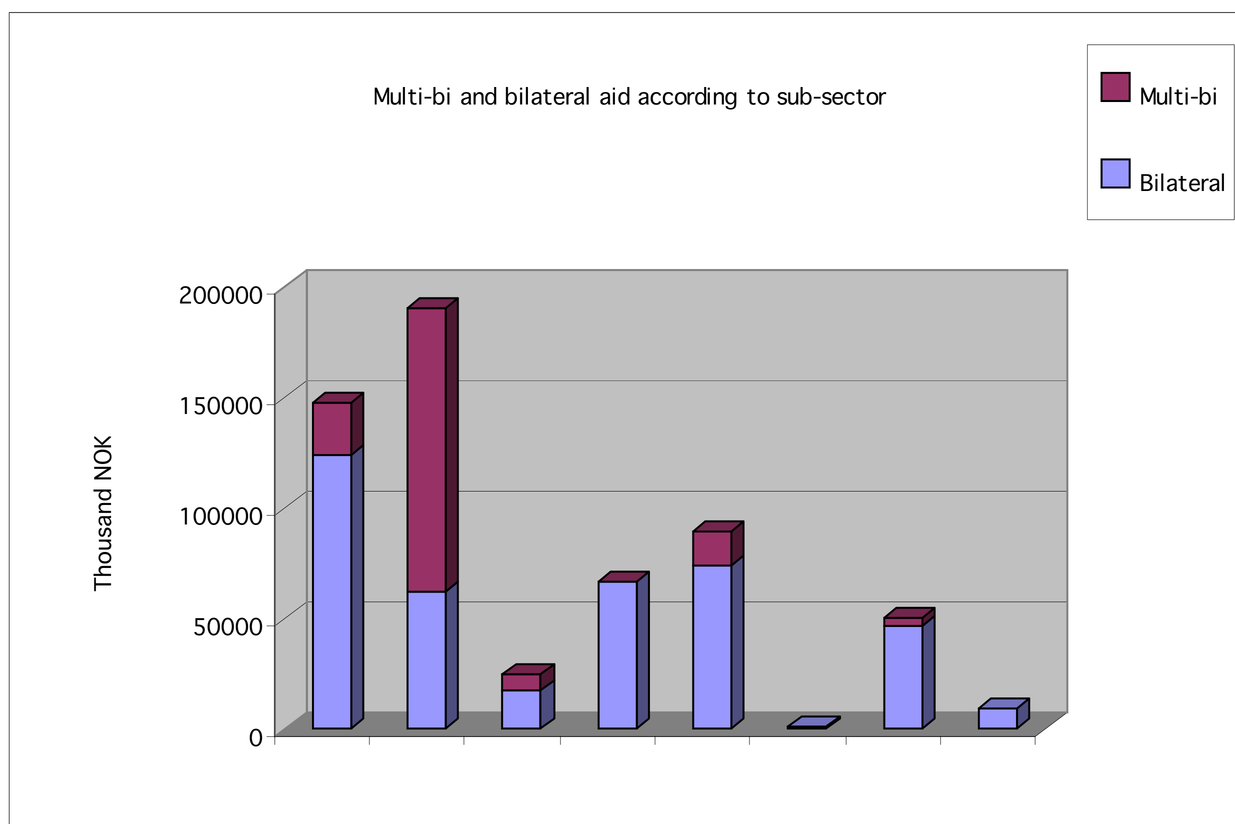

Fig. 22

In the following the AIDS-related support has been outlined as it is registered in the DAC database. The support channelled through NGOs and other bilateral aid is then specified for 1997, showing that Norwegian NGOs are the main actors with regard to AIDS-related support, accountable for approximately 39 per cent of the total, closely followed by local NGOs (37 per cent).

Table 18: Support to AIDS-related projects

	1997
Norw. NGO	18 125
Local NGO	17 324
Reg. NGO	2 090
Global NGO	29
Other bilateral	9 493
Total bilateral	47 061

4. Development-related Health Research

This chapter reviews the development-related health research undertaken during the last ten years and the policies guiding research activities, and identifies key issues and areas where there is a need for further assessment.

4.1 Policy and Objectives for Norwegian Development Research

Although development-related research is hardly a new phenomenon, it is nevertheless fair to say that explicit objectives for Norwegian research in the field of foreign assistance and technical cooperation were first developed during the 1990s. In 1999, a strategy for strengthening research and higher education in relation to Norwegian Development Cooperation ("Strategi for styrking av forskning og høyere utdanning i tilknytning til Norges forhold til utviklings-landene") was approved. The general policy of the Norwegian government in this field now consists of three main research ambitions:

1. Contribution to strengthening the capacity of developing countries to carry out their own research in accordance with the needs of each country, and to build up the ability to make use of existing research results.

2. Production of knowledge for the formulation and implementation of Norwegian development policy through multilateral and bilateral channels. This means that both long-term conceptual work and applied research are foreseen.

3. Contribution to the funding of the research programs of international organizations and advancing Norwegian participation in such programmes.

Norwegian authorities have furthermore argued that:

- Universities are significant actors in nation-building, and for democratic and social development;

- Norwegian research involvement should take place in areas where our country has comparative advantages;

- South–South collaboration should be encouraged; and

- Inter-disciplinary and sector-wide approaches should be promoted also with regard to research.

4.2 Policy for Development-related Health Research

Policy documents for the decade from 1989 to 1997 confirm a growing emphasis on development-related health research. Development-related health research was included as a separate budgetary item for the first time in the government budget of 1992. The specific item included support for WHO's research programmes with regard to human reproduction (HR) and tropical diseases (TDR).

No policy document has been published which explicitly specifies a policy for Norwegian development-related health research. Apart from general statements one can say that policies have been defined and refined in the process of research programme development and operation, and in the planning of assistance and cooperation in relation to specific countries and regions. Norwegian authorities have also adopted health research policy by subscribing to the research guidelines of international organizations. The budget document for FY 1999 (St. prop. nr. 1, 1998–99, p. 141) provides two important examples of this by its

- Emphasis on health sector reform in developing countries as a (continued) Norwegian priority including improved international cooperation concerning health systems and health policy research through the Global Forum for Health Systems Research which was established in 1996; and

- Financial support for a World Bank research programme on health and poverty reduction.

4.3 Channels for Funding Health Research

This presentation and discussion of Norwegian development-related health research is based on the four main channels of funding such research. These channels are:

- The Health and Population Research Program of the Norwegian Research Council (NFR–HEBUT);
- The Norwegian Council of Universities' Committee for Development Research and Education (NUFU);
- Health research as part of NORAD country and region-specific programmes
- Co-financing of international organizations.

These channels no doubt cover the majority of Norwegian development-related health research projects. However, to an unknown extent, development-related health research also takes place as part of the routine activities of universities, and of research institutes outside the university sector, and of consulting firms. In principle, the development-related medical and social science arms of the NFR also fund health research, i.e., outside of the exclusive research programmes focusing on developing countries as such.

No effort has been made here to address the latter avenues of Norwegian development-related health research. This report will concentrate on the main vehicles of such research.

4.4 Data Sources

The presentation and discussion to follow will reflect the large differences in the volume and quality of data available for an analysis of the four channels. The most comprehensive materials cover the research programme Health and Population of the NFR during 1989–1996, and the NUFU programme on university-collaboration. In both these cases data is available on: name of projects, content of projects, time period of projects, institutions involved, funding allocated, written publications derived from projects (including name of author, year of publication, name of contribution, place of publication, and publisher), as well as number and type of dissertations. In the case of NUFU, this material exists in an established database. Information on the NFR projects exists in a database of all Norwegian research projects. The Norwegian Social Science Service (NSD) operates this database at the University of Bergen. However, the NFR material being used in this report existed in written form. It also comprises an evaluation by the Programme Committee of the research programme in question.[32] These comprehensive data sets allow analyses of several relevant dimensions of the health research effort, such as type of problems addressed, countries of research participation, and number of dissertations and articles. The data concerning the NFR and NUFU also sensitizes us to those aspects of health research that are not so very well illuminated, and that, eventually, call for further investigation.

Data on health research in relation to country and regional foreign assistance and technical cooperation through NORAD exist in the NORAD database that produces OECD/DAC-compatible information. Here, health research can be isolated, and it is possible to portray: year of project, country/-ies involved, type of donor, name of project, funding allocation, shorthand name of project. The NFR allocation is included in the DAC 7 area where health programmes and projects are registered according to sub-sector and those that may be characterised as research-related, are identified. The criteria for classifying projects as research related are:

The support must cover the generation of new knowledge or the synthesizing of available knowledge. This also includes the dissemination of research results and research collaboration. If the research component is part of a

32. Norges Forskningsråd Miljø og utvikling: Forskningsprogrammet Helse og befolkning i utviklingsland. Programstyrets egenvurdering med prosjektkatalog 1989–1996.

larger project, only the research part of the whole shall be included. If the research part is not earmarked, the whole project shall be recorded as research when the research component is estimated at 50 per cent and more of total costs, and as zero if this component is estimated at less than 50 per cent.

The projects within the DAC main sector 7 can therefore be more or less research based, or oriented. The NUFU allocation however is registered in DAC 64 under Education/Training and Science where research activities that may not be located in a specific sector, are registered. They must also be pure research projects. The NORAD-material is less comprehensive than the NFR material and the NUFU information for the simple reason that the NORAD data is administrative data for financial management.

Least will be said about the development-related health research of international organizations to whose general operations Norway allocates funds over its foreign assistance budget. It is a difficult task to identify the proportion of general funds to multilateral and international organizations that are used for research, as these organizations usually specify their operations or their expenditures in terms of main blocks of activity (such as health or pension reform), but not in terms of specific activities such as research. Multilateral allocations for WHO are, however, earmarked for programmes and therefore facilitate such identification. Some trust funds in the World Bank are allocated for research.

4.5 Classification of Health Research

There are many ways to classify health research. The categories suggested in the ToR for this report are:

- Biological and social determinants of health problems and health behaviour;
- The relationship between political, economic, and social processes on a macro level and health;
- Health systems, health service functions and administration;
- Demography and population.

This taxonomy may appear too crude, and hence combine widely different phenomena. A possible modification to be applied in the limited analyses below is the following sixfold grouping:

- Biological determinants of health problems
- Social, economic, and political determinants and consequences of health problems
- Children's health and issues related to reproductive health
- Health behaviour and coping mechanisms
- Health systems and administration
- Demography

A problem here is that a project can belong to several of these categories simultaneously. The proposed sixfold taxonomy should be regarded as no more than a beginning. A review of development-related health research should devote time and energy to the elaboration of a productive and meaningful classification of such research. A classification should not comprise too many categories, yet enough scope to encompass significant strands and varieties of health research. Since development-related health research might be of a mixed character, one should also consider introducing primary and secondary categorizations.

A good understanding of the character of Norway's development-related health research activities requires classifications not only of the research but also of the researchers. Health research is not the exclusive province of any specific scientific discipline. Several disciplines have the potential to make a contribution, such as medicine, anthropology, sociology, economics, psychology, and nursing to mention some of the most important. What scientific disciplines are involved? This simple question may seem straightforward, however, three complicating elements deserve to be mentioned. The first complication is that

research teams are increasingly inter-disciplinary, and a simple categorization will not do full justice to this important phenomenon. The second problem is that a scholar may be trained in one discipline, for example as a medical doctor, but will become a competent anthropologist by his or her "second training". And the third issue is that some disciplines, such as medicine, are so multi-faceted that a classification of the major disciplinary backgrounds of the research team participants provides limited insight. Further re-examinations will have to struggle with these questions. There is no clear-cut answer to them. A beginning would be to classify the projects by the main disciplinary background of the project director. A possibility might be to supplement such a classification by a secondary classification of research project participants from other disciplines, if any. Last, but by no means least, although research is typically cosmopolitan and transnational, the nationality of the researcher matters when the issue is development-related health research.

4.6 Evaluation of Research

The concept of research is not clear-cut, nor is it self-evident how health research can and should be evaluated. A distinction is often made between theoretical research and applied research, yet this dichotomy obscures the fact that the distinction reveals a different dimension. Research means to arrive at knowledge through a certain (scientific) methodology that is inter-subjective and reproducible. However, development and consulting often make use of similar techniques. The point of departure for the present report is that a more comprehensive examination of Norwegian development-related health research does not necessarily require a very exclusive definition of research. Research, development, and consulting should be included in a working definition if the activities address health problems in developing countries by means of scientific approaches.

As a rule, it is taken for granted that one can distinguish between theoretical research and applied research, and indeed that it makes sense to do so. The idea is that the non-scientific effects of theoretical research are uncertain and may evolve only slowly and indirectly, whereas applied research on the other hand has a more direct bearing on current problems and challenges in society. It is important to note that Norwegian policy in the area of development-related health research includes both theoretical and applied research. That research is development-related implies two different things. Firstly, the research addresses health problems that developing countries struggle with, but these problems may be relevant for rich countries as well. And secondly, the research must promote capacity-building in developing countries.

The introductory comments above are relevant when evaluating development-related health research. Such an evaluation must describe Norwegian efforts in terms of traditional indicators of research outcomes such as: number of articles in referee journals, number of books, published chapters, conference papers, as well as MA and Ph.D. theses. However, these indicators are insufficient. For one thing, we want to know the precise relevance and impact of the research effort for one or more health problems. Secondly, we want to know if the candidates who graduated through the research projects were Norwegians or individuals from Third World countries. On top of this, we want to know if these authors and candidates had relevant research positions in their respective countries, let us say one, three, and five years after participation in the research project that was partly or fully funded by Norway. Development-related health research of high quality might take place at institutions of excellence in the Western world and with no participant from a developing country and with no involvement of institutions from developing countries. Or one may have such participation, yet the capacity-building effect is limited if the project members from the Third World stay in Norway or the UK, or if universities from the South are not involved in the research process. Therefore, a relevant training environment is an additional outcome criterion of development-related health research. This indicator relates to the issue of sustainability.

The purpose of the presentation and discussion below is to raise a number of relevant

questions for further critical analysis in relation to the four different channels of Norwegian development-related health research.

4.7 Research Programme on "Health and Population in Developing Countries"

The Research Council of Norway (NRC) has supported development-related health research during the period 1989–1996 through the research programme "Health and Population in Developing Countries". The NRC (NOK 4.9 million) and the Ministry of Foreign Affairs (NOK 24.5 million) jointly funded this programme. It was based on the understanding of Norwegian development authorities in the mid-1980s that the research competence in the country with regard to health and population issues was inadequate. Consequently, the main objective of the programme was to raise interdisciplinary capacity and capability in Norwegian research institutions concerning population and health issues in developing countries. A second objective was the expansion of knowledge as well as access to research results in these fields. The third objective was the promotion of centres of expertise that could assist development authorities in the formulation, implementation, and evaluation of foreign assistance projects.

Support to Research Institutions

The programme was designed as a concentrated effort through a small number of research centres based on the idea of a national division of labour. Two centres were chosen to act as "Schwerpunkte" for development-related health research, namely the Centre for International Health (SIH) at the University of Bergen, and the Programme for Development Research at the University of Oslo (PUFO). A research programme called HEBUT (health, population and development) under PUFO was incorporated in the Centre for Development and Environment (Senter for utvikling og miljø, SUM) in 1990 as a separate division. A plan to advance development-related health research in Oslo by the establishment of two professor positions, one in medicine and one in social science at the above Centre, to be later funded by the University, did not materialize. One reason for this was that two professor positions would leave little funding for operational research expenses. PUFO, including the professor position in medicine, was later (1994) transferred to the newly established Department of International Health linked to the Medical School of the University of Oslo. No professor position in social science was established in part because the Faculty of Social Science was unprepared to prioritize the position after initial funding from the NRC programme.

Support to Research Projects

In addition to the specific funding of the two core centres, the research programme supported research projects. Initially, the two main topical areas of the programme were the relationship between environment and life-style health, and health services and prevention respectively. A third component on population and health was added in 1992. Important criteria were research efforts aimed at areas characterized by knowledge gaps and areas where existing knowledge could be transformed into applied knowledge. Inter-disciplinary approaches and collaboration with colleagues and authorities in developing countries were encouraged. Based on these and other criteria the following issue areas were identified as focal points for research endeavours:

- Population development and health
- Children's health and development
- Health systems and organization of health services
- Health behaviour and coping processes
- Women and reproductive health

On top of this, the programme steering committee wanted to see applications in biotechnology and biochemistry if the leading researchers had a proven ability to build good research milieus. Health economics was also emphasized as a priority area for research support, however, due to limited Norwegian manpower capacity in this field as well as financial resources, health economics was not singled out for special effort by the programme.

NRC Self-evaluation

The evaluation carried out by the steering committee of the NRC-sponsored research programme is remarkably open about some of its problems. Essentially, these problems were related to the complicated issues of outside direction and instruction of university units. On the one hand, programme management is responsible for the successful implementation of operational goals, and must therefore assume that budgeted money is used loyally for the mandates specified by the Research Council, and also in collaboration with outside sponsors such as, in this case, the Ministry of Foreign Affairs. The University, on the other hand, wants to preserve academic freedom, protect its theoretical programme, and maintain stable longer-term financial forecasts. Here, according to the self-evaluation, there were disputes. This is not to say that the programme was a failure, or that lack of success was the conclusion of the self-evaluation. It means, however, that a certain set of problems did occur, and, in hindsight, these problems are understandable. The indicated problems should nevertheless stimulate further ideas as to how one could strike a fair and productive balance between disparate concerns such as programme instructions, academic freedom, and financial predictability. It is recommended, on this basis, that a study of development-related health research should discuss the issue of programme instruction versus academic freedom and financial predictability at length, and conduct interviews with the involved parties to evoke their valuable reflections on this complex issue. This deliberation should include a set of alternative operational solutions with discussions of their relative merits and weaknesses.

Project Portfolio

Thirty-nine projects were listed in the documentation of the NRC research programme, of which 33 or 85 per cent, were research projects in the conventional meaning of the term. Of the six remaining "numbers", two referred to conference/workshop participation, two covered the costs of producing books, and another two included basic funding (miljøstøtte) for the core research units in Oslo and Bergen respectively.

Of the 39 projects, 11, or 28 per cent, were initiated by the core unit in Oslo, and eight, or 21 per cent, by the corresponding unit in Bergen. Thus very close to half of the projects were core unit projects. In Bergen, only three additional institutions applied and received funding from the programme. These were all university institutions (the Department of Anthropology, the Department of Social Psychology, and the Centre for Development Studies). The number of participating institutions in Oslo was higher. Also here, three university institutions in addition to the core unit participated in the programme, namely the Department of Community Development, the Department of Social Anthropology, and the Section for Medical Anthropology. But in Oslo no less than five institutions outside the university system took part with a total of 11 projects. These institutions included two hospitals and two institute-sector research institutions (NIBR and DiS). On the basis of the figures above, one can argue that the research milieu in Bergen was more coherent and that the Oslo milieu appears to be more fragmented. The sheer number of institutions in Oslo made it of course more difficult to establish a research environment with a true and undisputed core. However, there certainly may also be other explanations.

Table 19 shows that the cost of the NRC programme amounted to NOK 35.3 million. The share of total funding for the Oslo institutions was somewhat smaller than their share of the projects. This indicates that, on average, the research projects in Bergen were larger.

Table 19: Projects and Funding of the NRC Programme on Development-related Health Research by Implementing Institution

	Number of projects	Share of projects	Million NOK	Share of funding
Core/Oslo	11	28.2	7.492	21.8
Other Univ/Oslo	4	10.3	2.994	8.5
Extra-univ. Institutions	11	28.2	9.309	26.4
Total Oslo	26	66.7	19.796	56.0
Core/Bergen	8	20.5	8.998	25.5
Other Univ/ Bergen	5	12.8	6.524	18.5
Total Bergen	13	33.3	15.523	44.0
Grand Total	39	100.0	35.319	100.0

Table 20 provides information concerning the written results of the programme. The outcome of the programme in this sense was a total of 167 contributions. The written contributions are presented in terms of four different types in the table: (1) articles in referee journals; (2) books or chapters in books; (3) mimeos; and (4) theses.

Table 20: Written Contributions by the NRC Programme on Development-related Health Research by Implementing Institution

	# of articles	% of articles	# of chapt/ books	% of chapt/ books	# of mimeos	% of mimeos	# of theses	% of theses	# of contri- butions	% of contri- butions
Core/Oslo	37	48.1	5	21.7	3	5.9	2	12.5	47	28.1
Oth. Univ/ Oslo	2	2.6	4	17.4	5	9.8	1	6.3	12	7.2
Extra-univ instit./Oslo	14	18.2	5	21.7	21	41.2	3	18.8	43	25.7
Total Oslo	53	68.8	14	60.9	29	56.9	6	37.5	102	61.1
Core/Bergen	10	13.0			15	29.4	4	25.0	29	17.4
Oth. Univ/ Bergen	14	18.2	9	39.1	7	13.7	6	37.5	36	21.6
Total Bergen	24	31.2	9	39.1	22	43.1	10	62.5	65	38.9
Grand Total	77	100.0	23	100.0	51	100.0	16	100.0	167	100.0

Table 21 shows the outcome of the programme in terms of dissertations. A total of 13 Ph.D.s. were awarded in connection with the program, of which 11 were awarded to Norwegian researchers and two for research fellows from the South. A total of six students graduated with MA or Cand. polit. degrees in connection with the program, two of whom were from the South.

Table 21: Projects of the NRC Programme to Stimulate Development-related Health Research; by Dissertations and Implementing Institution

	Norwegian fellows		Foreign fellows		Total fellows	
	Cand. polit./MA	Ph.D.	Cand. ma./MA	Ph.D.	Cand. polit./MA	Ph.D.
Core/Oslo		3				3
Other Univ/Oslo		1				1
Extra-univ inst/Oslo	1	2			1	2
Total Oslo	1	6			1	6
Core/Bergen	3	2	2	2	5	4
Other Univ/Bergen		3				3
Total Bergen	3	5	2	2		7
Grand Total	4	11	2	2	6	13
Share of total						

Table 22 highlights data on the main disciplinary focus of the research programme and makes a distinction between five categories: medicine, anthropology, psychology, and sociology, and finally a rest category. This table clearly shows that medicine is the major discipline with 51.4 per cent of the projects. Medicine is also represented in all the projects of the rest category. One can therefore say that 64.9 per cent of the projects had a strong medical content. Anthropology comes second, but far below medicine. Psychology is represented through its strong position in Bergen. Sociology is possibly less strongly represented than one would imagine given the scope of medical sociology. What is most striking is the total absence of political science here. There is also reason to point out the fact that economics is represented as a participant in a total of two out of 37 projects. Both these projects were carried out by the Centre for Partnership in Development (DiS).

Table 22: Health Research Projects of the NRC Programme by Major Disciplinary Focus and Institutions of Implementation.

	Medicine	Anthropology	Psychology	Sociology	Mixed/Other	Total
Core/Oslo	8				2	10
Oth. Univ/Oslo	1	3				4
Extra-univ. Institutions	5			4	2	11
Total Oslo	14	3		4	4	25
Core/Bergen	5		1		1	7
Oth. Univ/Bergen		3	2			5
Total Bergen	5	3	3		1	12
Grand Total	19	6	3	4	5	37
% of total	51.4	16.2	8.1	10.8	13.5	100.0

Observe that the category "Other" consists of two projects on Nutrition, one at the Core in Oslo and the other at the Bergen Core. The "Mixed" projects included one in Medicine/Sociology (Core/Oslo), one in Medicine/Anthropology (Core/Bergen), one in Medicine/Sociology/Economy (DiS-Oslo) and one in Medicine/Economy (DiS-Oslo).

Finally, Table 23 displays information on the topical orientation of the research projects, by classifying them into six broad categories of health research, and with the addition of one rest category. It turns out that more than one-third of the projects focused on child health and issues of reproductive health. The other large category, with approximately one-fifth of the projects, dealt with the biological determinants of health problems. It is remarkable that there was only one full project on health systems and health administration, however in

two additional projects these issues were included as a sub-component. Finally, projects trying to uncover the interrelationship between social, economic, and political circumstances and health problems were almost non-existent.

Table 23: Health Research Projects of the NRC Programme by Main Health Research Focus and Implementing Institutions

	I	II	III	IV	V	VI	VII	Total
Core/Oslo	2		7	1				10
Other univ/Oslo			1	2			1	4
Extra-univ inst/ Oslo	4	1				4	1	11
Total Oslo	6	1	8	3	1	4	2	25
Core/Bergen	2		4				1	7
Other univ/Bergen			1	2			2	5
Total Bergen	2		5	2			3	12
Grand Total	8	1	13	5	1	4	5	37
% of total	21.6	2.7	35.1	13.5	2.7	10.8	13.5	100.0

I Biological determinants of health problems
II Social, economic, and political determinants and consequences of health problems
III Children's health & issues related to reproductive health
IV Health behaviour and coping mechanisms
V Health systems & administration
VI Demography
VII Mixed/Other: The "Mixed" category consisted of two projects combining health behaviour (IV) and health systems & administration (V); one project combining one child health & reproductive health (III) and health behaviour (IV); and one project combining health systems & administration (V) and demography.

This description of the NRC programme raises several questions in addition to those already specified:

What can be done to promote research on health systems and administration? As of today, this area is strikingly under-represented.

There seem to be reasons to strive for a better balance in terms of disciplinary contributions. Political science, economics, and sociology are hardly optimally represented. Our understanding needs to be improved with respect to why these disciplines are under-represented, and how a better disciplinary balance could be achieved.

The impact of medium-term programmes like the one referred to here should be analyzed and discussed. To what extent do such programmes reduce the effort through the ordinary mechanisms of the NRC? Do they function optimally as incentive systems? In other words: to what extent do compact programmes of a limited duration by their very nature induce different actors to engage in less than optimal behaviour?

In what way and to what extent is it possible to argue that the NFR programme did contribute to capacity-building?

4.8 Norwegian Council of Universities' Committee for Development Research and Education – NUFU

The presentation of the NRC programme above was meant as a short case study and example. The chronicle of the NUFU programme, and other channels of Norwegian development-related health research, will be shorter since a more comprehensive account belongs to a full examination.

NUFU-supported projects and programmes constitute the second major instrument of Norwegian development-related health research. NUFU covers a much broader area of issues than health research, yet a review covering the period 1991–1998 showed that no

less than 26 per cent[33] of the projects in the NUFU programme were health research projects (NUFU, 1998: 18).

NUFU is the committee of the Council of Norwegian Universities for the promotion of development-related research and training. Established in 1988, and based on collaboration between Norwegian institutions of higher learning and research and similar institutions in developing countries, its main purpose is to advance the capacity of the latter to carry out research and offer research-based training programmes. The Ministry of Foreign Affairs (MFA) has funded NUFU activities. A total of NOK 110 million was allocated for development-related health research in the period 1991–1998, which made up 26 per cent of total NUFU funding. Two agreements between the MFA and NUFU have been signed so far, one for the period 1991–1995, and a second for the time span 1996–2000. Health research had greater priority during the present programme period.

An analysis of the project portfolio shows that 52 per cent of the funding for research projects could be classified as directly medical and health-related (epidemiology, bacteriology, vaccine etc). An additional 30 per cent has been allocated to one institution, namely the Armauer Hansen Research Institute in Ethiopia, specialising in Leprosy research. The rest (17 per cent) was for with issues related to health services and intervention.

As already mentioned, NUFU maintains a well-designed database of all its projects, including the health projects, with a series of relevant variables. However, although valuable, the database does not contain information on the geographical and functional "careers" of the research fellows, and thus is unable to provide information concerning the institutional sustainability of the NUFU programme. It can be argued that the improvement and expansion of the database should be considered so that the more dynamic aspects of the programme could be brought to the fore. The possibility of making the database available to the general public should also be discussed. It is important to determine whether it would be possible and beneficial to use this database as the core of a comprehensive information system in which data on *all* development-related health research funded by Norwegian authorities could be incorporated and made accessible.

There is a theoretical possibility that the NUFU projects are successful as such, yet successes may be obstructed by cuts in expenditure levels for universities and the research sector of the developing countries. The full macro-economic and policy contexts must be taken into consideration when outcomes are assessed.

NUFU can be described as the most demand-driven programme of the Norwegian development-related health research programmes in the sense that its profile is the result of approved applications from the research community. The idea is moreover that the projects should be initiated in the developing countries as integrated components of their development strategies. The accepted applications are thus not the outcome of some strategic plan completed by Norwegian authorities for development-related health research policy. This is one of the major differences, compared to the NRC programme already discussed above. The NUFU programme is compatible with traditional university practices and less in tune with the logic of focused research programs developed at the political level. Given that one must find a viable compromise between these different concerns, discussions of the deficiency of political control in relation to the NUFU programme should be stimulated. A better understanding would require a study of the decision-making processes of project initiations and investigate the extent to which the projects are truly in line with national priorities, and if these priorities are compatible with, or deviate from Norwegian perspectives or the point of views of international organizations.

A major objective of the NUFU programme according to its Handbook of 1995, is the building of expertise in developing countries so that they will become less dependent upon experts from the Western world (observe that

33. Figures taken from the report "NUFU samarbeidet innen helse. Seminar 4 mars 1998" Bergen, February 1998, and from overheads presented at the same seminar by Prof. Rune Nilsen.

experts is written in quotation marks in the NUFU handbook). Whether a verifiable reduction in the need for foreign expertise has in fact been achieved by NUFU collaboration, also with regard to defined issues in specified countries, should be substantiated.

NUFU collaboration according to the preamble is institutional partnership among equals. The notion and character of institutional collaboration should be discussed openly and critically. Does it represent old wine in new bottles, i.e., that nothing much has changed except the rhetoric? What do equals in this setting mean? Another problem with the notion of institutional collaboration is that the institutional structure of research in these countries tends to be taken for granted. The issue of developing productive organizational structures for development-related health research is an important question.

4.9 Research as Part of NORAD Country and Regional Programmes

The third avenue of Norwegian development-related health research funding is through NORAD country-specific and region-specific programmes of assistance and cooperation. These health research activities of the NORAD programmes can be isolated, described, and analyzed by NORAD statistical database that produces OECD/DAC-compatible information as mentioned earlier.

A total of NOK 165.4 million was allocated for development-related health research by NORAD during the period 1988–1997. As a rule, research is included here as one aspect in projects and programmes with a wider scope. The allocation for the NRC–HEBUT programme, NOK 24.5 million, is included in this amount and should be subtracted. Of the remaining NOK 140 million one project, the AIDS project in Tanzania, has received NOK 56 million. With the exception of this one project, there seems to be very little research connected to country programmes.

Although the information is certainly valuable, there are several problems with the NORAD database:
The first of these is whether the coding conventions with respect to research are followed in practice when reporting is carried out, or whether the research content of a certain number of health projects tends to be over-estimated.

The second problem is that the project description is restricted to one half of a line and hence contains very limited information, hardly sufficient for a meaningful classification of projects by major orientation. The possibility of including a subroutine with a more comprehensive project description in the database should be investigated.

The third problem is that the NORAD database does not contain information about the project participants and it is therefore impossible to classify the project by main disciplinary orientation. A discussion of how such information might be included in the NORAD database is required.

And finally, the fourth problem is that the data do not include information on outcomes. This pertains to the classical indicators of written contributions and dissertations, to the other scientific results and their eventual application, as well as to institutional sustainability and what has been called dynamic indicators of personnel careers above. A study of a representative sample of the NORAD health research projects according to the aforementioned indicators may be justified.

The last challenge is the characterization of the NORAD projects in relation to the NFR projects and the NUFU projects. What are the main differences, and what are the major similarities? Do these projects for example have a more applied profile? To what extent have process evaluations (“følgeforskning”) been carried out in connection with health projects in order to exploit such projects in terms of general knowledge and generalization of knowledge?

4.10 Co-financing of International Organizations

The multilateral channel represents the last of the major instruments of Norwegian development-related health research. However, it is by

no means the least important. Multilateral assistance has always been important in the Norwegian structure of development assistance and cooperation, and neither health policy nor research policy have been exceptions to this. It has remained and is the policy of the Norwegian government that half of the total technical assistance and cooperation should be funnelled through the multilateral system.

WHO, according to the data available for this study, has received by far the largest proportion of Norwegian support for development-related health research. In the last five years, it has received more than NOK 220 million[34] for two research programmes, namely Tropical Disease Research (TDR) and Human Reproduction Programme (HRP). The first has included support for other programmes such as the Global Forum for Health Research, which only in 1998 received US$1.8 million.

The Norwegian budget documents have called for social science contributions in these fields from 1994. They have thus promoted inter-disciplinary approaches. More applied research for the benefit of poor women has also been advocated from the same point in time. The follow-up of these two suggestions should be investigated and documented. The documentation should contain a presentation of what has been done and spell out achievements and shortcomings. The investigation must also check if the HR and TDR projects under WHO have yielded training possibilities for research fellows and scholars from the South, and if so, to what extent they have contributed to building sustainable research capacity in these countries.

Norway has in different ways supported efforts to promote health research at the international level. Thus, Norway has supported COHRED (Council of Health Research Development), an NGO established in 1993, with the goal of promoting the efforts of developing countries to carry out so-called "Essential National Health Research" (ENHR). The Norwegian authorities have also supported the Global Forum for Health Research for monitoring and discussion of needs for resource allocations in international health research as well as the Alliance for Health Policy/Systems Research. Both these organizations were established in 1997. All these research efforts try to support health research and help build relevant capacity in developing countries. It has been difficult to track the actual financial support for these programmes.

A common question regarding Norwegian aid to the different international organizations is if it has the necessary footing in the Norwegian research community. A considerable part of the Norwegian assistance in this field is multilateral. This is hardly controversial. However, the exact fraction of total aid could be debated. One item here might be whether more emphasis on Norwegian expertise and projects would be beneficial for development-related health policy, given both Norway's comparative advantage regarding health systems and, at the same time, lack of adequate research funding to take advantage of this advantage.

4.11 Concluding Remarks

Norway's funding of development-related health research takes place through four main avenues, or instruments. A core issue here is whether this is a productive structure for health research. The term productive structure means that a well-designed division of labour exists between the channels for funding, where each part addresses a separate and defined aspect of health research. Further and extensive discussion of this difficult topic would be advantageous. One problem that easily comes to mind is the possibility of duplication, and thus that the different parts of development-related health research could have been defined better. It should be kept in mind that the research community profits in a situation where there are several funding possibilities. It should also be kept in mind that a complete division of labour might obstruct constructive competition. Here, as in so many other instances, the task is to strike a productive balance between different legitimate concerns. Further work should address the issue of a productive structure for development-related health research.

34. 1US$ = NOK 7.35

5. Evaluations and Project Reviews of Norwegian Health-related Development Cooperation

This chapter maps the evaluations and project reviews of Norwegian health development cooperation to have been implemented over the last ten years, and explores what information these evaluations generate in terms of methodology, themes, achievements and, where possible, identifies information gaps.

5.1 Sample Description

We have been able to collect 132 reports[35] and have registered these in a database that summarises the main information from the evaluation and review, i.e. purpose and focus of the review, various aspects of methodology and implementation.

From these 132 reports, a total of 20 reports were selected for in-depth assessment. Most of them (15) were NGO evaluations as these had the greatest number of evaluations. Five criteria evaluations or reviews were related to bilateral/multilateral health support. The selection criteria have been somewhat arbitrary. Some were selected in consultation with organisations that indicated which reports, according to their judgement, provided interesting information. We have also tried to include a variety of organisations and types of projects. It is therefore not a random sample in strict research terms.

We registered whether the evaluators themselves explicitly assessed achievements and results in relation to these categories and if so, the justification given for the actual judgement. In addition the reviewer used the information provided in the report to judge whether it could be used to assess achievements and results. The degree of achievement in relation to these categories was noted and a short justification provided.

35. Eight more are added in the database, but not included in the analysis

Of the 132 evaluation and review reports,

- The largest number of evaluations/ reports were of Norwegian NGO projects and programmes, i.e., 83. This must be seen in relation to the large number of small projects that these organisations are involved in.

- We have identified some mid-term reviews of Norwegian bilateral country programmes as well as some evaluations of specific projects/programmes. In those cases where Norway co-finances multilateral organisations (WB, UNICEF and UNFPA) bilaterally (bi-multi-bi), a mid-term review report is usually prepared by the multilateral organisation itself, and a separate report produced by the Norwegian consultants.

- No evaluation has been commissioned by the MFA to assess bilateral country programme health sector support.

Only one evaluation has been commissioned by Norway on its own to evaluate multilateral aid.[36] Norway participated actively in the two multi-donor studies of WHO.

- The MFA has commissioned two thematic evaluations, the Special Aids Grant and the Strategy for Children in Norwegian Development Cooperation.

- The MFA has commissioned an evaluation of the function of the IPPF at the country level, which has still to be completed.

- In addition, the list of the evaluations includes available reports from UNFPA (10) and UNICEF (13), as well as the World Bank (12).

36. Evaluation Report 2.88. Evaluation of the Norwegian Multi-Bilateral Programme under UNFPA

5.2 Findings

General Overview

The database established a systemisation of the information on the evaluation and project review reports. Annex 3 includes tables that provide information about:

- Organisation, country of intervention, title and date of the reports.
- Evaluation characteristics; purpose, focus and timing, and who initiated the evaluation/review.
- Evaluation of team characteristics.

A summary of the findings from the analysis of this information is presented below.

When are evaluations done during the life of a project?
The definition of type of evaluation is somewhat arbitrary as we have used the term used by the authors and not made a strict distinction between the terms. Most of the reports are actually reviews as they are implemented during the life of the project or programme. Only 15 are defined[37] as evaluations at the completion of a project. Only two are defined as ex-post evaluations.

What are the most common purposes and focus of the evaluations?
We have used the following categories to define focus of the evaluations: Issues related to (i) policy and strategy; (ii) administration and organisation; (iii) finances; (iv) sustainability; and (v) various combinations of these.

Most frequently the evaluations have combined the focus (34) of these issues in various ways. However, if the evaluation had one specific focus this was most often on policy/strategic issues (20) and technical issues (26). Very few of the evaluations focused specifically on financial (3) or administrative and organisational (4) issues. The purpose of the evaluation is commonly expressed in general terms. However, some do state that the purpose is to assess effectiveness, impact, and achievements.

37. Either at end of planned project period/phase or at proper completion.

Evaluation method?
Nearly all the evaluations made use of conventional evaluation methods. Only six of the evaluations used what we could call participatory approaches (and not even six if we apply a very strict definition of the term). We have not systematically assessed the quality of the evaluation methods applied. The impression gained through the whole exercise and especially through the in-depth assessment is, however, that many of the evaluations and reviews do not follow a specific format for evaluation and the quality seems to suffer from lack of consistency and proper analysis of information. It is therefore difficult to evaluate results in terms of effectiveness, relevance etc. This is particularly true of the NGO evaluations. Evaluations of integrated projects naturally tend to assess the particular sectors in a more superficial way than in focused health projects.

Who initiates and implements the evaluations?
The Norwegian implementing organisation is most frequently the initiator of an evaluation mission. The local implementing organisation does this to a much lesser extent. However, it is becoming more and more common to have joint reviews. If we understand the UN organisations as funding agencies, these do very frequently take the initiative to review and evaluate a project and programme as well.

Most of the teams that evaluate Norwegian-funded or implemented projects and programmes are composed of both national and Norwegian team members. In half of the cases, the team leader is Norwegian, in the other half, from the particular country where the evaluation/review takes place. Not only is the international representation in evaluations of “Norwegian projects” relatively low, but also the use of “internal people” is striking. There are some few organisations (e.g. Redd Barna) that tend to use international consultants more often than others. The UN organisations seem to use very few local consultants.[38]

38. Caution: the sample is limited

In some NGOs (e.g. NCA) most of the evaluations are initiated and implemented by the implementing partner.

Most of the NGO evaluation reports are written in English or French. Reports from evaluation missions in South America are usually written in Norwegian. Reports from review missions and evaluations of country programme projects are usually written in Norwegian. These reports are mostly complementary to an aide memoir or review written by a multilateral organisation, but there are some that do not have a "counterpart" report in English.

In-depth Assessment

What do the reports tell us about results of the cooperation?

- Norwegian general development cooperation policies incl. target group

Among the NGO reports reviewed, only a few explicitly stated whether the project was in line with Norwegian development cooperation policies and whether the project interventions had achieved results that would contribute to the goals of Norwegian development cooperation. However, the reviewer's[39] assessment of the sample indicates that the project and programme portfolio is in agreement with general policies of Norwegian development cooperation.

Reports related to Norwegian country programmes, however, are much more explicit regarding this.

- Norwegian policies related to health development support

Also in this area, the reports do not discuss explicitly whether the project is consistent with Norwegian policies related to health development support and whether project interventions had achieved results that would contribute to the goals for health support. According to the reviewer's assessment, most of the projects in this limited sample did in one way or another adhere to the policies stated in terms of areas of interventions (PHC, MCH etc). It is however, impossible to establish the contribution of project interventions to overall goals, as the information needed to judge this comprehensively is limited in the reports. Some few projects were, however, not mainstream interventions in terms of policies and priorities.

- Effectiveness

Generally, the reports did address the effectiveness (degree of achievement in relation to stated objectives) of interventions. The NGO interventions were most commonly judged to be modest in terms of effectiveness, however, two were marginally effective and two highly effective. The reviewer's opinion in most cases coincided with the evaluator's conclusions. However, lack of measurable targets and indicators in many of the projects reported on, limit the possibility of assessing effectiveness in a proper way.

The reports in relation to bilateral country programmes are much more explicit when addressing this issue. The information base for judging effectiveness is also much better. Objectives have been stated more explicitly as well as targets and indicators. The same is true of a multilateral organisation such as the World Bank. The achievements are, however, not necessarily better.

- Cost-effectiveness

Two-thirds of the reports do in some way or another assess cost-effectiveness and the achievements are judged to be modest or marginal except in one of the projects, which is judged to be good.

The judgement is, however, usually based on an appraisal of general information without any proper analysis in economic terms. The exception is the World Bank where economic analysis is more frequent, but not as thorough as expected.

39. The reviewer is the person that in this exercise read the actual report.

> "It looks as if a lot of resources are invested in the clinic compared to the level of activity"
> "Resources not fully utilised – too few patients"
> "Results achieved do not reasonably equate with the level of investment made"

- Relevance

Three-fourths of the reports discuss relevance of intervention. In more cases than not, relevance is judged to be high (10/17), the rest to be moderate. However, the evaluators tend to judge relevance higher than the reviewer does. In half of the cases that the evaluators considered highly relevant, the reviewer judged them as moderate.

The following box reproduces some of the statements that have been used to judge interventions as moderately relevant:

> "The number of patients could be higher – one could question if physiotherapists is the most urgent need"
> "When the project was initiated … there were not enough key personnel. However, the situation has now changed, and one could question the relevance of providing Norwegian staff which is also much more expensive than national staff"
> "The project is relevant in terms of need, but not in terms of demand"
> "(The organisation) … does not have the distinctive competence to effectively play the role of a "market leader" in terms of promoting long term development"
> "No collaboration with local authorities or beneficiaries in site collection of health units (which proves irrelevantly located)"

5.3 Other Bilateral and Multilateral Organisations

Monitoring Systems

Given the increased attention to the effectiveness of development cooperation, many bilateral and multilateral organisations are in the process of introducing (UN) or have recently (DFID) introduced different systems for results-oriented monitoring and evaluation systems.

Some examples of monitoring systems:

> In 1995 *DFID* introduced HAPAE (Health and Population Aid Effectiveness Project) as a pilot project. HAPAE includes a Portfolio Performance Monitoring format to summarise the measurement of progress against outputs given in a log frame, enabling aggregation of results compared with thematic strategies and goals. This is now used as a model for an office-wide system, PRISM.
>
> *The World Bank* has introduced a more comprehensive assessment of The Bank's effectiveness, the Annual review of Development Effectiveness (ARDE). This establishes three categories of explanatory variables; country context, borrower performance, and Bank performance.
>
> A standard part of *CIDA*'s performance assessment includes internal audits, evaluations, and thematic performance reviews. A Framework of Results and Key Success Factors is used to assess results. It has in place an extensive system to assess results and progress of project activities. The Annual Performance Report reports on levels of achievements under all of its six programming priorities of which one is Basic Human Needs.

Evaluation

All the organisations visited have an independent evaluation department. The World Bank has the Operations, Evaluations Department (OED), UNFPA the Office of Oversight and Evaluation (OOE), and UNICEF the Office of Evaluation, Policy and Planning. All these report directly to the Director.

Many countries and agencies are now planning to or have already implemented comprehensive evaluations of the achievements of health sector development aid linking strategic and sector policies.

In the following we have given a brief overview of evaluations and reviews conducted by some selected multilateral and bilateral agencies. Some results and issues considered to be especially interesting in the process of developing an evaluation plan, have been highlighted.

World Bank

The only proper evaluation of the WB HNP portfolio before 1997 is the OED's study of the Bank's population work based on an analysis of its experience in eight countries.[40]

In 1997, the OED took on the major task of revealing the result of the increase in lending in the HNP portfolio. It started out by reviewing the literature on approaches to the evaluation of health programmes and policies.[41] The review concluded that while there has been major progress in the development of methods for the economic appraisal of investments in the sector, there is *a major gap in the understanding of how to measure the effectiveness of health care systems in other terms.* The paper develops a concept and frame to be used in a comprehensive assessment of the Bank's development effectiveness in the HNP sector. The assessment consists of a cross-country analysis of the Bank lending portfolio in HNP as well as Country Sector Impact studies where both lending and non-lending activities are included.

The cross-country study for assessing the Bank's development effectiveness in the HNP sector included a review of the performance of the HNP portfolio, analysing the OED database on HNP project outcomes and of findings in completion and audit reports (53 projects). It also reviews indicators of performance in the active portfolio based on findings in the recent Annual Review of Portfolio Performance (ARPP) and Quality Assurance Group (QAG). The Country Sector Impact studies include studies in four countries selected for different reasons: Brazil, Mali, Zimbabwe and India. The organisation is currently implementing major reforms of which some are based on the issues raised in these studies.

Two of the projects funded by Norwegian Trust Funds have been evaluated, Better Health for Africa and APAC. We have only received the first one.

40. OED: Population and the World Bank. Implications from eight case studies.

41. Stout. S. et al.: Evaluating Health Projects – Lessons from the Literature World Bank Discussion Paper No 356.

Snapshots of the results of the HNP from the OED 1998 reports
The *cross-country* study reveals the many challenges of the HNP portfolio; 60 per cent of completed HNP projects are evaluated as *satisfactory which is low relative to other social sector projects* (79 per cent). Most HNP projects achieve their physical objectives, but only 21 per cent of completed HNP projects made substantial contributions to *institutional development and policy change in sector.* There is little sign of success in matching project design to institutional capabilities or of building consensus among key stakeholders on how to apply the best "practice" due to little use of institutional analysis and relatively low scores for "quality at entry". Need for a smaller scale "learning process" given the complex features of the health sector.

Lessons learned in terms of measuring outcomes:
If the ultimate objective of the work of the HNP is to improve health outcomes (through, among other steps, reforming the role of the government in the sector) then the Bank should take steps to improve its own and borrower capacity to measure the extent to which these objectives are achieved.
Finding ways to link the management of the sector to the achievement of results is a key challenge for the Bank and its partners.

The *country case* (Brazil, Mali, Zimbabwe) studies of Bank operation point out some important *common issues:*

- The projects have in general targeted important and *relevant* concerns – (epidemiological profile and health sector needs),

- The projects have *not* taken the *complexity of political and institutional environment* adequately into consideration when planning and implementing reforms (e.g. pharmaceutical sector, health financial reforms, decentralisation etc.).

- *Generally weak link between World Bank macroeconomic policy dialogue, fiscal reforms (SAP) and health sector investments;* SAP inattention to social sector contributed to a decline in government health financing. A civil service reduction of targets depleted the basic health staff and senior health policy positions with negative repercussions on the health sector. (Mali and Zimbabwe.)

Programmes with narrow and specific objectives such as malaria control in Brazil and Family Planning in Zimbabwe have had measurable positive impact on disease incidence, contraceptive use and fertility rates.

Mixed results:
In the case of Brazil there is no evidence of enhanced health system performance, economic efficiency or improvements in consumer satisfaction. In Mali, the Bank intervention has contributed to capacity building for planning and managing health projects and services and "learning by doing".

UNFPA
The OOE implements Policy application reviews, thematic evaluations and ad hoc independent evaluation of major projects and programmes. An analysis of mid-term reviews is done once a year.

OOE-thematic evaluations done during the last years cover:

i) Strategic issues (TBA Training, Women and Micro Enterprises),

ii) Technical programme-related issues (Quality of Family Planning Services),

iii) Target group approaches (Adolescent Reproductive Health),

iv) Organisational issues (Technical Support System [TSS] and Execution Modalities).

It is important to note that as UNFPA is a decentralised organisation, an evaluation of programmes and projects at the country level is the responsibility of the country offices in collaboration with the Country Support Teams. The weakness is that no systems are established for the synthesis and application of the results of these evaluations. The new approach to evaluating country programmes is considered to be an opportunity to address current weaknesses in country programme evaluations. We do not know of any multi-donor comprehensive study of UNFPA operations at the country level such as those that have been done of UNICEF and WHO country operations. The Norwegian MDC commissioned an evaluation in 1988 to assess the Norwegian Multi-bilateral Programme under UNFPA in the period before 1988.

UNICEF

The Office for Evaluation, Policy and Planning engages in a wide-range of activities. We were given some examples of thematic studies and evaluations that the office has commissioned lately that focus mainly on strategic programme approaches (CDD, immunisation, growth monitoring).

UNICEF has developed an Evaluation Database where information about all evaluations, studies and reviews at the country level are entered. It is frequently up-dated. The last version from 1997 includes a list of more than 7000 reports from 1987. Of these 7000 more than 4000 cover issues related to health.

An independent multi-donor evaluation of UNICEF operations that included six study countries and a synthesis report was commissioned in 1992. The findings were taken into consideration when the Health Strategy was developed in 1995.

UNICEF multi-donor evaluation –
The theme running through findings and recommendations

UNICEF and its sponsors need to make more explicit strategic and operational choices at a global, regional and country programme level
by selecting the appropriate mixture of the three intervention models
Meeting Basic Needs through Service Delivery,
Strengthening National Programmes for Children though Capacity Building,
Guaranteeing the Rights of Children and Women though Empowerment.

The strategic choice from a management and governance perspective is to adopt an organisational identity which can effectively encompass the operational and specialised elements of its mandate as well as the human rights element. The three intervention models require different strategic choices in external cooperation.
It was found that UNICEF at the time of the evaluation:

- has placed increasing emphasis on support to public service delivery, aimed at rapid achievement of global goals, UCI

- has not emphasised capacity-building for sustained programme delivery, with focus on systems development in government, but has concentrated on implementation support to UNICEF programme operations.

- has given more attention to advocacy and alliance-building than to direct empowerment of children and women to address and solve their own problems.

DFID

The Evaluation Department is currently finalising an evaluation of the effectiveness of ODA/DFID support for health policy and systems development based on three ex-post evaluations, the HAPAE database and, for ongoing projects, output to purpose reviews. The focus is on the effectiveness of the support to health policy and systems development in improving access to health services, and promoting change in health sector policies as well as identifying lessons learned over the past ten years which may be of value to future DFID work in the sector. In the following box, we have explored issues of particularly interest for evaluation methodology.

Highlights from the draft evaluation report on support for health policy and systems development (HPSD) 1988–1998

Results in brief:

Using PCR and OPR ratings for the achievement of the project's purpose (rather than goal) and its evaluation score, around 40 per cent of projects by number were judged successful and 25 per cent by value. Even taking into account the methodological problems of comparing scores across countries, health policy and systems development projects are considerably less successful than others in the field, pointing out problems in design and evaluation. Some factors influencing success are highlighted. Lasting improvements in people's health requires work on several fronts; direct investment in health outcomes; work on policies and systems; and strengthening demand. DFID does not always get the balance right. DFID is missing opportunities to support health policy and systems in some important technical areas. Support to HRD policies has had a notable lack of success. HPSD research has had limited impact on national policies.

Issues of interest for evaluation methodology:

- It is difficult to demonstrate convincing causal linkages between DFID's work on health policies and systems development and health outcomes. Firstly the purpose and goals are stated at very different levels. Lower-level statements of purposes are more likely to be more precise. There are few instances where the impact on health can actually be demonstrated by changes in key indicators at the goal level. Clear indicators and targets have not been defined, and evaluation has to rely on changes in national statistics.

- Health outcomes are more easily assessed if the project is concerned with specific target groups in the population, a specific health problem or operates in a limited geographical area. Work on health policy and systems is usually concerned with the sector as a whole. If the purpose aims for a significantly higher level of achievement than the sum of the outputs, this will contribute to the difficulty of carrying out convincing or comparable OPRs or ex-post evaluations.

- Attributing changes in health outcomes – at a national rather than a local level – to an individual donor's input will always be difficult.

- There is little gained by trying to assess whether work on health policy and systems development is a more effective way of improving people's health than other forms of intervention.

- The interest in moving away from discrete projects towards sector-wide ways of thinking has implications for evaluation in the future. It would suggest that it is more useful to look at work in the health and population sector in a particular country than trying to assess impact of particular technical strategies across a range of different countries. Evaluating the impact of all health in collaboration with national and other partners, may reveal more useful lessons.

- HPD database is helpful in answering questions of what is done, but it says less about how and why.

DANIDA

DANIDA has during the period 1988–1997 implemented nine evaluations: seven country-specific evaluations, and two global. The organisation is currently carrying out a comprehensive evaluation of Danish Bilateral Assistance to Health during the period 1988–1997 including support to health research and support through non-governmental organisations. The emphasis will be on the lessons learned and special attention will be given to the transition from a project approach to a sector programme approach. The evaluation has a retrospective, ex-post and future directed, ex-ante perspective and will present an overview of the results of Danish bilateral assistance to health. The evaluation will comprise the following five clusters;

i) Overview of DANIDA-supported Health Activities

ii) Policy and Strategy Development

iii) Institutional Framework – Channelling, Implementation and Performance

iv) Targeting, Achievements and Perceived Impact

v) Sustainability and Cost Effectiveness

5.4 Development Output from Evaluations and Reviews

Result of disease control interventions and support to reproductive health as priority areas?

The evaluation of the Special *AIDS* Grant (SAG) provides first and foremost information about the usefulness of the Grant to promote AIDS interventions and assesses the relevance of the use of funds rather than the effectiveness of the programmes funded. The Tanzania country programme support for AIDS (MUTAN) was reviewed mid-term and a completion document (CD) exists. The CD does not assess results in relation to objectives, the mid-term review does. Several reviews and evaluations of NGO intervention have been implemented. No evaluation has been commissioned after the WHO General Programme on AIDS (GPA) was closed and UNAIDS established.

The National TB programme in Mozambique supported bilaterally has been monitored and reviewed regularly. National TB programmes supported through Norwegian NGOs – Madagascar (NMS), Nicaragua, and Malawi (Nasjonal Foreningen for Folkehelse) – were evaluated in 1997, the programme in Nepal (LHL) some few years ago (1994). The MFA support for IUATLD, which in relative terms is significant, has not been evaluated. All the evaluations provide information on results in terms of disease incidence and key performance indicators such as cure rate etc., and systems development from a programme point of view. There is, however, no comprehensive evaluation (multi-channel and multi country) of the Norwegian support for Tuberculosis control synthesis that considers results in terms of systems support from a wider systems perspective than results in these technical terms.

The IPPF multi-country evaluation, due shortly, will provide information on results and performance according to IPPF's "Vision 2000". These criteria are much the same as the Norwegian priorities and strategies for Reproductive Health. Several desk studies on the progress of the ICPD action plan are currently underway, but these do not include country studies. UNFPA has implemented several thematic evaluations of strategic and operational interest during the last few years, the latest still to be completed on Safe Motherhood. However, *no comprehensive evaluation of UNFPA operation at country level has been carried out.* The latest Parliamentary Bill states that continued support to UNFPA (and UNICEF) is justified because of good results at country level. No reference is provided.

Result of Norwegian support in terms of increased access to basic health service distributed justly and with acceptable quality?

Many of the reviews and evaluations of NGO-supported projects and programmes deal with health services in one way or another. They tend to focus on technical issues, and now also increasingly on sustainability. Indicators of utilization are frequently provided. Due to poor base-line information or lack of analysis of available data, it is often difficult to assess results in terms of, for instance, increased

coverage, increased accessibility and utilization of poor and marginalized groups – in other words a more just distribution (increased equity). *Quality* issues are seldom addressed in reviews and evaluations, regardless of channel.

Result of Norwegian support to health development through multilateral organisations?
The relatively recent multi-donor WHO study (EBF) assessed important issues in terms of results (relevance, cost-effectiveness, effectiveness) with donor policies and priorities as a point of departure. The follow-up study of the function of the WHO at country level speaks to the same issues. Reforms are currently being implemented.

The UNICEF multi-donor study is older and influenced UNICEF's 1995 Health Strategy work. Many issues still remain unsolved. However, UNICEF no longer considered to be a main channel for Norwegian support to health.

The recent World Bank evaluations of the organisation's entire HNP portfolio and case studies provide a broad basis for judging the impact, relevance, efficiency and effectiveness of the WB operations in general *from the point of view of the organisation itself and not the borrower or co-financiers*. It does, however, also provide an opportunity for Norway to judge the relevance of the WB as a channel for health development support in general terms.

Result of Norwegian support to health development through the bilateral channels, country to country programmes and NGOs?
In spite of the many project and programme evaluations and reviews, the 1992 evaluation of NGOs as partners for health development in Zambia is the only evaluation that addresses the appropriateness of NGO operations in a national context and their sustainability in a comprehensive manner.

The many evaluations and reviews implemented by the Mission organisations, members of BN, concerning sustainability should provide a rich information base to assess this issue in relation to this group of organisations and to bring out critical issues.

There has not been any particular evaluation of bilateral health support except for the regular monitoring reviews (mid-term reviews) and some evaluations of programmes (such as support for the TB programme in Mozambique and AIDS in Tanzania).

Contribution of Norwegian health sector support to the development of sustainable health systems (policy, reforms, national capacity-building) and the result of technical assistance and institutional collaboration in relation to Norwegian support to health development through all channels?
Institutional development[42] is emphasised in Norwegian development policy. Strengthening institutions and capacity building are considered to be strategic for achieving this and are also part of the main strategy to focus on "recipient responsibility".

The NGO evaluations address sustainability at the project level, but do not address the issue in a national perspective. The WB evaluations address the issues of institutional development and support for reforms. The UNFPA theme evaluation on modalities also addresses the issue to some extent and so does the UNICEF evaluation.

Since the Nordic evaluation[43] of technical assistance, there has been a drastic decrease in individual Norwegian experts involved in health sector support both in relation to bilateral country support and NGO operations. The recruitment of technical staff through the Peace Corps system has also ceased. Instead there has been an effort to recruit Norwegian institutions to enter into cooperation with similar institutions in partner countries, to promote the use and participation of Norwegian institutions and expert communities in multilateral aid activities as well as to recruit individuals for international

42. A thorough discussion and clarification of the terms institutional development, organisational development, and systems development are provided in Evaluation Report 5.98 and will not be repeated here.
43. Forss K. (1988): Evaluation of the Effectiveness of Technical Assistance personnel. Danida, Finnida, MCD/NORAD SIDA.

organisations. No assessment has been done of how the World Bank Norwegian Consultant Trust Fund has been utilised in relation to health.

The recent mid-term review of Botswana Health Sector support provides very little analysis of key issues in institutional cooperation. The recently completed study "Development through Institutions?" gathers experiences from institutional development efforts and addresses the issue in a general manner. However, it does not provide a basis for assessing the consequences of these policy changes specifically in relation health sector support. The consequence of these developments for the development of a knowledge base in Norway is an added concern.

There is no systemised information on the achievements and relevance of the operations to this aspect and no comprehensive evaluations of the entire system of support to health development in *one country*, which considers all channels for Norwegian support.

5.5 Summary

The evaluation and review reports collected through this exercise are mainly Norwegian project evaluations, but some evaluations implemented by multilateral and bilateral agencies are also included. Although limited and even arbitrary, for the purpose of this study, they provide sufficient information about what has been assessed and how it has been done. Along with the analysis of policy developments, it has provided the opportunity to identify gaps and possible issues that may be included in a comprehensive evaluation exercise that may eventually provide some answers to the question – what are the achievements of Norwegian development cooperation for health development.

The study demonstrates that there is an increased interest in the effectiveness of development cooperation and that both multilateral (the World Bank) and bilateral agencies (i.e. DANIDA and DFID) are now in the midst of evaluating the impact and effectiveness of their support to health development.

The evaluations of NGO projects are often multipurpose and run the risk of lacking focus. In many cases they do not follow a specific format or methodology and their quality suffers from a lack of consistency and proper analysis of information. This makes it difficult to evaluate results in terms of effectiveness and relevance.

The exercises implemented by the multilateral and bilateral organisations highlight some important methodological issues that should be taken into account in designing the evaluation exercise:

Both the HNP and the DFID experiences demonstrate that it is difficult to establish causal links between support to health policies and systems development and health outcomes. DFID states that it is equally difficult to attribute changes in health outcomes to an individual donor's input. The Danish Technical proposal for the evaluation of Bilateral Assistance does not consider this fact, neither does the WB exercise. Health outcomes are, of course, more easily assessed if the project is concerned with a specific target group, a specific health problem, or operates in a limited geographical area.

The trend towards moving away from discrete projects towards sector-wide ways of thinking has implications for evaluation in the future. It might be more useful to look at particular countries' work in the health and population sector rather than to try to assess the impact of particular technical strategies across a range of dissimilar countries. Evaluating the impact of all health support in collaboration with national and other partners may reveal more useful lessons than only focusing on a separate country's contribution.

The study has identified the following issues that should be considered for inclusion in an evaluation plan:

- Tuberculosis Control Programmes as a tracer to assess the results of Disease Control strategies (health outcome, institutional development – national capacity-

building, organisational development and systems development, sustainability)

- Basic health services – quality issues including access and equity

- Support through multilateral organisations: Norwegian influence and effect on policies, priorities, strategies and mode of operation (including the use of Norwegian expertise)

- UNFPA operations at the country level – from population control and family planning to reproductive health and rights – piecemeal or reality? Contribution to national capacity-building?

- Development of sustainable health systems – consequence of changes in policies for technical cooperation

- NGOs as a channel for health development cooperation (strengthening civil society/national capacity-building, role, comparative advantage)

- Bilateral health development cooperation; relevance of decreased importance? Complementary effect of Norwegian support to health development at country level through all channels

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Annex 1 Parliamentary Bills 1988–1997

1988–1990:
The Bills do not provide much information and the issues highlighted seem to reflect the Disarmament and Development Conference focusing on Humanitarian Aid.

1991–1994
The Bills are more elaborated:
General: Basic needs – development of health services is an effective tool to combat poverty

- AIDS intervention by supporting WHO, international, Norwegian and local NGOs.

- Focus on prevention by mapping of the epidemic, information, home-based care, and interventions for orphans – increased support in 1992. In 1994 it is said that multilateral organisations working with AIDS could receive increased financial support.

- Bilateral aid: Family planning, health, interventions directed towards mothers and children.

- NGO sector should be subject to the same criteria and quality requirements as the development aid in general.

- Multibilateral funds increased for areas that are high Norwegian priorities; among other things for health and family planning – poor countries esp. Africa (eastern and southern Africa). It states somewhere that supporting projects through multibilateral funds secures bilateral control.

- UNICEF interventions to decrease child mortality, strengthen MCH services and PHC and nutrition.

- In 1992 decreased number of projects, but same areas of priority. UNICEF should give priority to capacity building and integrate FP and AIDS.

- UNFPA Intervention in Family Planning, MCH services, information, census. Supports projects that coincide with Norwegian priorities. Focus on increasing national capacity and integration of FP in PHC. From 1993 phasing out multibilateral support. Support to preparation and implementation of ICPD.

- WHO Drug policy and AIDS and support to Research on HRH and TDR. Through the period Norway focuses on WHO support to countries and to further development of PHC and for programmes targeted at child health. In 1994 there is a reduction in the voluntary contribution. (Research contribution up?)

- IPPF Service interventions for women, strengthening men's responsibility and support for youth and AIDS. After 1993 Norway points out the need to integrate its activities into national plans.

- IUATLD: Increased importance in AIDS control. Norway has been the main contributor and others should come in. Therefore, decreased support from 1992.

- Multilateral: World Bank should especially focus on interventions to counterbalance negative social consequences of structural adjustment.

1995–1997
General: As a consequence of the recommendations from ICDP, Social Summit and Women Conference, the budget following 1996 puts more emphasis on social sector defined as health, education, water and increased support to health, family planning, women and children. Interventions to strengthen district health systems and services will be given priority though all channels.

- AIDS: high profile both through bilateral and multilateral channels. Continued focus on AIDS *prevention* and to integrate intervention into long-term development aid. The support to WHO is discontinued when GPA is closed and UNAIDS established.

- Bilateral aid: The AIDS issue should increasingly be taken into consideration when programmes and projects are developed and planned. Result indicators are included for the bilateral aid. As of 1996, the bilateral aid should be shaped towards social sectors and support interventions to reduce population related problems (connected to environment).

- Multibilateral:
  - UNICEF Continued priority as previous period, added support to Guinea worm eradication. The focus on capacity-building is now also directed towards district health systems. From 1997 Norway is a member of the board. It should point out the need for UNICEF to integrate its activities into national systems.
  - WHO Focus on integrated PHC and on control of child diseases.

- Multilateral support will be maintained at a high level. Especially to organisations working within Norwegian priority areas. Increased earmarked funds to social sector including health.

- UNFPA should give greater priority to Africa and Norway will contribute to UNFPA follow-up of ICPD and the operationalisation of the new programme priorities after ICPD. Norway will make sure that especially poor countries in Africa will benefit from UNFPA new strategy.

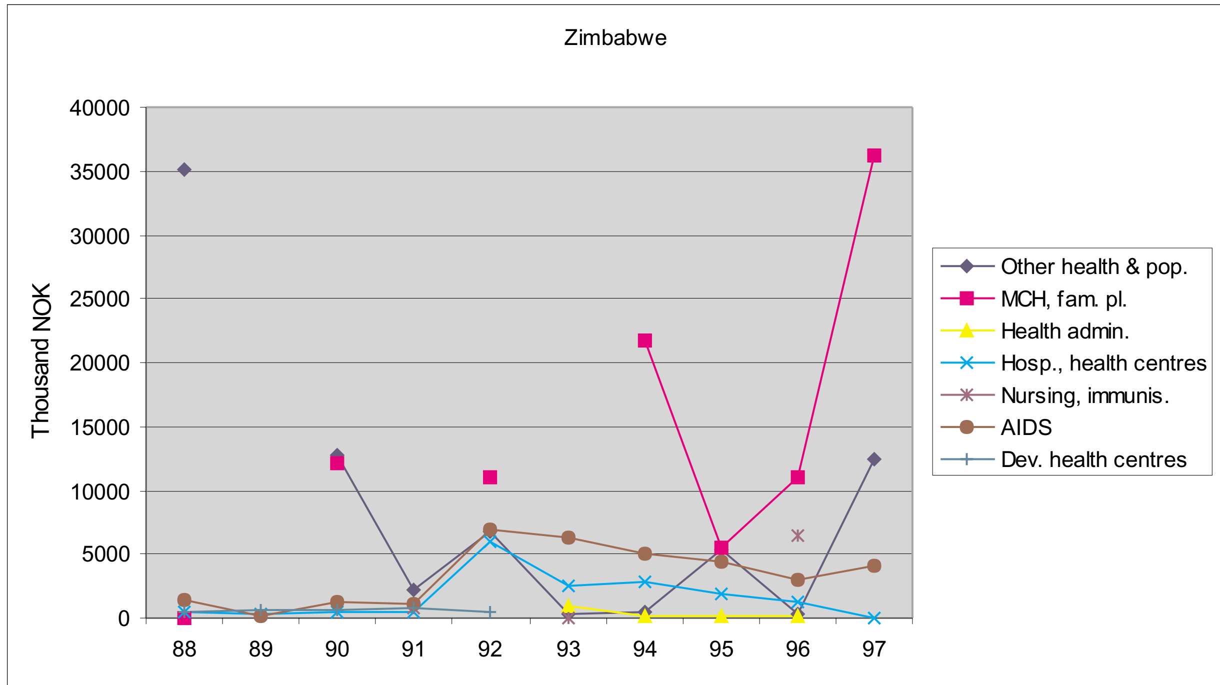
- The support through the development banks should contribute to the fact that the countries given priority by Norway benefit. Norway will influence the Bank to increase lending in the social sectors not only in quantitative terms, but also qualitative.

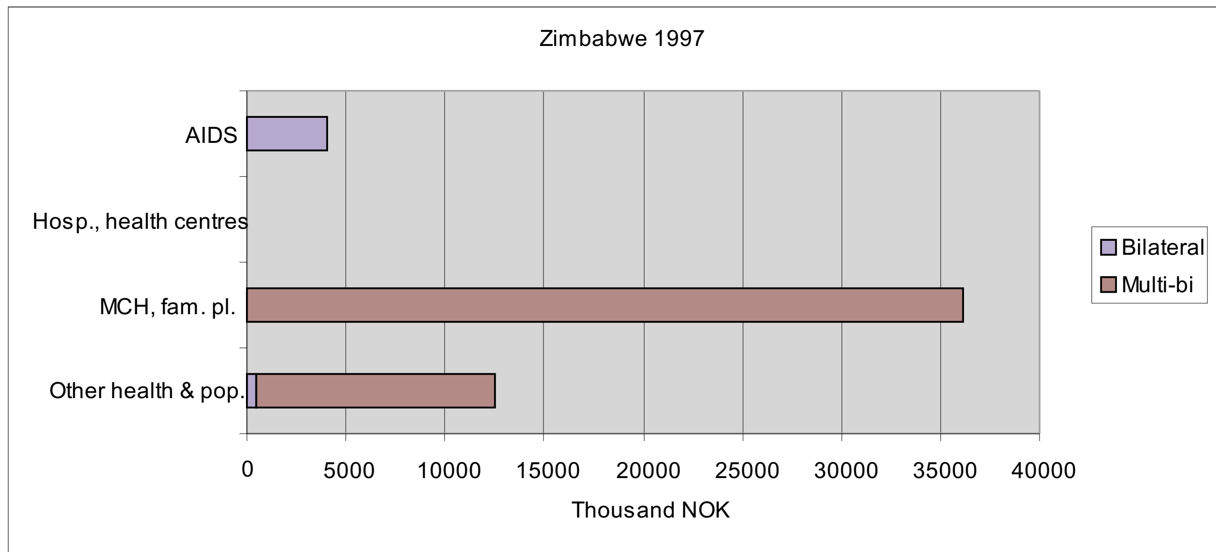
- IPPF is considered an important player in following-up ICPD. Norway points out that there is a need for institutional development and training in weak family planning organisations.

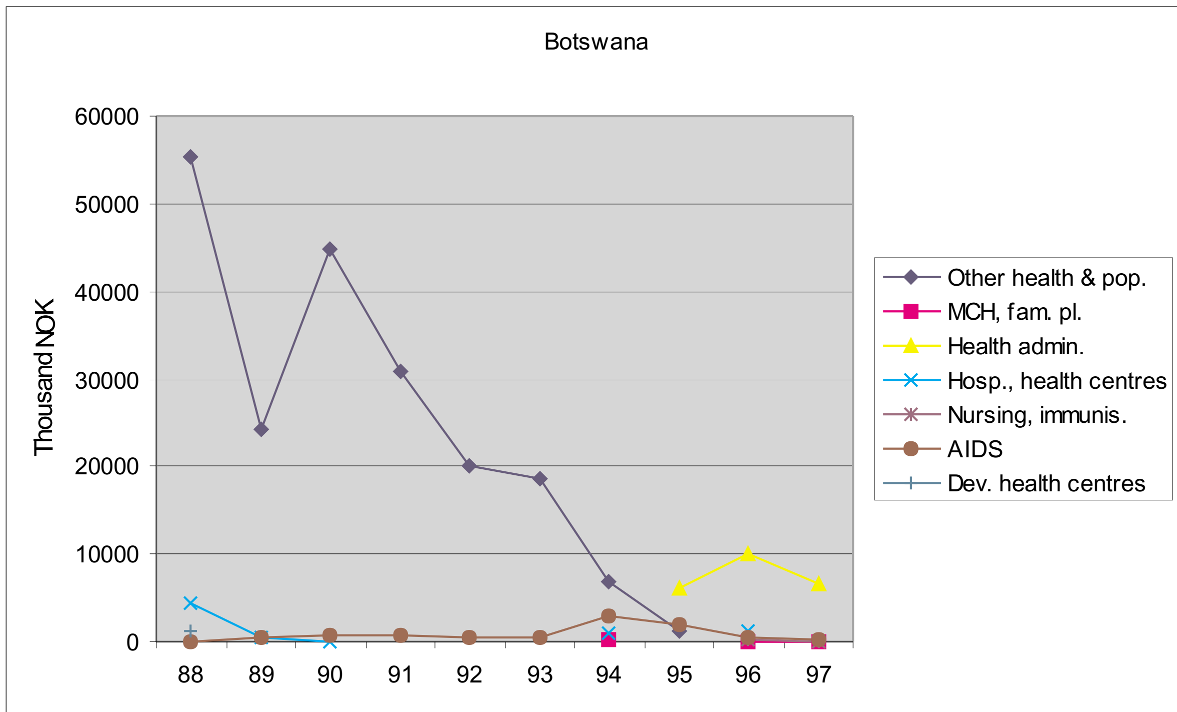
- IUATLD support is increased in the period (1996/97) because TB prevalence increases as a consequence of the AIDS epidemic.

Specific issues from 1999: Continued and increased support to social sector. The proportion for health should within the year 2000 reach 10 per cent of total development co-operation. In 1999 more support to combat HIV/AIDS, malaria and tuberculosis. The concentration is not only on AIDS prevention, but on the socio-economic consequences of the epidemic has gained increasing recognition. Continued support to UNICEF and UNFPA justified through “good results at country level”. In relation to WHO and the World Bank, not only the strengthening of PHC is mentioned, but also health systems support is mentioned for the first time.

Annex 2 Country Profiles



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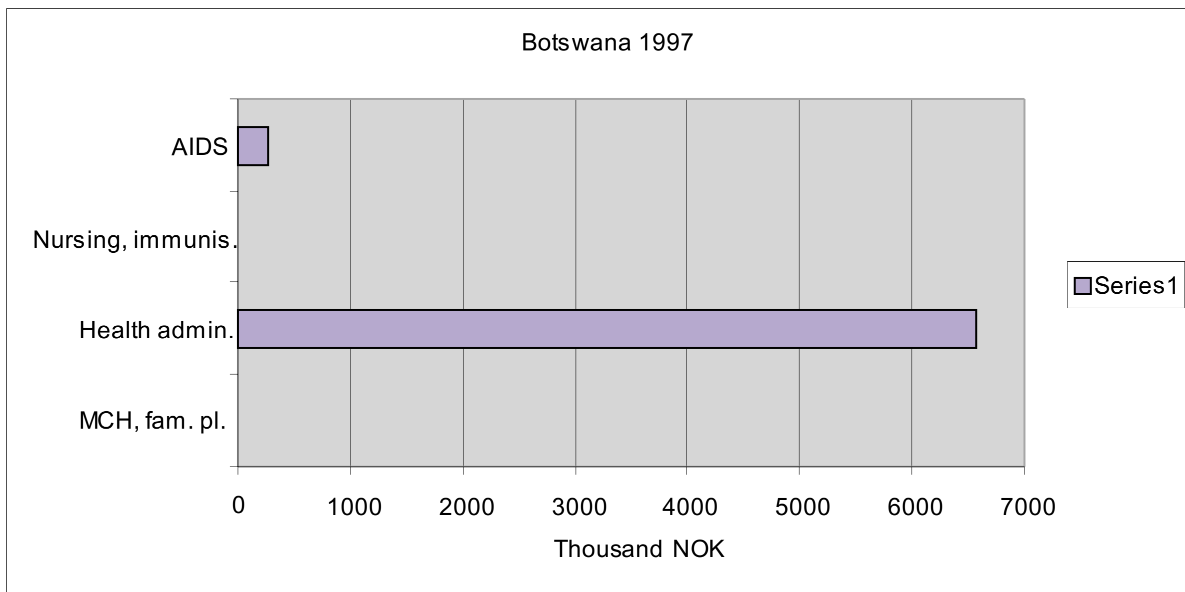
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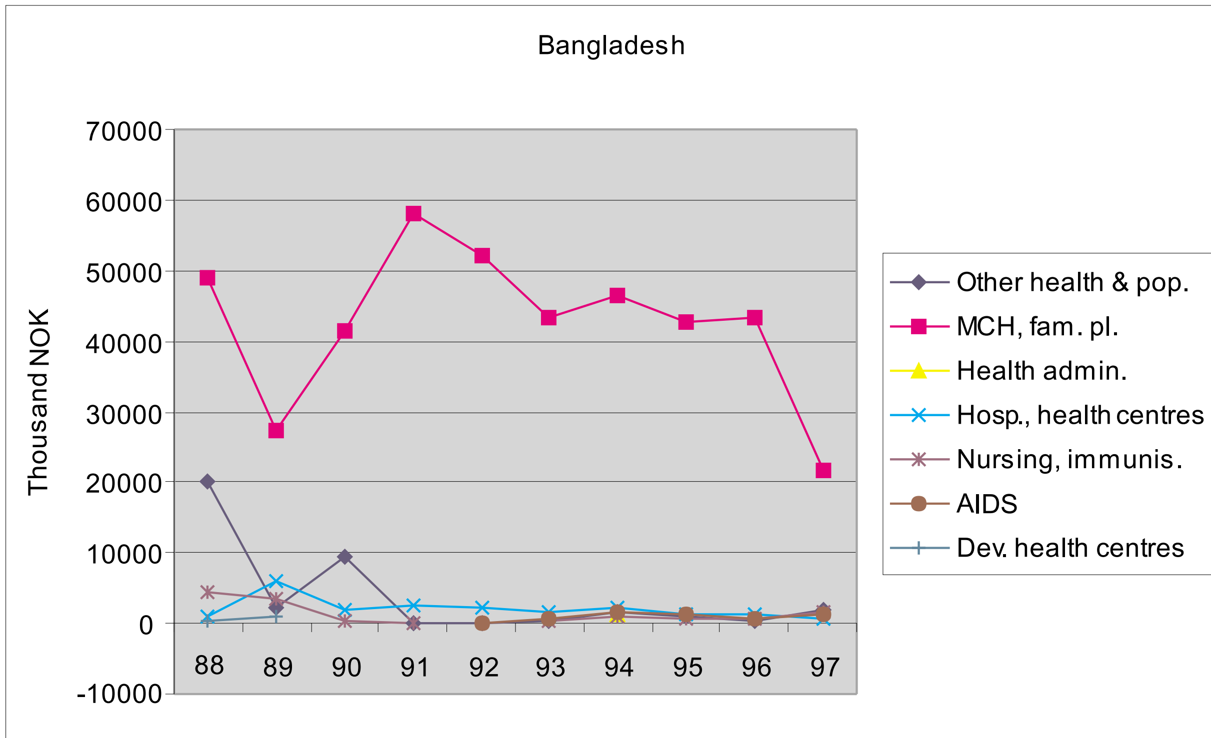
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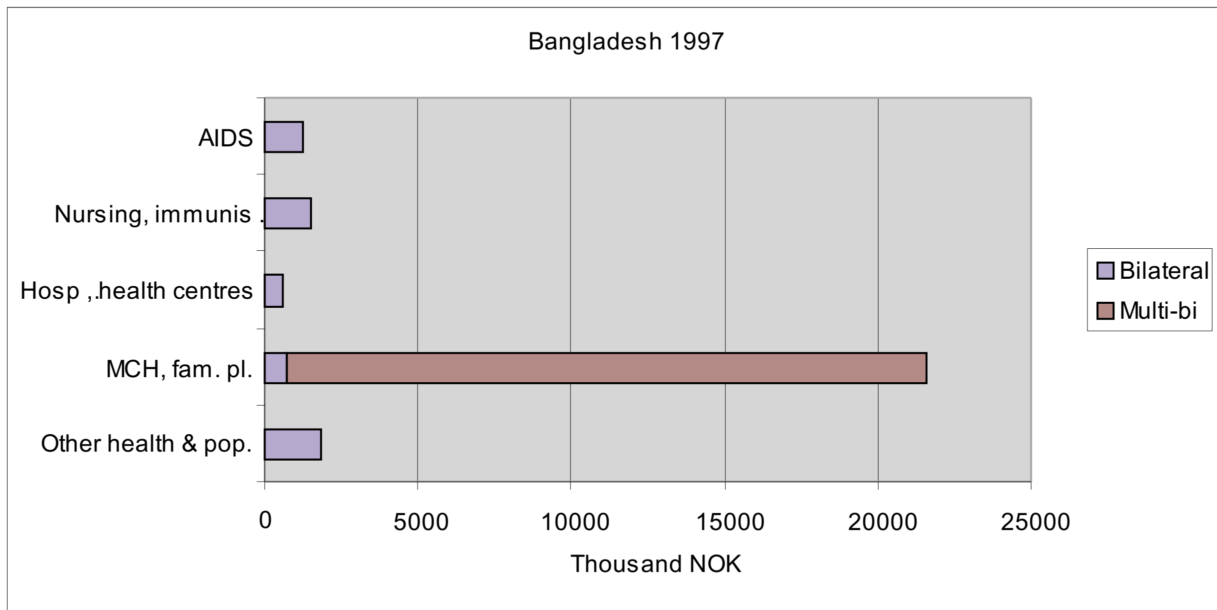
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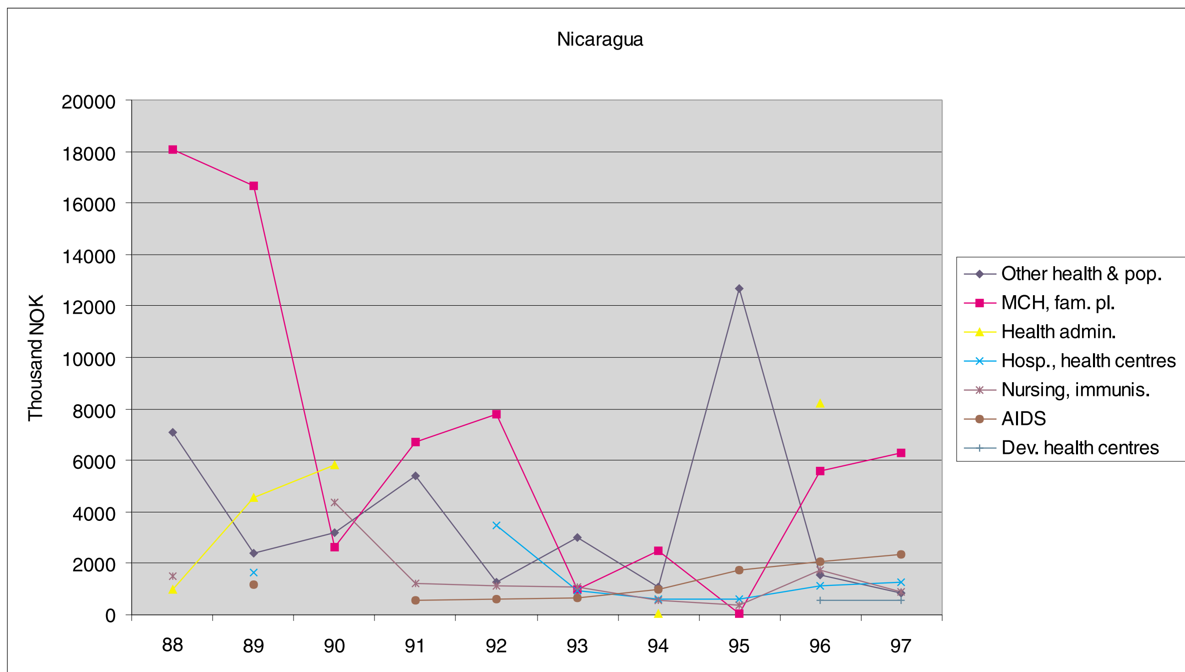
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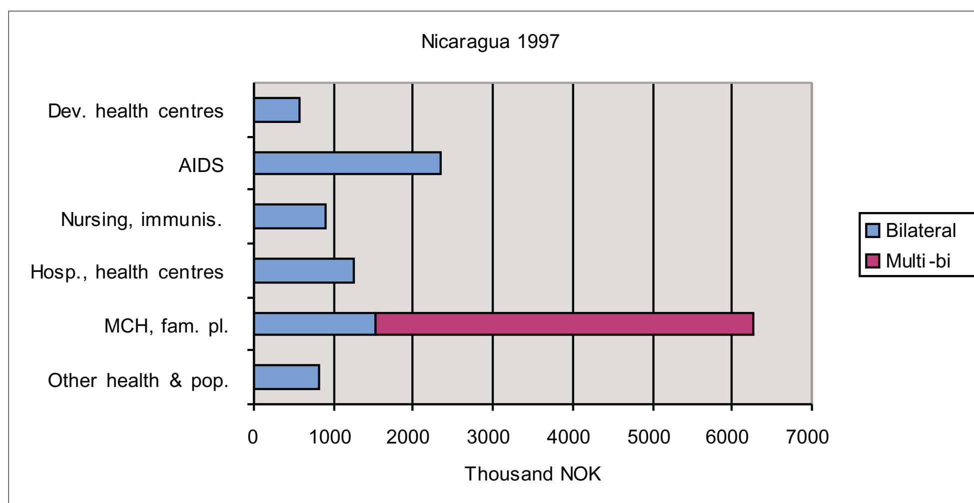
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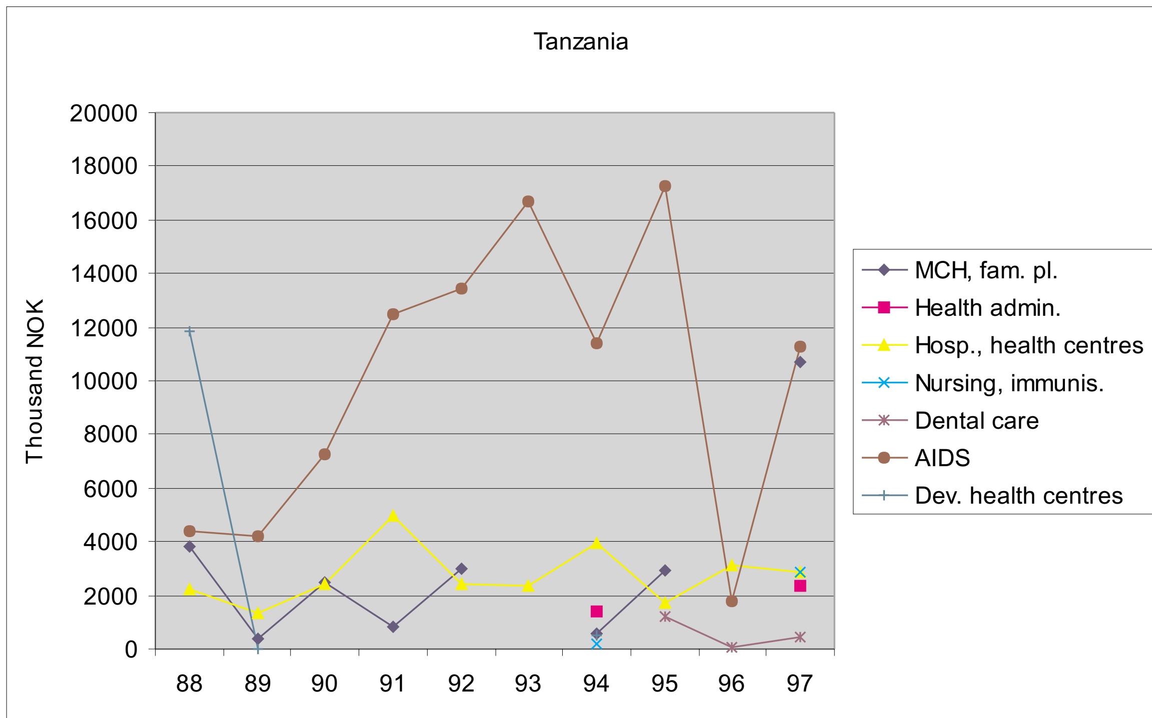
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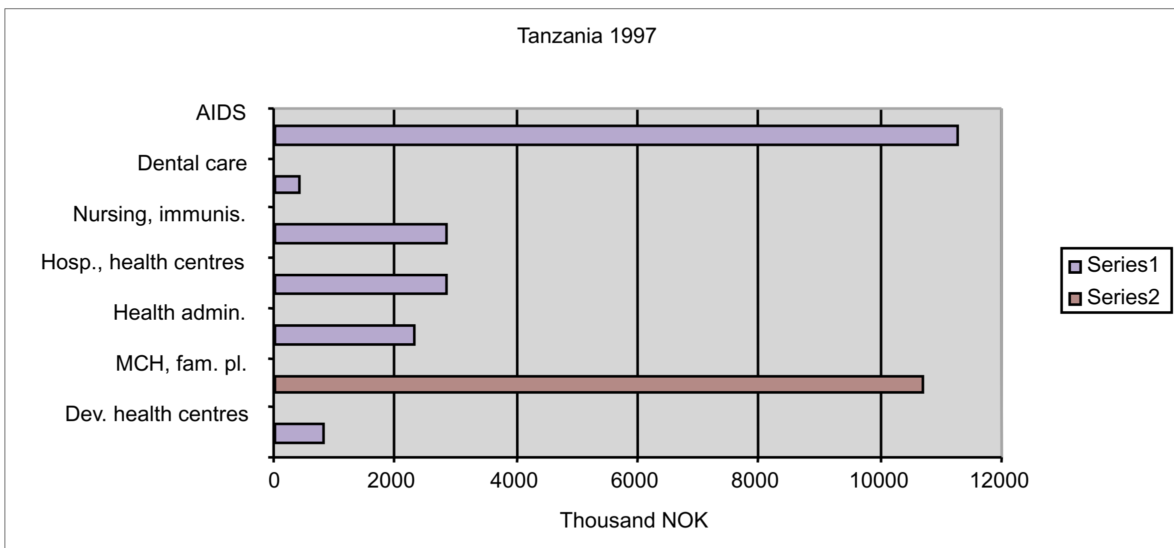
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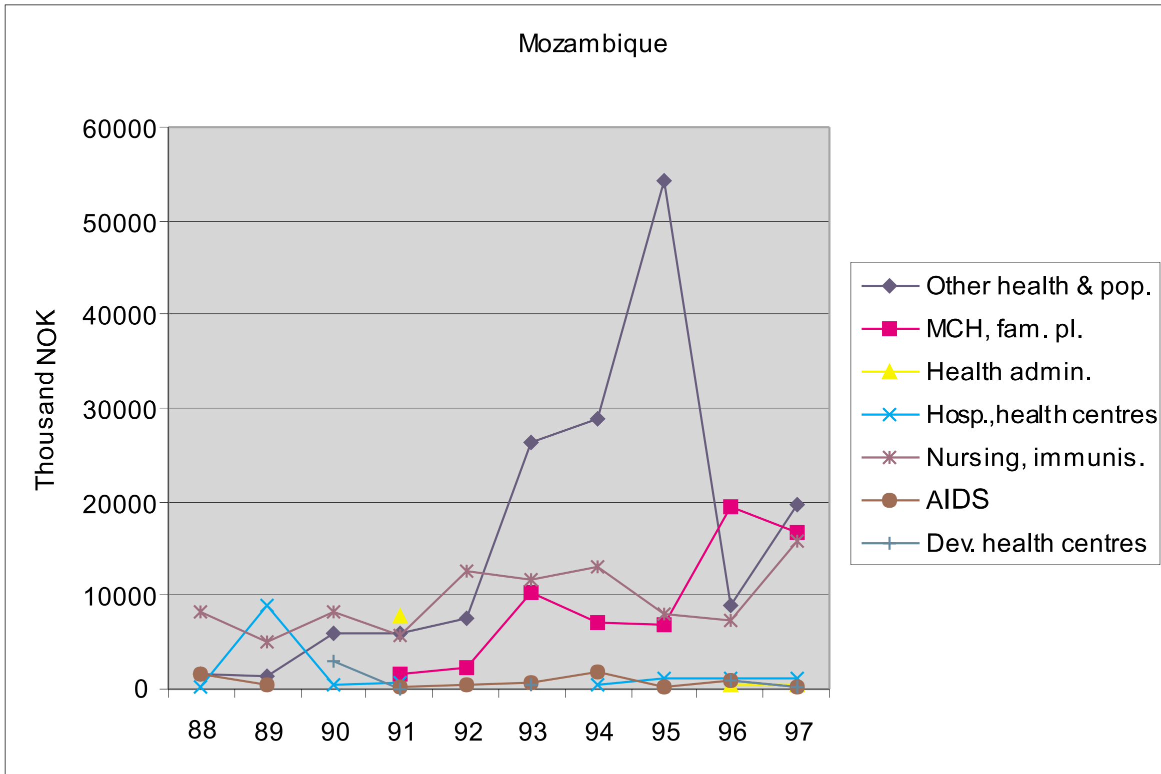
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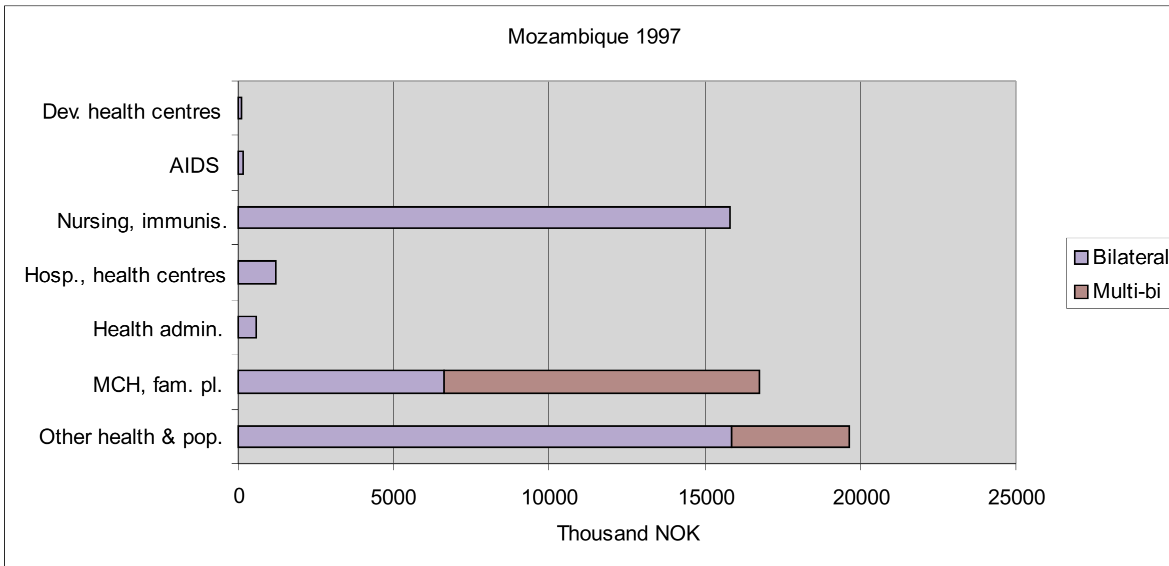
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